KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/25/2016 Time: 13:29 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL (14-1338) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		261,682	-866,384		294,680	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		29,704				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-485,956			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		291,386	-1,352,340		294,680	200

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 resopnd 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 this 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 this 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 appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1900 STATE STREET	P.O. Box:			1
2	City: CHESTER	State: IL	ZIP Code: 62233	County: RANDOLPH	2

Hospital and Hospital-Based Component Identification:

							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	MEMORIAL HOSPITAL	14-1338	99914	1	09 / 01 / 2004	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MEMORIAL HOSPITAL-SWING BEDS	14-Z338	99914		09 / 01 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CHESTER CLINIC	14-8543	99914		06 / 01 / 2015	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2015	To: 06 / 30 / 2016	20
21	Type of control (see instructions)	8		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the 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.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline 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 osteopathci 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

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	Y	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	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 each therapy.	Y	Y	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	279,327	14,394		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:		Contractor's Number:		141
142	Street:	P.O. Box:				142
143	City:	State:	ZIP Code:			143
144	Are provider based physicians' costs included in Worksheet A?			Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			Y	02 / 22 / 2014	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			Y		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			Y		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N		165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)			166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	41,305			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2015	06 / 30 / 2016	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	N			4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	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 instructions)	N		N		16
17	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 in columns 2 and 4. (see instructions)	Y	09/02/2016	Y	09/02/2016	17
18	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 the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	Y	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: GARY	Last name: ZEMAN	Title: VICE PRESIDENT	41
42	Employer: STRATEGIC REIMBURSEMENT, INC.			42
43	Phone number: 630-530-7100 X 112	E-mail Address: GARY.ZEMAN@SRGROUPLLC.COM		43

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	43,608.00		1,001	140	1,817	1
2	HMO and other (see instructions)									2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						140		140	5
6	Hospital Adults & Peds. Swing Bed NF								111	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	43,608.00		1,141	140	2,068	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	43,608.00		1,141	140	2,068	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					7,535	4,162	24,773	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								463	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					298	37	555	1
2	HMO and other (see instructions)								2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		173.71			298	37	555	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		42.97						26
27	Total (sum of lines 14-26)		216.68						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-8543** **WORKSHEET S-8**
STATISTICAL DATA

Check applicable box: **[XX] RHC [ ] FQHC**

Clinic Address and Identification:

1	Street: 2319 OLD PLANK	1
2	City: CHESTER State: IL ZIP Code: 62223 County: RANDOLPH	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

		1	2	
10	Does this facility operate as other than an RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	Y	2	13
14	Provider name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.473317	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,068,718	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	800,322	5
6	Medicaid charges	4,469,601	6
7	Medicaid cost (line 1 times line 6)	2,115,538	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	246,498	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	246,498	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	380,144		380,144	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	179,929		179,929	21
22	Partial payment by patients approved for charity care	47,526		47,526	22
23	Cost of charity care (line 21 minus line 22)	132,403		132,403	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	4,315,861	26
27	Medicare bad debts for the entire hospital complex (see instructions)	202,839	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,113,022	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,946,763	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,079,166	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,325,664	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		920,350	920,350	-412,954	507,396		507,396	1
2	00200	Cap Rel Costs-Mvble Equip				600,694	600,694	-41,305	559,389	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	173,391	3,058,455	3,231,846		3,231,846		3,231,846	4
5	00500	Administrative & General	1,357,263	1,054,401	2,411,664	226,221	2,637,885	-106,988	2,530,897	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	300,980	494,771	795,751	-25	795,726		795,726	7
8	00800	Laundry & Linen Service	47,814	59,386	107,200		107,200		107,200	8
9	00900	Housekeeping	294,982	61,514	356,496		356,496		356,496	9
10	01000	Dietary	355,252	226,354	581,606	-488,916	92,690		92,690	10
11	01100	Cafeteria				472,381	472,381	-59,801	412,580	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	293,804	6,987	300,791		300,791		300,791	13
14	01400	Central Services & Supply	61,808	759,547	821,355	-754,782	66,573		66,573	14
15	01500	Pharmacy	302,011	546,826	848,837	-535,116	313,721		313,721	15
16	01600	Medical Records & Library	381,371	83,636	465,007		465,007	-19,149	445,858	16
17	01700	Social Service	48,001	9,546	57,547		57,547		57,547	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,752,498	63,386	1,815,884		1,815,884		1,815,884	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	595,369	196,846	792,215	-66,000	726,215		726,215	50
54	05400	Radiology-Diagnostic	736,542	617,802	1,354,344	-150	1,354,194	-600	1,353,594	54
60	06000	Laboratory	622,428	736,691	1,359,119	-14,362	1,344,757		1,344,757	60
62	06200	Whole Blood & Packed Red Blood Cells	32,186	110,346	142,532		142,532		142,532	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy		91,037	91,037		91,037		91,037	64
65	06500	Respiratory Therapy	203,308	52,928	256,236	-540	255,696	-29,367	226,329	65
66	06600	Physical Therapy		399,307	399,307		399,307		399,307	66
67	06700	Occupational Therapy		78,316	78,316		78,316		78,316	67
68	06800	Speech Pathology		36,834	36,834		36,834		36,834	68
71	07100	Medical Supplies Charged to Patients				467,472	467,472	-1,241	466,231	71
72	07200	Impl. Dev. Charged to Patients				287,310	287,310		287,310	72
73	07300	Drugs Charged to Patients				408,747	408,747	-64,834	343,913	73
76	03950	CARDIAC REHAB		22,716	22,716	-22,716				76
76.01	03951	CHEMOTHERAPY	172,094	1,323,956	1,496,050	82,629	1,578,679	-10,637	1,568,042	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	2,397,418	2,040,056	4,437,474	-289,144	4,148,330	-804,900	3,343,430	88
90	09000	Clinic	136,216	39,681	175,897	39,251	215,148		215,148	90
91	09100	Emergency	535,473	1,506,092	2,041,565		2,041,565	-1,008,640	1,032,925	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	10,800,209	14,597,767	25,397,976		25,397,976	-2,147,462	23,250,514	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	3,921		3,921		3,921		3,921	190
192	19200	Physicians' Private Offices	16,645	1,153	17,798		17,798		17,798	192
193.01	19301	RHC								193.01
194	07950	NON-ALLOWABLE COSTS								194
200		TOTAL (sum of lines 118-199)	10,820,775	14,598,920	25,419,695		25,419,695	-2,147,462	23,272,233	200

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS DRUG COST	A	Drugs Charged to Patients	73		408,747	1
500	Total reclassifications					408,747	500
	Code Letter - A						
1	RECLASS DEPRECIATION	B	Cap Rel Costs-Mvble Equip	2		472,745	1
500	Total reclassifications					472,745	500
	Code Letter - B						
1	RECLASS MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		467,472	1
2	RECLASS MEDICAL SUPPLIES	C	Impl. Dev. Charged to Patient	72		287,310	2
500	Total reclassifications					754,782	500
	Code Letter - C						
1	RECLASS IV THERAPY	D	CHEMOTHERAPY	76.01		82,629	1
500	Total reclassifications					82,629	500
	Code Letter - D						
1	CARDIAC REHAB	E	Clinic	90		22,716	1
500	Total reclassifications					22,716	500
	Code Letter - E						
1	CAFETRIA	F	Cafeteria	11	296,980	175,401	1
2			Clinic	90		16,535	2
500	Total reclassifications				296,980	191,936	500
	Code Letter - F						
1	MALPRACTICE INSURANCE	G	Administrative & General	5		61,609	1
500	Total reclassifications					61,609	500
	Code Letter - G						
1	LEASE/RENTAL	H	Cap Rel Costs-Mvble Equip	2		127,949	1
2							2
3							3
4							4
5							5
6							6
7							7
500	Total reclassifications					127,949	500
	Code Letter - H						
1	RHC BILLING	I	Administrative & General	5		227,535	1
500	Total reclassifications					227,535	500
	Code Letter - I						
1	RECLASS PROPERTY INSURANCE	L	Cap Rel Costs-Bldg & Fixt	1		59,791	1
500	Total reclassifications					59,791	500
	Code Letter - L						
	GRAND TOTAL (Increases)				296,980	2,410,439	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS DRUG COST	A	Pharmacy	15		408,747		1
500	Total reclassifications					408,747		500
	Code letter - A							
1	RECLASS DEPRECIATION	B	Cap Rel Costs-Bldg & Fixt	1		472,745	9	1
500	Total reclassifications					472,745		500
	Code letter - B							
1	RECLASS MEDICAL SUPPLIES	C	Central Services & Supply	14		754,782		1
2	RECLASS MEDICAL SUPPLIES	C						2
500	Total reclassifications					754,782		500
	Code letter - C							
1	RECLASS IV THERAPY	D	Pharmacy	15		82,629		1
500	Total reclassifications					82,629		500
	Code letter - D							
1	CARDIAC REHAB	E	CARDIAC REHAB	76		22,716		1
500	Total reclassifications					22,716		500
	Code letter - E							
1	CAFETRIA	F	Dietary	10	296,980	175,401		1
2			Dietary	10		16,535		2
500	Total reclassifications				296,980	191,936		500
	Code letter - F							
1	MALPRACTICE INSURANCE	G	Rural Health Clinic	88		61,609		1
500	Total reclassifications					61,609		500
	Code letter - G							
1	LEASE/RENTAL	H	Administrative & General	5		3,132	10	1
2			Operation of Plant	7		25	10	2
3			Pharmacy	15		43,740	10	3
4			Operating Room	50		66,000	10	4
5			Radiology-Diagnostic	54		150	10	5
6			Laboratory	60		14,362	10	6
7			Respiratory Therapy	65		540	10	7
500	Total reclassifications					127,949		500
	Code letter - H							
1	RHC BILLING	I	Rural Health Clinic	88		227,535		1
500	Total reclassifications					227,535		500
	Code letter - I							
1	RECLASS PROPERTY INSURANCE	L	Administrative & General	5		59,791	12	1
500	Total reclassifications					59,791		500
	Code letter - L							
	GRAND TOTAL (Decreases)				296,980	2,410,439		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	237,440				36,036	201,404		1
2	Land Improvements	530,400					530,400		2
3	Buildings and Fixtures	14,817,179				129,434	14,687,745		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	10,041,025				496,117	9,544,908		6
7	HIT-designated Assets	1,560,155	126,872		126,872		1,687,027		7
8	Subtotal (sum of lines 1-7)	27,186,199	126,872		126,872	661,587	26,651,484		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	27,186,199	126,872		126,872	661,587	26,651,484		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	920,350						920,350	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	920,350						920,350	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	16,083,909		16,083,909	0.581915					1
2	Cap Rel Costs-Mvble Equ	11,555,720		11,555,720	0.418085					2
3	Total (sum of lines 1-2)	27,639,629		27,639,629	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	447,605			59,791			507,396	1
2	Cap Rel Costs-Mvble Equip	431,440	127,949					559,389	2
3	Total (sum of lines 1-2)	879,045	127,949		59,791			1,066,785	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-1,241	Medical Supplies Charged to Patients	71		4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-7,264	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,048,644				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-59,801	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-19,149	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-41,305	Cap Rel Costs-Mvble Equip	2	9	32
33							33
34							34
35							35
35.50	REBATES	B	-64,834	Drugs Charged to Patients	73		35.50
36							36
36.03	ADMINISTRATIVE & GENERAL - MISC	B	-1,631	Administrative & General	5		36.03
37							37
38	NON ALLOWABLE SALARIES	A	-4,884	Administrative & General	5		38
38.01	NON ALLOWABLE RHC	A	-661	Rural Health Clinic	88		38.01
39	NON ALLOWABLE OTHER	A	-74,060	Administrative & General	5		39
39.01	NON ALLOWABLE RHC	A	-4,858	Rural Health Clinic	88		39.01
40	CRNA AND MD BILLING EXPENSE	A	-54,526	Rural Health Clinic	88		40
41	RHC CRNA EXPENSE	A	-455,500	Rural Health Clinic	88		41
42	RHC SURGEON	A	-57,115	Rural Health Clinic	88		42
42.01	RHC CONTRACT SURGEON	A	-232,240	Rural Health Clinic	88		42.01
43	MISC INC ANALYSIS 5010-0220	B	-19,149	Administrative & General	5		43
44							44
45							45
45.02	MISC REV PET SCANNER	B	-600	Radiology-Diagnostic	54		45.02
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,147,462				50

(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.

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2	60	Laboratory AGGREGATE	20,400		20,400					2
3	65	Respiratory Therapy AGGREGATE	29,367	29,367						3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE	101,637	10,637	91,000					5
6	91	Emergency AGGREGATE	1,483,250	1,008,640	474,610					6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,634,654	1,048,644	586,010					200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE							29,367	3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE							10,637	5
6	91	Emergency AGGREGATE							1,008,640	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,048,644	200

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	1,133.00	1,299.00	248.00			9
10	AHSEA (see instructions)	70.63	70.63	55.90			10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.32	35.32	27.95			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	80,024	14
15	Therapists (column 2, line 9 times column 2, line 10)	91,748	15
16	Assistants (column 3, line 9 times column 3, line 10)	13,863	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	185,635	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	185,635	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	185,635	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	185,635	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	185,635	63
64	Total cost of outside supplier services (from provider records)	78,316	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	1,136.00	3,815.00	5,214.00	2,092.00		9
10	AHSEA (see instructions)	74.53	74.53	55.90	37.27		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.27	37.27	27.95			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	84,666	14
15	Therapists (column 2, line 9 times column 2, line 10)	284,332	15
16	Assistants (column 3, line 9 times column 3, line 10)	291,463	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	660,461	17
18	Aides (column 4, line 9 times column 4, line 10)	77,969	18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	738,430	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	738,430	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	738,430	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	738,430	63
64	Total cost of outside supplier services (from provider records)	389,591	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	507,396	507,396					1
2	Cap Rel Costs-Mvble Equip	559,389		559,389				2
4	Employee Benefits Department	3,231,846	9,727	10,584	3,252,157			4
5	Administrative & General	2,530,897	60,284	77,115	535,036	3,203,332	3,203,332	5
6	Maintenance & Repairs							6
7	Operation of Plant	795,726	73,791	80,293	118,647	1,068,457	170,544	7
8	Laundry & Linen Service	107,200	4,116	4,479	18,848	134,643	21,491	8
9	Housekeeping	356,496	7,401	8,053	116,282	488,232	77,930	9
10	Dietary	92,690	6,315	6,872	22,971	128,848	20,566	10
11	Cafeteria	412,580	10,593	11,526	117,070	551,769	88,072	11
12	Maintenance of Personnel							12
13	Nursing Administration	300,791	9,704	10,559	115,818	436,872	69,732	13
14	Central Services & Supply	66,573	6,927	7,537	24,365	105,402	16,824	14
15	Pharmacy	313,721	6,460	7,029	119,053	446,263	71,231	15
16	Medical Records & Library	445,858	21,336	23,215	150,337	640,746	102,274	16
17	Social Service	57,547	2,119	2,305	18,922	80,893	12,912	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,815,884	54,650	56,462	690,843	2,617,839	417,852	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	726,215	40,409	43,969	234,696	1,045,289	166,846	50
54	Radiology-Diagnostic	1,353,594	35,363	38,479	290,346	1,717,782	274,187	54
60	Laboratory	1,344,757	14,201	15,452	245,362	1,619,772	258,543	60
62	Whole Blood & Packed Red Blood Cells	142,532	831	904	12,688	156,955	25,053	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	91,037				91,037	14,531	64
65	Respiratory Therapy	226,329	9,900	10,772	80,144	327,145	52,218	65
66	Physical Therapy	399,307	53,952	57,480		510,739	81,523	66
67	Occupational Therapy	78,316	2,038	2,217		82,571	13,180	67
68	Speech Pathology	36,834				36,834	5,879	68
71	Medical Supplies Charged to Patients	466,231				466,231	74,418	71
72	Impl. Dev. Charged to Patients	287,310				287,310	45,860	72
73	Drugs Charged to Patients	343,913				343,913	54,894	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,568,042	14,103	15,345	67,840	1,665,330	265,815	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,343,430				3,343,430	533,661	88
90	Clinic	215,148	21,549	23,448	53,697	313,842	50,095	90
91	Emergency	1,032,925	27,062	29,446	211,085	1,300,518	207,585	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	23,250,514	492,831	543,541	3,244,050	23,211,994	3,193,716	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,921	5,167	5,622	1,546	16,256	2,595	190
192	Physicians' Private Offices	17,798	5,882	6,401	6,561	36,642	5,849	192
193.01	RHC		3,516	3,825		7,341	1,172	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,272,233	507,396	559,389	3,252,157	23,272,233	3,203,332	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,239,001						7
8	Laundry & Linen Service	14,177	170,311					8
9	Housekeeping	25,491		591,653				9
10	Dietary	21,753		10,745	181,912			10
11	Cafeteria	36,487		18,024		694,352		11
12	Maintenance of Personnel							12
13	Nursing Administration	33,425		16,511		34,614	591,154	13
14	Central Services & Supply	23,861		11,787		7,282		14
15	Pharmacy	22,250		10,991		35,581		15
16	Medical Records & Library	73,491		36,302		44,930		16
17	Social Service	7,297		3,605		5,655	10,494	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	178,736	170,311	88,291	181,912	206,468	315,823	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	139,187		68,755		70,142	115,467	50
54	Radiology-Diagnostic	121,808		60,170		86,774		54
60	Laboratory	48,914		24,162		73,330		60
62	Whole Blood & Packed Red Blood Cells	2,863		1,414		3,792		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	34,101		16,845		23,952		65
66	Physical Therapy	181,957		89,881				66
67	Occupational Therapy	7,019		3,467				67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	48,576		23,995		20,275	31,053	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	74,226		36,666		16,048		90
91	Emergency	93,215		45,260		63,086	118,317	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,188,834	170,311	566,871	181,912	691,929	591,154	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	17,796		8,791		462		190
192	Physicians' Private Offices	20,262		10,009		1,961		192
193.01	RHC	12,109		5,982				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,239,001	170,311	591,653	181,912	694,352	591,154	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	165,156						14
15	Pharmacy	14,639	600,955					15
16	Medical Records & Library			897,743				16
17	Social Service				120,856			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			51,614	120,856	4,349,702		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			58,875		1,664,561		50
54	Radiology-Diagnostic			228,452		2,489,173		54
60	Laboratory			191,504		2,216,225		60
62	Whole Blood & Packed Red Blood Cells			9,839		199,916		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	14,651				120,219		64
65	Respiratory Therapy			37,080		491,341		65
66	Physical Therapy			37,248		901,348		66
67	Occupational Therapy			5,869		112,106		67
68	Speech Pathology			1,980		44,693		68
71	Medical Supplies Charged to Patients	82,885		85,945		709,479		71
72	Impl. Dev. Charged to Patients	50,942		18,881		402,993		72
73	Drugs Charged to Patients		152,618	38,150		589,575		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		448,337	86,870		2,590,251		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,039				3,879,130		88
90	Clinic			7,786		498,663		90
91	Emergency			37,650		1,865,631		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	165,156	600,955	897,743	120,856	23,125,006		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					45,900		190
192	Physicians' Private Offices					74,723		192
193.01	RHC					26,604		193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	165,156	600,955	897,743	120,856	23,272,233		202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,349,702						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,664,561						50
54	Radiology-Diagnostic	2,489,173						54
60	Laboratory	2,216,225						60
62	Whole Blood & Packed Red Blood Cells	199,916						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	120,219						64
65	Respiratory Therapy	491,341						65
66	Physical Therapy	901,348						66
67	Occupational Therapy	112,106						67
68	Speech Pathology	44,693						68
71	Medical Supplies Charged to Patients	709,479						71
72	Impl. Dev. Charged to Patients	402,993						72
73	Drugs Charged to Patients	589,575						73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	2,590,251						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,879,130						88
90	Clinic	498,663						90
91	Emergency	1,865,631						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	23,125,006						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	45,900						190
192	Physicians' Private Offices	74,723						192
193.01	RHC	26,604						193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,272,233						202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		9,727	10,584	20,311	20,311		4
5	Administrative & General		60,284	77,115	137,399	3,342	140,741	5
6	Maintenance & Repairs							6
7	Operation of Plant		73,791	80,293	154,084	741	7,493	7
8	Laundry & Linen Service		4,116	4,479	8,595	118	944	8
9	Housekeeping		7,401	8,053	15,454	726	3,424	9
10	Dietary		6,315	6,872	13,187	143	904	10
11	Cafeteria		10,593	11,526	22,119	731	3,870	11
12	Maintenance of Personnel							12
13	Nursing Administration		9,704	10,559	20,263	723	3,064	13
14	Central Services & Supply		6,927	7,537	14,464	152	739	14
15	Pharmacy		6,460	7,029	13,489	744	3,130	15
16	Medical Records & Library		21,336	23,215	44,551	939	4,494	16
17	Social Service		2,119	2,305	4,424	118	567	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		54,650	56,462	111,112	4,315	18,359	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		40,409	43,969	84,378	1,466	7,331	50
54	Radiology-Diagnostic		35,363	38,479	73,842	1,813	12,047	54
60	Laboratory		14,201	15,452	29,653	1,532	11,359	60
62	Whole Blood & Packed Red Blood Cells		831	904	1,735	79	1,101	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						638	64
65	Respiratory Therapy		9,900	10,772	20,672	501	2,294	65
66	Physical Therapy		53,952	57,480	111,432		3,582	66
67	Occupational Therapy		2,038	2,217	4,255		579	67
68	Speech Pathology						258	68
71	Medical Supplies Charged to Patients						3,270	71
72	Impl. Dev. Charged to Patients						2,015	72
73	Drugs Charged to Patients						2,412	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		14,103	15,345	29,448	424	11,679	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic						23,444	88
90	Clinic		21,549	23,448	44,997	335	2,201	90
91	Emergency		27,062	29,446	56,508	1,318	9,121	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		492,831	543,541	1,036,372	20,260	140,319	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,167	5,622	10,789	10	114	190
192	Physicians' Private Offices		5,882	6,401	12,283	41	257	192
193.01	RHC		3,516	3,825	7,341		51	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		507,396	559,389	1,066,785	20,311	140,741	202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	162,318						7
8	Laundry & Linen Service	1,857	11,514					8
9	Housekeeping	3,340		22,944				9
10	Dietary	2,850		417	17,501			10
11	Cafeteria	4,780		699		32,199		11
12	Maintenance of Personnel							12
13	Nursing Administration	4,379		640		1,605	30,674	13
14	Central Services & Supply	3,126		457		338		14
15	Pharmacy	2,915		426		1,650		15
16	Medical Records & Library	9,628		1,408		2,083		16
17	Social Service	956		140		262	545	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	23,416	11,514	3,424	17,501	9,576	16,388	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,234		2,666		3,253	5,991	50
54	Radiology-Diagnostic	15,958		2,333		4,024		54
60	Laboratory	6,408		937		3,400		60
62	Whole Blood & Packed Red Blood Cells	375		55		176		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	4,467		653		1,111		65
66	Physical Therapy	23,838		3,486				66
67	Occupational Therapy	920		134				67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	6,364		931		940	1,611	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	9,724		1,422		744		90
91	Emergency	12,212		1,755		2,925	6,139	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	155,747	11,514	21,983	17,501	32,087	30,674	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,331		341		21		190
192	Physicians' Private Offices	2,654		388		91		192
193.01	RHC	1,586		232				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	162,318	11,514	22,944	17,501	32,199	30,674	202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	19,276						14
15	Pharmacy	1,709	24,063					15
16	Medical Records & Library			63,103				16
17	Social Service				7,012			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			3,629	7,012	226,246		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			4,139		127,458		50
54	Radiology-Diagnostic			16,047		126,064		54
60	Laboratory			13,464		66,753		60
62	Whole Blood & Packed Red Blood Cells			692		4,213		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	1,710				2,348		64
65	Respiratory Therapy			2,607		32,305		65
66	Physical Therapy			2,619		144,957		66
67	Occupational Therapy			413		6,301		67
68	Speech Pathology			139		397		68
71	Medical Supplies Charged to Patients	9,673		6,043		18,986		71
72	Impl. Dev. Charged to Patients	5,946		1,327		9,288		72
73	Drugs Charged to Patients		6,111	2,682		11,205		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		17,952	6,108		75,457		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	238				23,682		88
90	Clinic			547		59,970		90
91	Emergency			2,647		92,625		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,276	24,063	63,103	7,012	1,028,255		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					13,606		190
192	Physicians' Private Offices					15,714		192
193.01	RHC					9,210		193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	19,276	24,063	63,103	7,012	1,066,785		202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	226,246						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	127,458						50
54	Radiology-Diagnostic	126,064						54
60	Laboratory	66,753						60
62	Whole Blood & Packed Red Blood Cells	4,213						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	2,348						64
65	Respiratory Therapy	32,305						65
66	Physical Therapy	144,957						66
67	Occupational Therapy	6,301						67
68	Speech Pathology	397						68
71	Medical Supplies Charged to Patients	18,986						71
72	Impl. Dev. Charged to Patients	9,288						72
73	Drugs Charged to Patients	11,205						73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	75,457						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	23,682						88
90	Clinic	59,970						90
91	Emergency	92,625						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,028,255						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	13,606						190
192	Physicians' Private Offices	15,714						192
193.01	RHC	9,210						193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,066,785						202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT SQ FEET	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	87,896						1
2	Cap Rel Costs-Mvble Equip		89,057					2
4	Employee Benefits Department	1,685	1,685	8,249,966				4
5	Administrative & General	10,443	12,277	1,357,263	-3,203,332	20,068,901		5
6	Maintenance & Repairs							6
7	Operation of Plant	12,783	12,783	300,980		1,068,457	62,312	7
8	Laundry & Linen Service	713	713	47,814		134,643	713	8
9	Housekeeping	1,282	1,282	294,982		488,232	1,282	9
10	Dietary	1,094	1,094	58,272		128,848	1,094	10
11	Cafeteria	1,835	1,835	296,980		551,769	1,835	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,681	1,681	293,804		436,872	1,681	13
14	Central Services & Supply	1,200	1,200	61,808		105,402	1,200	14
15	Pharmacy	1,119	1,119	302,011		446,263	1,119	15
16	Medical Records & Library	3,696	3,696	381,371		640,746	3,696	16
17	Social Service	367	367	48,001		80,893	367	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,467	8,989	1,752,498		2,617,839	8,989	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,000	7,000	595,369		1,045,289	7,000	50
54	Radiology-Diagnostic	6,126	6,126	736,542		1,717,782	6,126	54
60	Laboratory	2,460	2,460	622,428		1,619,772	2,460	60
62	Whole Blood & Packed Red Blood Cells	144	144	32,186		156,955	144	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					91,037		64
65	Respiratory Therapy	1,715	1,715	203,308		327,145	1,715	65
66	Physical Therapy	9,346	9,151			510,739	9,151	66
67	Occupational Therapy	353	353			82,571	353	67
68	Speech Pathology					36,834		68
71	Medical Supplies Charged to Patients					466,231		71
72	Impl. Dev. Charged to Patients					287,310		72
73	Drugs Charged to Patients					343,913		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	2,443	2,443	172,094		1,665,330	2,443	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					3,343,430		88
90	Clinic	3,733	3,733	136,216		313,842	3,733	90
91	Emergency	4,688	4,688	535,473		1,300,518	4,688	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	85,373	86,534	8,229,400	-3,203,332	20,008,662	59,789	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	895	895	3,921		16,256	895	190
192	Physicians' Private Offices	1,019	1,019	16,645		36,642	1,019	192
193.01	RHC	609	609			7,341	609	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	507,396	559,389	3,252,157		3,203,332	1,239,001	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.772686	6.281247	0.394202		0.159617	19.883827	203
204	Cost to be allocated (Per Wkst. B, Part II)			20,311		140,741	162,318	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.002462		0.007013	2.604924	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINI-STRATION SALARIES	CENTRAL SERVICES & SUPPLY COSTED REQUIS	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	1,817						8
9	Housekeeping		60,237					9
10	Dietary		1,094	1,817				10
11	Cafeteria		1,835		5,893,675			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,681		293,804	2,987,982		13
14	Central Services & Supply		1,200		61,808		931,473	14
15	Pharmacy		1,119		302,011		82,562	15
16	Medical Records & Library		3,696		381,371			16
17	Social Service		367		48,001	53,040		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,817	8,989	1,817	1,752,498	1,596,327		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		7,000		595,369	583,625		50
54	Radiology-Diagnostic		6,126		736,542			54
60	Laboratory		2,460		622,428			60
62	Whole Blood & Packed Red Blood Cells		144		32,186			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						82,629	64
65	Respiratory Therapy		1,715		203,308			65
66	Physical Therapy		9,151					66
67	Occupational Therapy		353					67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						467,472	71
72	Impl. Dev. Charged to Patients						287,310	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		2,443		172,094	156,959		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic						11,500	88
90	Clinic		3,733		136,216			90
91	Emergency		4,608		535,473	598,031		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,817	57,714	1,817	5,873,109	2,987,982	931,473	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		895		3,921			190
192	Physicians' Private Offices		1,019		16,645			192
193.01	RHC		609					193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	170,311	591,653	181,912	694,352	591,154	165,156	202
203	Unit Cost Multiplier (Wkst. B, Part I)	93.731976	9.822086	100.116676	0.117813	0.197844	0.177306	203
204	Cost to be allocated (Per Wkst. B, Part II)	11,514	22,944	17,501	32,199	30,674	19,276	204
205	Unit Cost Multiplier (Wkst. B, Part II)	6.336819	0.380895	9.631811	0.005463	0.010266	0.020694	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS				
		15	16	17				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	1,609,501						15
16	Medical Records & Library		41,910,729					16
17	Social Service			1,817				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,409,615	1,817				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,748,584					50
54	Radiology-Diagnostic		10,664,684					54
60	Laboratory		8,940,415					60
62	Whole Blood & Packed Red Blood Cells		459,360					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy		1,731,076					65
66	Physical Therapy		1,738,917					66
67	Occupational Therapy		274,016					67
68	Speech Pathology		92,450					68
71	Medical Supplies Charged to Patients		4,012,391					71
72	Impl. Dev. Charged to Patients		881,465					72
73	Drugs Charged to Patients	408,747	1,781,026					73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,200,754	4,055,552					76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic		363,473					90
91	Emergency		1,757,705					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,609,501	41,910,729	1,817				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193.01	RHC							193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	600,955	897,743	120,856				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.373380	0.021420	66.514034				203
204	Cost to be allocated (Per Wkst. B, Part II)	24,063	63,103	7,012				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.014951	0.001506	3.859108				205

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,349,702		4,349,702			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,664,561		1,664,561			50
54	Radiology-Diagnostic	2,489,173		2,489,173			54
60	Laboratory	2,216,225		2,216,225			60
62	Whole Blood & Packed Red Blood Cells	199,916		199,916			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	120,219		120,219			64
65	Respiratory Therapy	491,341		491,341			65
66	Physical Therapy	901,348		901,348			66
67	Occupational Therapy	112,106		112,106			67
68	Speech Pathology	44,693		44,693			68
71	Medical Supplies Charged to Patients	709,479		709,479			71
72	Impl. Dev. Charged to Patients	402,993		402,993			72
73	Drugs Charged to Patients	589,575		589,575			73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	2,590,251		2,590,251			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	3,879,130		3,879,130			88
90	Clinic	498,663		498,663			90
91	Emergency	1,865,631		1,865,631			91
92	Observation Beds (Non-Distinct Part)	829,145		829,145			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	23,954,151		23,954,151			200
201	Less Observation Beds	829,145		829,145			201
202	Total (line 200 minus line 201)	23,125,006		23,125,006			202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	1,873,548		1,873,548				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	379,276	2,369,308	2,748,584	0.605607			50
54	Radiology-Diagnostic	357,444	10,307,240	10,664,684	0.233403			54
60	Laboratory	903,491	8,036,924	8,940,415	0.247888			60
62	Whole Blood & Packed Red Blood Cells	109,997	349,363	459,360	0.435206			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	184,173	1,458,637	1,642,810	0.073179			64
65	Respiratory Therapy	372,280	1,358,796	1,731,076	0.283836			65
66	Physical Therapy	267,968	1,470,949	1,738,917	0.518339			66
67	Occupational Therapy	81,713	192,303	274,016	0.409122			67
68	Speech Pathology	18,400	74,050	92,450	0.483429			68
71	Medical Supplies Charged to Patients	1,007,668	3,004,723	4,012,391	0.176822			71
72	Impl. Dev. Charged to Patients	535,916	345,549	881,465	0.457185			72
73	Drugs Charged to Patients	514,431	1,266,595	1,781,026	0.331031			73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	139,865	2,272,879	2,412,744	1.073571			76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		6,946,630	6,946,630				88
90	Clinic	146	363,327	363,473	1.371940			90
91	Emergency	6,930	1,750,775	1,757,705	1.061402			91
92	Observation Beds (Non-Distinct Part)		536,067	536,067	1.546719			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	6,753,246	42,104,115	48,857,361				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	6,753,246	42,104,115	48,857,361				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1338** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.605607		748,515			453,306		50
54	Radiology-Diagnostic	0.233403		3,234,033			754,833		54
60	Laboratory	0.247888		3,162,716			783,999		60
62	Whole Blood & Packed Red Blood	0.435206		76,953			33,490		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.073179		196,093			14,350		64
65	Respiratory Therapy	0.283836		461,522			130,997		65
66	Physical Therapy	0.518339		548,377			284,245		66
67	Occupational Therapy	0.409122		52,662			21,545		67
68	Speech Pathology	0.483429		34,007			16,440		68
71	Medical Supplies Charged to Pat	0.176822		1,277,008			225,803		71
72	Impl. Dev. Charged to Patients	0.457185		93,334			42,671		72
73	Drugs Charged to Patients	0.331031		309,042			102,302		73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.073571		1,381,049	6,354		1,482,654	6,821	76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.371940		145,530			199,658		90
91	Emergency	1.061402		569,019	2,340		603,958	2,484	91
92	Observation Beds (Non-Distinct	1.546719		201,679			311,941		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			12,491,539	8,694		5,462,192	9,305	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			12,491,539	8,694		5,462,192	9,305	202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z338** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.605607							50
54	Radiology-Diagnostic	0.233403							54
60	Laboratory	0.247888							60
62	Whole Blood & Packed Red Blood	0.435206							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.073179							64
65	Respiratory Therapy	0.283836							65
66	Physical Therapy	0.518339							66
67	Occupational Therapy	0.409122							67
68	Speech Pathology	0.483429							68
71	Medical Supplies Charged to Pat	0.176822							71
72	Impl. Dev. Charged to Patients	0.457185							72
73	Drugs Charged to Patients	0.331031							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.073571							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.371940							90
91	Emergency	1.061402							91
92	Observation Beds (Non-Distinct	1.546719							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	226,246	13,870	212,376	2,280	93.15	140	13,041	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	226,246		212,376	2,280		140	13,041	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1338** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	127,458	2,748,584	0.046372	30,312	1,406	50
54	Radiology-Diagnostic	126,064	10,664,684	0.011821	64,734	765	54
60	Laboratory	66,753	8,940,415	0.007466	99,125	740	60
62	Whole Blood & Packed Red Blood	4,213	459,360	0.009171	7,386	68	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	2,348	1,642,810	0.001429			64
65	Respiratory Therapy	32,305	1,731,076	0.018662	18,661	348	65
66	Physical Therapy	144,957	1,738,917	0.083361			66
67	Occupational Therapy	6,301	274,016	0.022995			67
68	Speech Pathology	397	92,450	0.004294			68
71	Medical Supplies Charged to Pat	18,986	4,012,391	0.004732	72,419	343	71
72	Impl. Dev. Charged to Patients	9,288	881,465	0.010537	6,507	69	72
73	Drugs Charged to Patients	11,205	1,781,026	0.006291			73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	75,457	2,412,744	0.031274			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	23,682	6,946,630	0.003409			88
90	Clinic	59,970	363,473	0.164992			90
91	Emergency	92,625	1,757,705	0.052697			91
92	Observation Beds (Non-Distinct	43,127	536,067	0.080451			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	845,136	46,983,813		299,144	3,739	200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[ ] PPS
[ ] TEFRA
[XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,280		140		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	2,280		140		200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1338** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1338** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [ ] PPS [ ] TEFRA [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,748,584			30,312				50
54	Radiology-Diagnostic	10,664,684			64,734				54
60	Laboratory	8,940,415			99,125				60
62	Whole Blood & Packed Red Blood	459,360			7,386				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,642,810							64
65	Respiratory Therapy	1,731,076			18,661				65
66	Physical Therapy	1,738,917							66
67	Occupational Therapy	274,016							67
68	Speech Pathology	92,450							68
71	Medical Supplies Charged to Pat	4,012,391			72,419				71
72	Impl. Dev. Charged to Patients	881,465			6,507				72
73	Drugs Charged to Patients	1,781,026							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	2,412,744							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	6,946,630							88
90	Clinic	363,473							90
91	Emergency	1,757,705							91
92	Observation Beds (Non-Distinct	536,067							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	46,983,813			299,144				200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1338** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[XX] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.605607							50
54	Radiology-Diagnostic	0.233403							54
60	Laboratory	0.247888							60
62	Whole Blood & Packed Red Blood	0.435206							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.073179							64
65	Respiratory Therapy	0.283836							65
66	Physical Therapy	0.518339							66
67	Occupational Therapy	0.409122							67
68	Speech Pathology	0.483429							68
71	Medical Supplies Charged to Pat	0.176822							71
72	Impl. Dev. Charged to Patients	0.457185							72
73	Drugs Charged to Patients	0.331031							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.073571							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.371940							90
91	Emergency	1.061402							91
92	Observation Beds (Non-Distinct	1.546719							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1338** **WORKSHEET D-1 PART I**

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,531	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,280	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,817	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	70	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	70	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	55	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	56	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,001	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	70	10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	70	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.66	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.73	20
21	Total general inpatient routine service cost (see instructions)	4,349,702	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	7,681	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	8,273	25
26	Total swing-bed cost (see instructions)	266,666	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,083,036	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,083,036	37

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[ ] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,790.80	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,792,591	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,792,591	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					750,413	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,543,004	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					125,356	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					125,356	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					250,712	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[ ] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					463	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,790.81	88
89	Observation bed cost (line 87 x line 88) (see instructions)					829,145	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	226,246	4,349,702	0.052014	829,145	43,127	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1338** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,531	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,280	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,817	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	70	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	70	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	55	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	56	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	140	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.66	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.73	20
21	Total general inpatient routine service cost (see instructions)	4,349,702	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	7,681	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	8,273	25
26	Total swing-bed cost (see instructions)	266,666	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,083,036	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,083,036	37

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,790.80	38
39	Program general inpatient routine service cost (line 9 x line 38)					250,712	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					250,712	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					82,329	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					333,041	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					13,041	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,739	51
52	Total Program excludable cost (sum of lines 50 and 51)					16,780	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					463	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1338** **WORKSHEET D-3**

Check	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		937,665		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.605607	147,512	89,334	50
54	Radiology-Diagnostic	0.233403	234,654	54,769	54
60	Laboratory	0.247888	544,126	134,882	60
62	Whole Blood & Packed Red Blood Cells	0.435206	37,396	16,275	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.073179	508	37	64
65	Respiratory Therapy	0.283836	233,628	66,312	65
66	Physical Therapy	0.518339	102,283	53,017	66
67	Occupational Therapy	0.409122	22,111	9,046	67
68	Speech Pathology	0.483429	16,094	7,780	68
71	Medical Supplies Charged to Patients	0.176822	581,910	102,894	71
72	Impl. Dev. Charged to Patients	0.457185	189,073	86,441	72
73	Drugs Charged to Patients	0.331031	379,163	125,515	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.073571			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.371940			90
91	Emergency	1.061402	3,873	4,111	91
92	Observation Beds (Non-Distinct Part)	1.546719			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,492,331	750,413	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,492,331		202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z338** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.605607	4,807	2,911	50
54	Radiology-Diagnostic	0.233403	3,735	872	54
60	Laboratory	0.247888	24,472	6,066	60
62	Whole Blood & Packed Red Blood Cells	0.435206			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.073179			64
65	Respiratory Therapy	0.283836	11,496	3,263	65
66	Physical Therapy	0.518339	45,989	23,838	66
67	Occupational Therapy	0.409122	21,342	8,731	67
68	Speech Pathology	0.483429	1,086	525	68
71	Medical Supplies Charged to Patients	0.176822	22,373	3,956	71
72	Impl. Dev. Charged to Patients	0.457185			72
73	Drugs Charged to Patients	0.331031	20,203	6,688	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.073571			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.371940			90
91	Emergency	1.061402			91
92	Observation Beds (Non-Distinct Part)	1.546719			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		155,503	56,850	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		155,503		202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1338** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		100,038		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.605607	30,312	18,357	50
54	Radiology-Diagnostic	0.233403	64,734	15,109	54
60	Laboratory	0.247888	99,125	24,572	60
62	Whole Blood & Packed Red Blood Cells	0.435206	7,386	3,214	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.073179			64
65	Respiratory Therapy	0.283836	18,661	5,297	65
66	Physical Therapy	0.518339			66
67	Occupational Therapy	0.409122			67
68	Speech Pathology	0.483429			68
71	Medical Supplies Charged to Patients	0.176822	72,419	12,805	71
72	Impl. Dev. Charged to Patients	0.457185	6,507	2,975	72
73	Drugs Charged to Patients	0.331031			73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.073571			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.371940			90
91	Emergency	1.061402			91
92	Observation Beds (Non-Distinct Part)	1.546719			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		299,144	82,329	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		299,144		202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1338** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,471,497			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,471,497			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	5,526,212			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	15,226			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,892,194			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,618,792			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,618,792			30
31	Primary payer payments	90			31
32	Subtotal (line 30 minus line 31)	3,618,702			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	244,357			34
35	Adjusted reimbursable bad debts (see instructions)	158,832			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	186,153			36
37	Subtotal (see instructions)	3,777,534			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,777,534			40
40.01	Sequestration adjustment (see instructions)	75,551			40.01
41	Interim payments	4,568,367			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-866,384			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1338** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,255,049		4,723,400	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				33,083		192,915	2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	03/01/2016	154,399	03/01/2016	215,401	3.51
		Provider	.52	06/16/2016	68,686	06/16/2016	132,547	3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-223,085		-347,948	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,065,047		4,568,367	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		261,682			6.01
	based on the cost report (1)		.02				-866,384	6.02
7	Total Medicare program liability (see instructions)				2,326,729		3,701,983	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z338** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [XX] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				299,511			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	03/01/2016	20,854			3.50
			.51	06/16/2016	5,325			3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-26,179			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				273,332			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		29,704			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				303,036			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	555	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,001	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,817	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	48,857,361	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	380,144	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	41,305	7
8	Calculation of the HIT incentive payment (see instructions)	31,194	8
9	Sequestration adjustment amount (see instructions)	624	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	30,570	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	30,570	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z338** **WORKSHEET E-2**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX** **[XX] Swing Bed - SNF** **[ ] Swing Bed - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	253,219		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	57,419		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	140		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	310,638		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	310,638		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	310,638		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,418		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	309,220		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	309,220		19
19.01	Sequestration adjustment (see instructions)	6,184		19.01
20	Interim payments	273,332		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	29,704		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART V

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services	2,543,004	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,543,004	4
5	Primary payer payments	2,200	5
6	Total cost (see instructions)	2,566,234	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,566,234	19
20	Deductibles (exclude professional component)	215,320	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,350,914	22
23	Coinsurance	3,521	23
24	Subtotal (line 22 minus line 23)	2,347,393	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41,261	25
26	Adjusted reimbursable bad debts (see instructions)	26,820	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,771	27
28	Subtotal (sum of lines 24 and 26)	2,374,213	28
29	Other adjustments (QUESTRATION)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,374,213	30
30.01	Sequestration adjustment (see instructions)	47,484	30.01
31	Interim payments	2,065,047	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	261,682	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1338** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	333,041		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	333,041		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	333,041		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	90,936		8
9	Ancillary service charges	299,144		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	390,080		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	390,080		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	333,041		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	333,041		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	333,041		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	333,041		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	333,041		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	333,041		40
41	Interim payments	38,361		41
42	Balance due provider/program (line 40 minus line 41)	294,680		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	5,672,185				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	16,948,306				4
5	Other receivables	241,340				5
6	Allowances for uncollectible notes and accounts receivable	-12,147,952				6
7	Inventory	679,632				7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	11,393,511				11
	FIXED ASSETS					
12	Land	201,404				12
13	Land improvements	607,492				13
14	Accumulated depreciation	-472,950				14
15	Buildings	14,023,904				15
16	Accumulated depreciation	-7,665,810				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	922,709				19
20	Accumulated depreciation	-812,110				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,945,992				23
24	Accumulated depreciation	-9,892,578				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	8,858,053				30
	OTHER ASSETS					
31	Investments	23,198,965				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)	23,198,965				35
36	Total assets (sum of lines 11, 30 and 35)	43,450,529				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	930,177				37
38	Salaries, wages and fees payable	940,066				38
39	Payroll taxes payable	10,349				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,104,650				44
45	Total current liabilities (sum of lines 37 thru 44)	2,985,242				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)	2,985,242				51
	CAPITAL ACCOUNTS					
52	General fund balance	40,465,287				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	40,465,287				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	43,450,529				60

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		38,145,829			1
2	Net income (loss) (from Worksheet G-3, line 29)		-5,331,208			2
3	Total (sum of line 1 and line 2)		32,814,621			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		32,814,621			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,814,621			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,415,271		2,415,271	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	2,415,271		2,415,271	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	2,415,271		2,415,271	17
18	Ancillary services	4,992,289		4,992,289	18
19	Outpatient services		36,384,849	36,384,849	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,407,560	36,384,849	43,792,409	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		25,419,695	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		25,419,695	43

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	43,792,409	1
2	Less contractual allowances and discounts on patients' accounts	24,262,527	2
3	Net patient revenues (line 1 minus line 2)	19,529,882	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	25,419,695	4
5	Net income from service to patients (line 3 minus line 4)	-5,889,813	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	93,499	6
7	Income from investments	366,601	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER NON OPERATING REVENUE)	410,404	24
24.01	Other (OTHER NON OPERATING)	-464,612	24.01
24.02	Other (RHC OTHER AND NON OPERATING)	152,713	24.02
25	Total other income (sum of lines 6-24)	558,605	25
26	Total (line 5 plus line 25)	-5,331,208	26
29	Net income (or loss) for the period (line 26 minus line 28)	-5,331,208	29

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193.01	RHC							193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-8543

WORKSHEET M-1

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	984,446	687,740	1,672,186		1,672,186	-512,615	1,159,571	1
2	Physician Assistant	207,540		207,540		207,540		207,540	2
3	Nurse Practitioner	98,286		98,286		98,286		98,286	3
4	Visiting Nurse								4
5	Other Nurse	270,089		270,089		270,089		270,089	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian	88,159		88,159		88,159		88,159	8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	1,648,520	687,740	2,336,260		2,336,260	-512,615	1,823,645	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		148,834	148,834		148,834		148,834	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		61,609	61,609	-61,609				18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		210,443	210,443	-61,609	148,834		148,834	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,648,520	898,183	2,546,703	-61,609	2,485,094	-512,615	1,972,479	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		230,809	230,809		230,809		230,809	29
30	Administrative Costs	748,900	911,062	1,659,962	-227,535	1,432,427	-292,285	1,140,142	30
31	Total Facility Overhead (sum of lines 29 and 30)	748,900	1,141,871	1,890,771	-227,535	1,663,236	-292,285	1,370,951	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	2,397,420	2,040,054	4,437,474	-289,144	4,148,330	-804,900	3,343,430	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8543** **WORKSHEET M-2**

Check applicable box: [XX] RHC I [ ] FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	3.00	14,263	4,200	12,600		1
2	Physician Assistants	2.00	7,018	2,100	4,200		2
3	Nurse Practitioners	1.00	3,492	2,100	2,100		3
4	Subtotal (sum of lines 1 through 3)	6.00	24,773		18,900	24,773	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	6.00	24,773			24,773	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,972,479	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,972,479	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	1,370,951	14
15	Parent provider overhead allocated to facility (see instructions)	535,700	15
16	Total overhead (sum of lines 14 and 15)	1,906,651	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,906,651	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,906,651	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	3,879,130	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8543** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	3,879,130	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	300,575	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	3,578,555	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	24,773	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	24,773	6
7	Adjusted cost per visit (line 3 divided by line 6)	144.45	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	300.00			8
9	Rate for program covered visits (see instructions)	144.45	144.45	144.45	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	7,535			10
11	Program cost excluding costs for mental health services (line 9 x line 10)	1,088,431			11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,088,431		16
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		870,745		16.04
16.05	Total program cost (see instructions)		870,745		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)				18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				19
20	Net Medicare cost excluding vaccines (see instructions)		870,745		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		147,909		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,018,654		22
23	Allowable bad debts (see instructions)		26,442		23
23.01	Adjusted reimbursable bad debts (see instructions)		17,187		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		26,442		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,035,841		26
26.01	Sequestration adjustment (see instructions)		20,717		26.01
27	Interim payments		1,501,080		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-485,956		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8543** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,823,645	1,823,645	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002384	0.012862	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,348	23,456	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	58,087	66,947	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	62,435	90,403	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,972,479	1,972,479	6
7	Total overhead (from Wkst. M-2, line 16)	1,906,651	1,906,651	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.031653	0.045832	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	60,351	87,386	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	122,786	177,789	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	235	1,268	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	522.49	140.21	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	110	645	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	57,474	90,435	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		300,575	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		147,909	16

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 13:29 Version: 2016.05 (11/15/2016)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8543

WORKSHEET M-5

Check applicable box: [XX] RHC I [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				913,301	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01	03/01/2016	454,274	3.01
	amount based on subsequent revision of the interim		.02	06/16/2016	133,505	3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		587,779	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				1,501,080	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02		-485,956	6.02
7	Total Medicare program liability (see instructions)				1,015,124	
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.