



COMPU-MAX

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/22/2014 Run Time: 12:50 Version: 2014.10
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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. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 11/22/2014	TIME: 12:50
		2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
		3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
		4. <input type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____	
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____	
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.	
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN		
	4 -REOPENED			
	5 -AMENDED			

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 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 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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		-296,246	178,680	-9,811	159,043	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-75,162				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-371,408	178,680	-9,811	159,043	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 RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE 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.



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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	
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	
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								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 / 2013	To: 06 / 30 / 2014						20	
21	Type of control (see instructions)	8							21	
Inpatient PPS Information								1	2	
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
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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									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 in effect in the cost reporting period.								37	
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:	Ending:			38	
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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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 Worksheet L, Part III and L-1, Parts I through 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 Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part 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 osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
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 received 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 Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63



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WORKSHEET S-2
PART I

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 non-provider 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)						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 non-provider 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 Facility 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						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
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



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WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX			
		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/MR 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	Column 1: 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. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.	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		
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
		Physical	Occupational	Speech	Respiratory	
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'	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:	4,392				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
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 certified 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 certified 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 Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.		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, section 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		Title V	Title XIX
		Part A	Part B	2	3
			1		
155	Hospital	N	N	N	N
156	Subprovider - IPF	N	N		
157	Subprovider - IRF	N	N		
158	Subprovider - Other				
159	SNF	N	N		
160	HHA	N	N		
161	CMHC		N		
161.10	CORF				
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.				166
	Name	County	State	ZIP Code	CBSA
	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)		867,890		168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional 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)			07/01/2012	09/30/2012



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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
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		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 ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	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	
PS&R REPORT DATA		Y/N	DATE	Y/N	DATE
		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	
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	09/05/2014	Y	09/05/2014
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	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



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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 COSTS			
22	HAVE ASSETS BEEN RELIEFED 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 CAPITALIZED 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
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1 N	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
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	
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N	
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
COST REORT PREPARER INFORMATION			
41	FIRST NAME: RAJ	LAST NAME: SHAH	TITLE: SR. CONSULTANT
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.		
43	PHONE NUMBER: 630-530-7100 X 107	E-MAIL ADDRESS: RAJ.SHAH@SRINC.ORG	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						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	38,064.00		1,004	73	1,586	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						247		247	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								51	6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		25	9,125	38,064.00		1,251	73	1,884	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	38,064.00		1,251	73	1,884	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								26
27	TOTAL (sum of lines 14-26)		25							27
28	OBSERVATION BED DAYS								432	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		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)					282	21	471	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)		165.49			282	21	471	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								26
27	TOTAL (sum of lines 14-26)		165.49						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (see instructions)	200	7,942,261		344,229.00		1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A - ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (in an approved program)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (see instructions)		15,986	19,612	1,203.00		10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		38,505		388.00		11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING						16
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)						17
18	WAGE-RELATED COSTS (other)(see instructions)		2,573,169				18
19	EXCLUDED AREAS		11,372				19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (in an approved program)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		153,033		6,253.00		26
27	ADMINISTRATIVE & GENERAL		1,438,973		55,762.00		27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		35,222		204.00		28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		331,313		13,259.00		30
31	LAUNDRY & LINEN SERVICE		55,322		3,740.00		31
32	HOUSEKEEPING		250,646		21,203.00		32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)						33
34	DIETARY		331,453	-218,804	9,770.00		34
35	DIETARY UNDER CONTRACT (see instructions)						35
36	CAFETERIA			199,192	17,275.00		36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		272,148		9,724.00		38
39	CENTRAL SERVICES AND SUPPLY		53,904		3,827.00		39
40	PHARMACY		302,266		7,694.00		40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		351,275		19,503.00		41
42	SOCIAL SERVICE		64,320		2,903.00		42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		7,977,483		7,977,483	344,433.00	23.16	1
2	EXCLUDED AREA SALARIES (see instructions)		15,986	19,612	35,598	1,203.00	29.59	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		7,961,497	-19,612	7,941,885	343,230.00	23.14	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		38,505		38,505	388.00	99.24	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		2,573,169		2,573,169		32.40%	5
6	TOTAL (sum of lines 3 through 5)		10,573,171	-19,612	10,553,559	343,618.00	30.71	6
7	TOTAL OVERHEAD COST (see instructions)		3,639,875	-19,612	3,620,263	171,117.00	21.16	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	619,528	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,288,574	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)	1,755	12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	107,969	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	564,980	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	1,735	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	2,584,541	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S) 11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3

PART V - CONTRACT LABOR AND BENEFIT COST

PART V

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18



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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
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 IN COLUMN 1 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



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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	
69	PE2				69
70	PE1				70
71	PD2				71
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 CATEGORY. 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



COMPU-MAX

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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)	0.550126	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	1,133,495	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?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	3,107,319	6
7	MEDICAID COST (line 1 times line 6)	1,709,417	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.	575,922	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 AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING 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)	575,922	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	393,331		393,331	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	216,382		216,382	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	216,382		216,382	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)	2,125,788	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	294,883	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,830,905	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,007,228	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,223,610	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	1,799,532	31



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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		1,450,624	1,450,624	-949,101	501,523		501,523	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,134,694	1,134,694	-605,844	528,850	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	153,033	2,626,913	2,779,946		2,779,946		2,779,946	4
5	00500	ADMINISTRATIVE & GENERAL	1,438,973	1,092,927	2,531,900	-56,024	2,475,876	-194,392	2,281,484	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	331,313	458,516	789,829	-202	789,627	-1,276	788,351	7
8	00800	LAUNDRY & LINEN SERVICE	55,322	51,990	107,312		107,312		107,312	8
9	00900	HOUSEKEEPING	250,646	51,125	301,771		301,771		301,771	9
10	01000	DIETARY	331,453	231,453	562,906	-371,594	191,312	-290	191,022	10
11	01100	CAFETERIA				338,287	338,287	-55,462	282,825	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	272,148	6,352	278,500		278,500		278,500	13
14	01400	CENTRAL SERVICES & SUPPLY	53,904	559,347	613,251	-555,176	58,075		58,075	14
15	01500	PHARMACY	302,266	502,746	805,012	-412,879	392,133		392,133	15
16	01600	MEDICAL RECORDS & LIBRARY	351,275	72,310	423,585		423,585	-5,545	418,040	16
17	01700	SOCIAL SERVICE	64,320	7,175	71,495		71,495		71,495	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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,505,857	45,443	1,551,300		1,551,300		1,551,300	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	541,626	164,713	706,339	-66,000	640,339	-2,000	638,339	50
54	05400	RADIOLOGY-DIAGNOSTIC	713,457	526,821	1,240,278	-900	1,239,378	-1,300	1,238,078	54
60	06000	LABORATORY	588,278	683,203	1,271,481	-14,362	1,257,119		1,257,119	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	29,715	95,823	125,538		125,538		125,538	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	222,093	46,436	268,529	-720	267,809	-9,371	258,438	65
66	06600	PHYSICAL THERAPY		453,393	453,393		453,393		453,393	66
67	06700	OCCUPATIONAL THERAPY		31,103	31,103		31,103		31,103	67
68	06800	SPEECH PATHOLOGY		38,505	38,505		38,505		38,505	68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				317,548	317,548	399	317,947	71
71.01	07101	IMPLANTABLE SUPPLIES								71.01
71.02	07102	PACEMAKERS								71.02
72	07200	IMPL. DEV. CHARGED TO PATIENTS				237,628	237,628		237,628	72
72.10	07201	INTRAOCULAR LENS								72.10
73	07300	DRUGS CHARGED TO PATIENTS				365,494	365,494	-37,312	328,182	73
76	03950	CARDIAC REHAB		23,274	23,274	-23,274				76
76.01	03951	CHEMOTHERAPY	157,649	934,882	1,092,531		1,092,531	-83,508	1,009,023	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								
90	09000	CLINIC	117,193	4,604	121,797		121,797		121,797	90
91	09100	EMERGENCY	445,754	1,457,033	1,902,787		1,902,787	-934,971	967,816	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	7,926,275	11,616,711	19,542,986	-56,581	19,486,405	-1,930,872	17,555,533	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,899		4,899		4,899		4,899	190
192	19200	PHYSICIANS' PRIVATE OFFICES	11,087	1,607	12,694		12,694		12,694	192
193.01	19301	CARDIAC REHAB				23,274	23,274		23,274	193.01
194	07950	NON-ALLOWABLE COSTS				33,307	33,307		33,307	194
200		TOTAL (sum of lines 118-199)	7,942,261	11,618,318	19,560,579		19,560,579	-1,930,872	17,629,707	200



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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		231,795	1
500	TOTAL RECLASSIFICATIONS					231,795	500
	CODE LETTER - A						
1	RECLASS DEPRECIATION	B	CAP REL COSTS-MVBLE EQUIP	2		1,001,581	1
500	TOTAL RECLASSIFICATIONS					1,001,581	500
	CODE LETTER - B						
1	RECLASS MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		317,548	1
2	RECLASS MEDICAL SUPPLIES	C	IMPL. DEV. CHARGED TO PATIENT	72		237,628	2
500	TOTAL RECLASSIFICATIONS					555,176	500
	CODE LETTER - C						
1	RECLASS IV THERAPY	D	DRUGS CHARGED TO PATIENTS	73		133,699	1
500	TOTAL RECLASSIFICATIONS					133,699	500
	CODE LETTER - D						
1	CARDIAC REHAB	E	CARDIAC REHAB	193.01		23,274	1
500	TOTAL RECLASSIFICATIONS					23,274	500
	CODE LETTER - E						
1	CAFETERIA	F	CAFETERIA	11	199,192	139,095	1
2	NON ALLOWABLE MEALS	F	NON-ALLOWABLE COSTS	194	19,612	13,695	2
500	TOTAL RECLASSIFICATIONS				218,804	152,790	500
	CODE LETTER - F						
1	LEASE/RENTAL	H	CAP REL COSTS-MVBLE EQUIP	2		133,113	1
2							2
3							3
4							4
5							5
6							6
7							7
500	TOTAL RECLASSIFICATIONS					133,113	500
	CODE LETTER - H						
1	RECLASS PROPERTY INSURANCE	L	CAP REL COSTS-BLDG & FIXT	1		52,480	1
500	TOTAL RECLASSIFICATIONS					52,480	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				218,804	2,283,908	

(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.



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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		231,795		
500	TOTAL RECLASSIFICATIONS					231,795	500	
	CODE LETTER - A							
1	RECLASS DEPRECIATION	B	CAP REL COSTS-BLDG & FIXT	1		1,001,581	9	
500	TOTAL RECLASSIFICATIONS					1,001,581	500	
	CODE LETTER - B							
1	RECLASS MEDICAL SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		555,176		
2	RECLASS MEDICAL SUPPLIES	C						
500	TOTAL RECLASSIFICATIONS					555,176	500	
	CODE LETTER - C							
1	RECLASS IV THERAPY	D	PHARMACY	15		133,699		
500	TOTAL RECLASSIFICATIONS					133,699	500	
	CODE LETTER - D							
1	CARDIAC REHAB	E	CARDIAC REHAB	76		23,274		
500	TOTAL RECLASSIFICATIONS					23,274	500	
	CODE LETTER - E							
1	CAFETRIA	F	DIETARY	10	199,192	139,095		
2	NON ALLOWABLE MEALS	F	DIETARY	10	19,612	13,695		
500	TOTAL RECLASSIFICATIONS				218,804	152,790	500	
	CODE LETTER - F							
1	LEASE/RENTAL	H	ADMINISTRATIVE & GENERAL	5		3,544	10	
2			OPERATION OF PLANT	7		202	10	
3			PHARMACY	15		47,385	10	
4			OPERATING ROOM	50		66,000	10	
5			RADIOLOGY-DIAGNOSTIC	54		900	10	
6			LABORATORY	60		14,362	10	
7			RESPIRATORY THERAPY	65		720	10	
500	TOTAL RECLASSIFICATIONS					133,113	500	
	CODE LETTER - H							
1	RECLASS PROPERTY INSURANCE	L	ADMINISTRATIVE & GENERAL	5		52,480	12	
500	TOTAL RECLASSIFICATIONS					52,480	500	
	CODE LETTER - L							
	GRAND TOTAL (DECREASES)				218,804	2,283,908		

(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.



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	237,440					237,440		1
2	LAND IMPROVEMENTS	501,866					501,866		2
3	BUILDINGS AND FIXTURES	14,426,614	269,615		269,615		14,696,229		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	894,937				9,123	885,814		5
6	MOVABLE EQUIPMENT	10,119,599				124,034	9,995,565		6
7	HIT DESIGNATED ASSETS	1,560,155					1,560,155		7
8	SUBTOTAL (sum of lines 1-7)	27,740,611	269,615		269,615	133,157	27,877,069		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	27,740,611	269,615		269,615	133,157	27,877,069		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	1,450,624							1,450,624	1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)	1,450,624							1,450,624	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

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	449,043			52,480				501,523	1
2	CAP REL COSTS-MVBLE EQUIP	395,737	133,113						528,850	2
3	TOTAL (sum of lines 1-2)	844,780	133,113		52,480				1,030,373	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.)



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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
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	-965	ADMINISTRATIVE & GENERAL	5	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	-5,518	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	-1,027,850			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-1,276	OPERATION OF PLANT	7	11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1				12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-55,462	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	399	MEDICAL SUPPLIES CHARGED TO PATIENTS	71	16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-5,545	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 AND	A	-605,844	CAP REL COSTS-MVBLE EQUIP	2	9
33						33
34						34
35						35
35.50	REBATES	A	-37,312	DRUGS CHARGED TO PATIENTS	73	35.50
36						36
36.01	CRNA FEES	A	-2,000	OPERATING ROOM	50	36.01
36.03	ADMINISTRATIVE & GENERAL - MISC	B	-109	ADMINISTRATIVE & GENERAL	5	36.03
37						37
38	NON ALLOWABLE SALARIES	A	-50,745	ADMINISTRATIVE & GENERAL	5	38
39	NON ALLOWABLE OTHER	A	-85,784	ADMINISTRATIVE & GENERAL	5	39
40	CRNA AND MD BILLING EXPENSE	A	-37,392	ADMINISTRATIVE & GENERAL	5	40
41	OPERATING REVENUE	B	-290	DIETARY	10	41
42						42
43	MISC INC ANALYSIS 5010-0220	B	-9,829	ADMINISTRATIVE & GENERAL	5	43
44	MED TECH FEES FROM CMG	B	-4,050	ADMINISTRATIVE & GENERAL	5	44
45						45
45.02	MISC REV PET SCANNER	A	-1,300	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)		-1,930,872			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



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

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

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

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.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
			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	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1										1
2	60	LABORATORY AGGREGATE	20,300		20,300					2
3	65	RESPIRATORY THERAPY AGGREGATE	9,096	9,096						3
4	65	RESPIRATORY THERAPY AGGREGATE	275	275						4
5	76.01	CHEMOTHERAPY AGGREGATE	83,508	83,508						5
6	91	EMERGENCY AGGREGATE	1,427,606	934,971	492,635					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	1,540,785	1,027,850	512,935					200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1										1
2	60	LABORATORY AGGREGATE								2
3	65	RESPIRATORY THERAPY AGGREGATE							9,096	3
4	65	RESPIRATORY THERAPY AGGREGATE							275	4
5	76.01	CHEMOTHERAPY AGGREGATE							83,508	5
6	91	EMERGENCY AGGREGATE							934,971	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							1,027,850	200



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IVCHECK APPLICABLE BOX: 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 VISIT(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	1,500.53	1,057.82				9
10	AHSEA (see instructions)	70.63	70.63				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				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)					105,982	14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					74,714	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					180,696	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)					180,696	20
21	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)					180,696	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	OPTIONAL 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 PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 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 in column 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 OVERTIME 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)		180,696	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)		180,696	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		31,103	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 V-VI

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 VISIT(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		4,191.93	4,885.52	2,434.09	9
10	AHSEA (see instructions)		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)					14
15	THERAPISTS (column 2, line 9 times column 2, line 10)				312,425	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)				273,101	16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)				585,526	17
18	AIDES (column 4, line 9 times column 4, line 10)				90,719	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)				676,245	20
21	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)				676,245	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	OPTIONAL 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



COMPU-MAX

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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

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 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 in column 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 OVERTIME 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)		676,245	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)		676,245	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		437,781	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)			65



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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	501,523	501,523					1
2	CAP REL COSTS-MVBLE EQUIP	528,850		528,850				2
4	EMPLOYEE BENEFITS DEPARTMENT	2,779,946	9,614	10,138	2,799,698			4
5	ADMINISTRATIVE & GENERAL	2,281,484	70,051	73,868	517,213	2,942,616	2,942,616	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	788,351	72,939	76,913	119,084	1,057,287	211,832	7
8	LAUNDRY & LINEN SERVICE	107,312	4,068	4,290	19,884	135,554	27,159	8
9	HOUSEKEEPING	301,771	7,315	7,713	90,090	406,889	81,522	9
10	DIETARY	191,022	6,242	6,582	40,490	244,336	48,954	10
11	CAFETERIA	282,825	10,470	11,041	71,596	375,932	75,319	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	278,500	9,592	10,114	97,819	396,025	79,345	13
14	CENTRAL SERVICES & SUPPLY	58,075	6,847	7,220	19,375	91,517	18,336	14
15	PHARMACY	392,133	6,385	6,733	108,644	513,895	102,961	15
16	MEDICAL RECORDS & LIBRARY	418,040	21,089	22,238	126,259	587,626	117,733	16
17	SOCIAL SERVICE	71,495	2,094	2,208	23,119	98,916	19,818	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	1,551,300	51,290	54,085	541,254	2,197,929	440,363	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	638,339	39,941	42,117	194,678	915,075	183,339	50
54	RADIOLOGY-DIAGNOSTIC	1,238,078	34,954	36,859	256,439	1,566,330	313,820	54
60	LABORATORY	1,257,119	14,036	14,801	211,446	1,497,402	300,010	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	125,538	822	866	10,681	137,907	27,630	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	258,438	9,786	10,319	79,827	358,370	71,801	65
66	PHYSICAL THERAPY	453,393	52,214	55,059		560,666	112,332	66
67	OCCUPATIONAL THERAPY	31,103	2,014	2,124		35,241	7,061	67
68	SPEECH PATHOLOGY	38,505				38,505	7,715	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	317,947				317,947	63,702	71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS	237,628				237,628	47,610	72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS	328,182				328,182	65,753	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,009,023	13,939	14,699	56,664	1,094,325	219,252	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	121,797	14,476	15,265	42,123	193,661	38,801	90
91	EMERGENCY	967,816	26,749	28,207	160,218	1,182,990	237,017	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	17,555,533	486,927	513,459	2,786,903	17,512,751	2,919,185	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,899	5,107	5,385	1,761	17,152	3,436	190
192	PHYSICIANS' PRIVATE OFFICES	12,694	6,014	6,342	3,985	29,035	5,817	192
193.01	CARDIAC REHAB	23,274	3,475	3,664		30,413	6,093	193.01
194	NON-ALLOWABLE COSTS	33,307			7,049	40,356	8,085	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	17,629,707	501,523	528,850	2,799,698	17,629,707	2,942,616	202



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		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	1,269,119						7
8	LAUNDRY & LINEN SERVICE	14,797	177,510					8
9	HOUSEKEEPING	26,606		515,017				9
10	DIETARY	22,705		9,524	325,519			10
11	CAFETERIA	38,083		15,976		505,310		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	34,887		14,635		25,461	550,353	13
14	CENTRAL SERVICES & SUPPLY	24,905		10,447		5,043		14
15	PHARMACY	23,224		9,742		28,279		15
16	MEDICAL RECORDS & LIBRARY	76,706		32,178		32,864		16
17	SOCIAL SERVICE	7,617		3,195		6,018	13,037	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	186,556	177,510	78,259	325,519	140,884	305,227	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	145,277		60,943		50,672	109,784	50
54	RADIOLOGY-DIAGNOSTIC	127,138		53,333		66,748		54
60	LABORATORY	51,054		21,417		55,037		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,989		1,254		2,780		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	35,593		14,931		20,778		65
66	PHYSICAL THERAPY	189,918		79,670				66
67	OCCUPATIONAL THERAPY	7,326		3,073				67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS							72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	50,702		21,269		14,749	31,954	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	52,653		22,087		10,964		90
91	EMERGENCY	97,294		40,814		41,703	90,351	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,216,030	177,510	492,747	325,519	501,980	550,353	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,575		7,792		458		190
192	PHYSICIANS' PRIVATE OFFICES	21,875		9,176		1,037		192
193.01	CARDIAC REHAB	12,639		5,302				193.01
194	NON-ALLOWABLE COSTS					1,835		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,269,119	177,510	515,017	325,519	505,310	550,353	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	150,248						14
15	PHARMACY		678,101					15
16	MEDICAL RECORDS & LIBRARY			847,107				16
17	SOCIAL SERVICE				148,601			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			53,939	148,601	4,054,787		30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			56,720		1,521,810		50
54	RADIOLOGY-DIAGNOSTIC			212,952		2,340,321		54
60	LABORATORY			157,041		2,081,961		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			9,755		182,315		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			37,445		538,918		65
66	PHYSICAL THERAPY			49,311		991,897		66
67	OCCUPATIONAL THERAPY			2,882		55,583		67
68	SPEECH PATHOLOGY			2,579		48,799		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,938		63,864		531,451		71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS	64,310		21,661		371,209		72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS		172,519	89,300		655,754		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		505,582	40,346		1,978,179		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			8,021		326,187		90
91	EMERGENCY			41,291		1,731,460		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	150,248	678,101	847,107	148,601	17,410,631		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					47,413		190
192	PHYSICIANS' PRIVATE OFFICES					66,940		192
193.01	CARDIAC REHAB					54,447		193.01
194	NON-ALLOWABLE COSTS					50,276		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	150,248	678,101	847,107	148,601	17,629,707		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	4,054,787					30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,521,810					50
54	RADIOLOGY-DIAGNOSTIC	2,340,321					54
60	LABORATORY	2,081,961					60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	182,315					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	538,918					65
66	PHYSICAL THERAPY	991,897					66
67	OCCUPATIONAL THERAPY	55,583					67
68	SPEECH PATHOLOGY	48,799					68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	531,451					71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS	371,209					72
72.10	INTRAOCULAR LENS						72.10
73	DRUGS CHARGED TO PATIENTS	655,754					73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	1,978,179					76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	326,187					90
91	EMERGENCY	1,731,460					91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	17,410,631					118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,413					190
192	PHYSICIANS' PRIVATE OFFICES	66,940					192
193.01	CARDIAC REHAB	54,447					193.01
194	NON-ALLOWABLE COSTS	50,276					194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	17,629,707					202



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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		9,614	10,138	19,752	19,752		4
5	ADMINISTRATIVE & GENERAL		70,051	73,868	143,919	3,649	147,568	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		72,939	76,913	149,852	840	10,623	7
8	LAUNDRY & LINEN SERVICE		4,068	4,290	8,358	140	1,362	8
9	HOUSEKEEPING		7,315	7,713	15,028	636	4,088	9
10	DIETARY		6,242	6,582	12,824	286	2,455	10
11	CAFETERIA		10,470	11,041	21,511	505	3,777	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		9,592	10,114	19,706	690	3,979	13
14	CENTRAL SERVICES & SUPPLY		6,847	7,220	14,067	137	919	14
15	PHARMACY		6,385	6,733	13,118	767	5,163	15
16	MEDICAL RECORDS & LIBRARY		21,089	22,238	43,327	891	5,904	16
17	SOCIAL SERVICE		2,094	2,208	4,302	163	994	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		51,290	54,085	105,375	3,818	22,088	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		39,941	42,117	82,058	1,374	9,194	50
54	RADIOLOGY-DIAGNOSTIC		34,954	36,859	71,813	1,809	15,737	54
60	LABORATORY		14,036	14,801	28,837	1,492	15,044	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		822	866	1,688	75	1,386	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		9,786	10,319	20,105	563	3,601	65
66	PHYSICAL THERAPY		52,214	55,059	107,273		5,633	66
67	OCCUPATIONAL THERAPY		2,014	2,124	4,138		354	67
68	SPEECH PATHOLOGY						387	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						3,194	71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS						2,387	72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS						3,297	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		13,939	14,699	28,638	400	10,995	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		14,476	15,265	29,741	297	1,946	90
91	EMERGENCY		26,749	28,207	54,956	1,130	11,886	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		486,927	513,459	1,000,386	19,662	146,393	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,107	5,385	10,492	12	172	190
192	PHYSICIANS' PRIVATE OFFICES		6,014	6,342	12,356	28	292	192
193.01	CARDIAC REHAB		3,475	3,664	7,139		306	193.01
194	NON-ALLOWABLE COSTS					50	405	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		501,523	528,850	1,030,373	19,752	147,568	202



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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	161,315						7
8	LAUNDRY & LINEN SERVICE	1,881	11,741					8
9	HOUSEKEEPING	3,382		23,134				9
10	DIETARY	2,886		428	18,879			10
11	CAFETERIA	4,841		718		31,352		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	4,434		657		1,580	31,046	13
14	CENTRAL SERVICES & SUPPLY	3,166		469		313		14
15	PHARMACY	2,952		438		1,755		15
16	MEDICAL RECORDS & LIBRARY	9,750		1,445		2,039		16
17	SOCIAL SERVICE	968		144		373	735	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	23,713	11,741	3,515	18,879	8,741	17,218	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	18,466		2,737		3,144	6,193	50
54	RADIOLOGY-DIAGNOSTIC	16,160		2,396		4,142		54
60	LABORATORY	6,489		962		3,415		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	380		56		172		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,524		671		1,289		65
66	PHYSICAL THERAPY	24,139		3,580				66
67	OCCUPATIONAL THERAPY	931		138				67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS							72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	6,445		955		915	1,803	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	6,693		992		680		90
91	EMERGENCY	12,367		1,833		2,588	5,097	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	154,567	11,741	22,134	18,879	31,146	31,046	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,361		350		28		190
192	PHYSICIANS' PRIVATE OFFICES	2,780		412		64		192
193.01	CARDIAC REHAB	1,607		238				193.01
194	NON-ALLOWABLE COSTS					114		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	161,315	11,741	23,134	18,879	31,352	31,046	202



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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	19,071						14
15	PHARMACY		24,193					15
16	MEDICAL RECORDS & LIBRARY			63,356				16
17	SOCIAL SERVICE				7,679			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			4,034	7,679	226,801		30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			4,242		127,408		50
54	RADIOLOGY-DIAGNOSTIC			15,924		127,981		54
60	LABORATORY			11,746		67,985		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			730		4,487		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			2,801		33,554		65
66	PHYSICAL THERAPY			3,688		144,313		66
67	OCCUPATIONAL THERAPY			216		5,777		67
68	SPEECH PATHOLOGY			193		580		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,908		4,777		18,879		71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS	8,163		1,620		12,170		72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS		6,155	6,679		16,131		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		18,038	3,018		71,207		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			600		40,949		90
91	EMERGENCY			3,088		92,945		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,071	24,193	63,356	7,679	991,167		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					13,415		190
192	PHYSICIANS' PRIVATE OFFICES					15,932		192
193.01	CARDIAC REHAB					9,290		193.01
194	NON-ALLOWABLE COSTS					569		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	19,071	24,193	63,356	7,679	1,030,373		202



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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	226,801					30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	127,408					50
54	RADIOLOGY-DIAGNOSTIC	127,981					54
60	LABORATORY	67,985					60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,487					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	33,554					65
66	PHYSICAL THERAPY	144,313					66
67	OCCUPATIONAL THERAPY	5,777					67
68	SPEECH PATHOLOGY	580					68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,879					71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS	12,170					72
72.10	INTRAOCULAR LENS						72.10
73	DRUGS CHARGED TO PATIENTS	16,131					73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	71,207					76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	40,949					90
91	EMERGENCY	92,945					91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	991,167					118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,415					190
192	PHYSICIANS' PRIVATE OFFICES	15,932					192
193.01	CARDIAC REHAB	9,290					193.01
194	NON-ALLOWABLE COSTS	569					194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	1,030,373					202



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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		87,896					2
4	EMPLOYEE BENEFITS DEPARTMENT	1,685	1,685	7,789,228				4
5	ADMINISTRATIVE & GENERAL	12,277	12,277	1,438,973	-2,942,616	14,687,091		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,783	12,783	331,313		1,057,287	61,151	7
8	LAUNDRY & LINEN SERVICE	713	713	55,322		135,554	713	8
9	HOUSEKEEPING	1,282	1,282	250,646		406,889	1,282	9
10	DIETARY	1,094	1,094	112,649		244,336	1,094	10
11	CAFETERIA	1,835	1,835	199,192		375,932	1,835	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,681	1,681	272,148		396,025	1,681	13
14	CENTRAL SERVICES & SUPPLY	1,200	1,200	53,904		91,517	1,200	14
15	PHARMACY	1,119	1,119	302,266		513,895	1,119	15
16	MEDICAL RECORDS & LIBRARY	3,696	3,696	351,275		587,626	3,696	16
17	SOCIAL SERVICE	367	367	64,320		98,916	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	8,989	8,989	1,505,857		2,197,929	8,989	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	7,000	7,000	541,626		915,075	7,000	50
54	RADIOLOGY-DIAGNOSTIC	6,126	6,126	713,457		1,566,330	6,126	54
60	LABORATORY	2,460	2,460	588,278		1,497,402	2,460	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	144	144	29,715		137,907	144	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,715	1,715	222,093		358,370	1,715	65
66	PHYSICAL THERAPY	9,151	9,151			560,666	9,151	66
67	OCCUPATIONAL THERAPY	353	353			35,241	353	67
68	SPEECH PATHOLOGY					38,505		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					317,947		71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS					237,628		72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS					328,182		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	2,443	2,443	157,649		1,094,325	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							
90	CLINIC	2,537	2,537	117,193		193,661	2,537	90
91	EMERGENCY	4,688	4,688	445,754		1,182,990	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)	85,338	85,338	7,753,630	-2,942,616	14,570,135	58,593	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	895	895	4,899		17,152	895	190
192	PHYSICIANS' PRIVATE OFFICES	1,054	1,054	11,087		29,035	1,054	192
193.01	CARDIAC REHAB	609	609			30,413	609	193.01
194	NON-ALLOWABLE COSTS			19,612		40,356		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	501,523	528,850	2,799,698		2,942,616	1,269,119	202
203	UNIT COST MULT-WS B PT I	5,705,868	6,016,770	0,359,432		0,200,354	20,753,855	203
204	COST TO BE ALLOC PER B PT II			19,752		147,568	161,315	204
205	UNIT COST MULT-WS B PT II			0,002,536		0,010,047	2,637,978	205



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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 ADMINISTRATION 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	1,586						8
9	HOUSEKEEPING		59,156					9
10	DIETARY		1,094	1,586				10
11	CAFETERIA		1,835		5,401,133			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		1,681		272,148	2,715,206		13
14	CENTRAL SERVICES & SUPPLY		1,200		53,904		555,176	14
15	PHARMACY		1,119		302,266			15
16	MEDICAL RECORDS & LIBRARY		3,696		351,275			16
17	SOCIAL SERVICE		367		64,320	64,320		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	1,586	8,989	1,586	1,505,857	1,505,857		30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		7,000		541,626	541,626		50
54	RADIOLOGY-DIAGNOSTIC		6,126		713,457			54
60	LABORATORY		2,460		588,278			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		144		29,715			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		1,715		222,093			65
66	PHYSICAL THERAPY		9,151					66
67	OCCUPATIONAL THERAPY		353					67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						317,548	71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS						237,628	72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		2,443		157,649	157,649		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		2,537		117,193			90
91	EMERGENCY		4,688		445,754	445,754		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,586	56,598	1,586	5,365,535	2,715,206	555,176	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		895		4,899			190
192	PHYSICIANS' PRIVATE OFFICES		1,054		11,087			192
193.01	CARDIAC REHAB		609					193.01
194	NON-ALLOWABLE COSTS				19,612			194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	177,510	515,017	325,519	505,310	550,353	150,248	202
203	UNIT COST MULT-WS B PT I	111.923077	8.706082	205.245271	0.093556	0.202693	0.270631	203
204	COST TO BE ALLOC PER B PT II	11,741	23,134	18,879	31,352	31,046	19,071	204
205	UNIT COST MULT-WS B PT II	7.402900	0.391068	11.903531	0.005805	0.011434	0.034351	205



COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE			
	COSTED REQUIS	GROSS REVENUE	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	1,136,621					15
16	MEDICAL RECORDS & LIBRARY		31,648,444				16
17	SOCIAL SERVICE			1,586			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		2,015,218	1,586			30
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		2,119,093				50
54	RADIOLOGY-DIAGNOSTIC		7,955,951				54
60	LABORATORY		5,867,170				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		364,459				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,398,990				65
66	PHYSICAL THERAPY		1,842,290				66
67	OCCUPATIONAL THERAPY		107,674				67
68	SPEECH PATHOLOGY		96,342				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,386,005				71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS		809,276				72
72.10	INTRAOCULAR LENS						72.10
73	DRUGS CHARGED TO PATIENTS	289,173	3,336,315				73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	847,448	1,507,351				76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		299,653				90
91	EMERGENCY		1,542,657				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,136,621	31,648,444	1,586			118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
193.01	CARDIAC REHAB						193.01
194	NON-ALLOWABLE COSTS						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	678,101	847,107	148,601			202
203	UNIT COST MULT-WS B PT I	0.596594	0.026766	93.695460			203
204	COST TO BE ALLOC PER B PT II	24,193	63,356	7,679			204
205	UNIT COST MULT-WS B PT II	0.021285	0.002002	4.841740			205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4



COMPU-MAX

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,054,787		4,054,787			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,521,810		1,521,810			50
54	RADIOLOGY-DIAGNOSTIC	2,340,321		2,340,321			54
60	LABORATORY	2,081,961		2,081,961			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	182,315		182,315			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	538,918		538,918			65
66	PHYSICAL THERAPY	991,897		991,897			66
67	OCCUPATIONAL THERAPY	55,583		55,583			67
68	SPEECH PATHOLOGY	48,799		48,799			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	531,451		531,451			71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS	371,209		371,209			72
72.10	INTRAOCULAR LENS						72.10
73	DRUGS CHARGED TO PATIENTS	655,754		655,754			73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	1,978,179		1,978,179			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	326,187		326,187			90
91	EMERGENCY	1,731,460		1,731,460			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	771,967		771,967			92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	18,182,598		18,182,598			200
201	LESS OBSERVATION BEDS	771,967		771,967			201
202	TOTAL (SEE INSTRUCTIONS)	17,410,631		17,410,631			202



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,513,886		1,513,886				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	285,863	1,833,230	2,119,093	0.718142			50
54	RADIOLOGY-DIAGNOSTIC	278,948	7,677,003	7,955,951	0.294160			54
60	LABORATORY	739,346	5,127,824	5,867,170	0.354849			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	106,890	257,569	364,459	0.500235			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	263,412	1,135,578	1,398,990	0.385219			65
66	PHYSICAL THERAPY	205,718	1,636,572	1,842,290	0.538404			66
67	OCCUPATIONAL THERAPY	27,139	80,535	107,674	0.516216			67
68	SPEECH PATHOLOGY	9,908	86,434	96,342	0.506518			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	658,252	1,727,753	2,386,005	0.222737			71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS	581,457	227,819	809,276	0.458693			72
72.10	INTRAOCULAR LENS							72.10
73	DRUGS CHARGED TO PATIENTS	720,948	2,615,367	3,336,315	0.196550			73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,105	1,506,246	1,507,351	1.312355			76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	67	299,586	299,653	1.088549			90
91	EMERGENCY	1,000	1,541,657	1,542,657	1.122388			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		501,332	501,332	1.539832			92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	5,393,939	26,254,505	31,648,444				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		26,254,505	31,648,444				202



COMPU-MAX

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1338

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.718142		702,187			504,270		50
54	RADIOLOGY-DIAGNOSTIC	0.294160		2,696,783			793,286		54
60	LABORATORY	0.354849		2,106,907			747,634		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.500235		89,231			44,636		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.385219		652,113			251,206		65
66	PHYSICAL THERAPY	0.538404		673,835			362,795		66
67	OCCUPATIONAL THERAPY	0.516216		27,492			14,192		67
68	SPEECH PATHOLOGY	0.506518		84,926			43,017		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222737		1,036,524			230,872		71
71.01	IMPLANTABLE SUPPLIES								71.01
71.02	PACEMAKERS								71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.458693		87,481			40,127		72
72.10	INTRAOCULAR LENS								72.10
73	DRUGS CHARGED TO PATIENTS	0.196550		428,041			84,131		73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.312355		1,230,583	6,354		1,614,962	8,339	76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.088549		138,179			150,415		90
91	EMERGENCY	1.122388		526,050	2,340		590,432	2,626	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.539832		201,282			309,940		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			10,681,614	8,694		5,781,915	10,965	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			10,681,614	8,694		5,781,915	10,965	202

(A) Worksheet A line numbers



COMPU-MAX

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/22/2014 Run Time: 12:50 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z338

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES				PROGRAM COST		
			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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.718142						50	
54	RADIOLOGY-DIAGNOSTIC	0.294160						54	
60	LABORATORY	0.354849						60	
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.500235						62	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65	RESPIRATORY THERAPY	0.385219						65	
66	PHYSICAL THERAPY	0.538404						66	
67	OCCUPATIONAL THERAPY	0.516216						67	
68	SPEECH PATHOLOGY	0.506518						68	
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222737						71	
71.01	IMPLANTABLE SUPPLIES							71.01	
71.02	PACEMAKERS							71.02	
72	IMPL. DEV. CHARGED TO PATIENTS	0.458693						72	
72.10	INTRAOCULAR LENS							72.10	
73	DRUGS CHARGED TO PATIENTS	0.196550						73	
76	CARDIAC REHAB							76	
76.01	CHEMOTHERAPY	1.312355						76.01	
76.97	CARDIAC REHABILITATION							76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.088549						90	
91	EMERGENCY	1.122388						91	
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.539832						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



COMPU-MAX

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	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)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	226,801	25,098	201,703	2,018	99.95	73	7,296	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)	226,801		201,703	2,018		73	7,296	200

(A) Worksheet A line numbers



COMPU-MAX

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/22/2014 Run Time: 12:50 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1338

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII, PART A [] IPF
 BOXES: [XX] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	127,408	2,119,093	0.060124	22,744	1,367	50
54	RADIOLOGY-DIAGNOSTIC	127,981	7,955,951	0.016086	18,336	295	54
60	LABORATORY	67,985	5,867,170	0.011587	41,078	476	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,487	364,459	0.012311			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	33,554	1,398,990	0.023984	10,090	242	65
66	PHYSICAL THERAPY	144,313	1,842,290	0.078333	3,243	254	66
67	OCCUPATIONAL THERAPY	5,777	107,674	0.053653			67
68	SPEECH PATHOLOGY	580	96,342	0.006020			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,879	2,386,005	0.007912	84,027	665	71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS	12,170	809,276	0.015038	110	2	72
72.10	INTRAOCULAR LENS						72.10
73	DRUGS CHARGED TO PATIENTS	16,131	3,336,315	0.004835	31,818	154	73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	71,207	1,507,351	0.047240			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	40,949	299,653	0.136655			90
91	EMERGENCY	92,945	1,542,657	0.060250			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	48,552	501,332	0.096846			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	812,918	30,134,558		211,446	3,455	200

(A) Worksheet A line numbers



COMPU-MAX

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERV 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



COMPU-MAX

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
		6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	2,018		73		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)	2,018		73		200

(A) Worksheet A line numbers



COMPU-MAX

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1338

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR
 APPLICABLE TITLE XVIII, PART A IPF SNF
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	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
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS							72
72.10	INTRAOCULAR LENS							72.10
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							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1338

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR
 APPLICABLE TITLE XVIII, PART A IPF SNF
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	2,119,093			22,744				50
54	RADIOLOGY-DIAGNOSTIC	7,955,951			18,336				54
60	LABORATORY	5,867,170			41,078				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	364,459							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	1,398,990			10,090				65
66	PHYSICAL THERAPY	1,842,290			3,243				66
67	OCCUPATIONAL THERAPY	107,674							67
68	SPEECH PATHOLOGY	96,342							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,386,005			84,027				71
71.01	IMPLANTABLE SUPPLIES								71.01
71.02	PACEMAKERS								71.02
72	IMPL. DEV. CHARGED TO PATIENTS	809,276			110				72
72.10	INTRAOCULAR LENS								72.10
73	DRUGS CHARGED TO PATIENTS	3,336,315			31,818				73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1,507,351							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	299,653							90
91	EMERGENCY	1,542,657							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	501,332							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	30,134,558			211,446				200

(A) Worksheet A line numbers



COMPU-MAX

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1338

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.718142							50
54	RADIOLOGY-DIAGNOSTIC	0.294160							54
60	LABORATORY	0.354849							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.500235							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.385219							65
66	PHYSICAL THERAPY	0.538404							66
67	OCCUPATIONAL THERAPY	0.516216							67
68	SPEECH PATHOLOGY	0.506518							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222737							71
71.01	IMPLANTABLE SUPPLIES								71.01
71.02	PACEMAKERS								71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.458693							72
72.10	INTRAOCULAR LENS								72.10
73	DRUGS CHARGED TO PATIENTS	0.196550							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.312355							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.088549							90
91	EMERGENCY	1.122388							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.539832							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



COMPU-MAX

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1338

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] 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)	2,316	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,018	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)	1,586	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	124	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)	123	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	26	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)	25	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,004	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)	124	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)	123	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	4,054,787	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)	3,631	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	3,693	25
26	TOTAL SWING-BED COST (see instructions)	448,703	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,606,084	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 - line 36)	3,606,084	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1338

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,786.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,794,108	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)					1,794,108	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

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					829,845	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					2,623,953	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet 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 ENTER 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)					221,583	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					219,796	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only, For CAH, see instructions)					441,379	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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1338

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					432	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,786.96	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					771,967	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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	226,801	3,606,084	0.062894	771,967	48,552	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1338

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [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)	2,316	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,018	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)	1,586	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	124	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)	123	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	26	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)	25	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	73	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	4,054,787	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)	3,631	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	3,693	25
26	TOTAL SWING-BED COST (see instructions)	448,703	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,606,084	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 - line 36)	3,606,084	37



COMPU-MAX

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1338

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,786.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					130,448	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)					130,448	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 (Worksheet D-3, column 3, line 200)					66,956	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					197,404	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					7,296	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					3,455	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					10,751	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 ENTER 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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1338

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					432	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 27)	column 1 ÷ column 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 COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1338

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX IRF NF ICF/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		820,019		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.718142	167,705	120,436	50
54	RADIOLOGY-DIAGNOSTIC	0.294160	178,171	52,411	54
60	LABORATORY	0.354849	455,808	161,743	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.500235	46,447	23,234	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.385219	185,692	71,532	65
66	PHYSICAL THERAPY	0.538404	89,552	48,215	66
67	OCCUPATIONAL THERAPY	0.516216	6,775	3,497	67
68	SPEECH PATHOLOGY	0.506518	9,210	4,665	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222737	522,923	116,474	71
71.01	IMPLANTABLE SUPPLIES				71.01
71.02	PACEMAKERS				71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.458693	356,342	163,452	72
72.10	INTRAOCULAR LENS				72.10
73	DRUGS CHARGED TO PATIENTS	0.196550	321,660	63,222	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.312355			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.088549			90
91	EMERGENCY	1.122388	859	964	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.539832			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		2,341,144	829,845	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		2,341,144		202

(A) Worksheet A line numbers



COMPU-MAX

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z338

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX IRF NF ICF/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.718142	66	47	50
54	RADIOLOGY-DIAGNOSTIC	0.294160	3,609	1,062	54
60	LABORATORY	0.354849	61,954	21,984	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.500235	2,490	1,246	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.385219	18,517	7,133	65
66	PHYSICAL THERAPY	0.538404	77,056	41,487	66
67	OCCUPATIONAL THERAPY	0.516216	17,144	8,850	67
68	SPEECH PATHOLOGY	0.506518			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222737	44,146	9,833	71
71.01	IMPLANTABLE SUPPLIES				71.01
71.02	PACEMAKERS				71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.458693			72
72.10	INTRAOCULAR LENS				72.10
73	DRUGS CHARGED TO PATIENTS	0.196550	42,542	8,362	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.312355			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.088549			90
91	EMERGENCY	1.122388			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.539832			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		267,524	100,004	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		267,524		202

(A) Worksheet A line numbers



COMPU-MAX

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/22/2014 Run Time: 12:50 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1338

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX IRF NF ICF/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		54,957		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.718142	22,744	16,333	50
54	RADIOLOGY-DIAGNOSTIC	0.294160	18,336	5,394	54
60	LABORATORY	0.354849	41,078	14,576	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.500235			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.385219	10,090	3,887	65
66	PHYSICAL THERAPY	0.538404	3,243	1,746	66
67	OCCUPATIONAL THERAPY	0.516216			67
68	SPEECH PATHOLOGY	0.506518			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222737	84,027	18,716	71
71.01	IMPLANTABLE SUPPLIES				71.01
71.02	PACEMAKERS				71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.458693	110	50	72
72.10	INTRAOCULAR LENS				72.10
73	DRUGS CHARGED TO PATIENTS	0.196550	31,818	6,254	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.312355			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.088549			90
91	EMERGENCY	1.122388			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.539832			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		211,446	66,956	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		211,446		202

(A) Worksheet A line numbers



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1338

WORKSHEET E
PART B

CHECK APPLICABLE BOX: 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)	5,792,880			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (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 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	5,792,880			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, line 69, col. 4)				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 REASONABLE 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)	5,850,809			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	23,812			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,738,191			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	4,088,806			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)	4,088,806			30
31	PRIMARY PAYER PAYMENTS	90			31
32	SUBTOTAL (line 30 minus line 31)	4,088,716			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)	283,322			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	249,323			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	256,080			36
37	SUBTOTAL (see instructions)	4,338,039			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	4,338,039			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	86,761			40.01
41	INTERIM PAYMENTS	4,072,598			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	178,680			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see 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



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1338

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,482,484		3,750,835	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 A ZERO					2	
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)						
		.01	02/24/2014	148,884	02/24/2014	269,377	3.01
		.02	06/20/2014	49,729	06/20/2014	52,386	3.02
		PROGRAM					3.03
		TO					3.04
		PROVIDER					3.05
							3.06
							3.07
							3.08
							3.09
							3.10
							3.50
							3.51
							3.52
		PROVIDER					3.52
		TO					3.53
		PROGRAM					3.54
							3.55
							3.56
							3.57
							3.58
							3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		198,613		321,763	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)			2,681,097		4,072,598	4
	TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)						
		.01					5.01
		.02					5.02
		PROGRAM					5.03
		TO					5.04
		PROVIDER					5.05
							5.06
							5.07
							5.08
							5.09
							5.10
							5.50
							5.51
							5.52
		PROVIDER					5.52
		TO					5.53
		PROGRAM					5.54
							5.55
							5.56
							5.57
							5.58
							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) BASED ON THE COST REPORT (1)	.01				265,441	6.01
		.02		-247,576			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			2,433,521		4,338,039	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.



COMPU-MAX

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z338

WORKSHEET E-1
PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOXES: [] IRF [XX] SWING BED SNF

		INPATIENT PART A		PART B		
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		563,155			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 A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
		.01	02/24/2014		36,070	3.01
		.02	06/20/2014		8,752	3.02
	PROGRAM	.03				3.03
	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			44,822	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)				607,977	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
		.01				5.01
		.02				5.02
	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) BASED ON THE COST REPORT (1)	.01				6.01
		.02			-64,288	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				543,689	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.



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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL CAH
 APPLICABLE BOX:

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 FROM WKST S-3, PART I, COLUMN 15, LINE 14	471	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,004	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,586	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	31,648,444	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	393,331	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	867,890	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	729,982	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	739,793	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-9,811	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z338

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES: [] TITLE XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	445,793		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, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)	101,004		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	247		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 1-3 plus lines 6 and 7)	546,797		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	546,797		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	546,797		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	3,108		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)	543,689		15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
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)	543,689		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	10,874		19.01
20	INTERIM PAYMENTS	607,977		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	-75,162		22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23



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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		2,623,953	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)			2
3	ORGAN ACQUISITION			3
4	SUBTOTAL (sum of lines 1-3)		2,623,953	4
5	PRIMARY PAYER PAYMENTS			5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)		2,650,193	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 TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)			18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)		2,650,193	19
20	DEDUCTIBLES (exclude professional component)		262,232	20
21	EXCESS REASONABLE COST (from line 16)			21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)		2,387,961	22
23	COINSURANCE			23
24	SUBTOTAL (line 22 minus line 23)		2,387,961	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)		51,773	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		45,560	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		44,016	27
28	SUBTOTAL (sum of lines 24 and 26)		2,433,521	28
29	OTHER ADJUSTMENTS (QUESTRATION)			29
30	SUBTOTAL (line 28 plus or minus line 29)		2,433,521	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)		48,670	30.01
31	INTERIM PAYMENTS		2,681,097	31
32	TENTATIVE SETTLEMENT (for contractor use only)			32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)		-296,246	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			34



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1338

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
 BOXES: SNF OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	INPATIENT HOSPITAL SNF/NF SERVICES	197,404		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	197,404		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	197,404		7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	ROUTINE SERVICE CHARGES	90,936		8
9	ANCILLARY SERVICE CHARGES	211,446		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)			12
CUSTOMARY CHARGES				
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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)			15
16	TOTAL CUSTOMARY CHARGES (see instructions)			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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)	197,404		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	SUM OF LINES 27 AND 21	197,404		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)	197,404		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)	197,404		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	197,404		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	197,404		40
41	INTERIM PAYMENTS	38,361		41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	159,043		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	4,418,496				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	6,960,747				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-4,530,470				6
7	INVENTORY					7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	150,998				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	6,999,771				11
FIXED ASSETS						
12	LAND	237,440				12
13	LAND IMPROVEMENTS	501,866				13
14	ACCUMULATED DEPRECIATION	-438,534				14
15	BUILDINGS	14,696,229				15
16	ACCUMULATED DEPRECIATION	-7,148,399				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	885,814				19
20	ACCUMULATED DEPRECIATION	-826,610				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	11,555,720				23
24	ACCUMULATED DEPRECIATION	-9,552,621				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)	9,910,905				30
OTHER ASSETS						
31	INVESTMENTS	20,158,286				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)	20,158,286				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	37,068,962				36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	625,650				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,539,958				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	2,165,608				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)	2,165,608				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	34,903,354				52
53	SPECIFIC PURPOSE FUND BALANCE					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 52-58)	34,903,354				59



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	37,068,962				60



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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		32,301,543			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		2,601,811			2
3	TOTAL (sum of line 1 and line 2)		34,903,354			3
4	ADDITIONS (credit adjustments)					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)		34,903,354			11
12	DEDUCTIONS (debit adjustments)					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)		34,903,354			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)					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)					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



COMPU-MAX

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/22/2014 Run Time: 12:50 Version: 2014.10
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	1,488,687		1,488,687	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)	1,488,687		1,488,687	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)	1,488,687		1,488,687	17
18	ANCILLARY SERVICES	3,838,834		3,838,834	18
19	OUTPATIENT SERVICES		27,784,690	27,784,690	19
20	RHC				20
21	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)	5,327,521	27,784,690	33,112,211	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		19,560,579	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)		19,560,579	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	33,112,211	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	12,264,815	2
3	NET PATIENT REVENUES (line 1 minus line 2)	20,847,396	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	19,560,579	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	1,286,817	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	117,967	6
7	INCOME FROM INVESTMENTS	563,152	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	55,462	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER 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, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER NON OPERATING REVENUE)	481,825	24
24.01	OTHER (RENTAL REVENUE)	96,588	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,314,994	25
26	TOTAL (line 5 plus line 25)	2,601,811	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	2,601,811	29



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY 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 SERV 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
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENTS							72
72.10	INTRAOCULAR LENS							72.10
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							
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	CARDIAC REHAB							193.01
194	NON-ALLOWABLE COSTS							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202