MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/27/2015 Time: 14:22 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(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		-414,405	-405,085		286,235	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-44,329				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			16,284			10
10.01	HEALTH CLINIC - RHC II			50,253			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-458,734	-338,548		286,235	200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence

not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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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	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MEMORIAL HOSPITAL-SWING BEDS	14-Z338	99914		09 / 01 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	STEELEVILLE FAMILY PRACTICCE	14-8542	99914		06 / 01 / 2015	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	CHESTER CLINIC	14-8543	99914		06 / 01 / 2015	N	O	N	15.01
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 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	8		21

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

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

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

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

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

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

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

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

Inpatient Psychiatric Faciltiy PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118

		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	112,420	7,905		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 cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

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

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the 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 / 2014	06 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/09/2015	Y	09/09/2015	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

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

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA **WORKSHEET S-3 PART I**

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	46,488.00		1,142	140	1,932	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						209		209	5
6	Hospital Adults & Peds. Swing Bed NF								110	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	46,488.00		1,351	140	2,251	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	46,488.00		1,351	140	2,251	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					187		555	26
26.01	RHC II	88.01					396		1,424	26.01
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								533	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					298	38	567	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)		168.66			298	38	567	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		1.19						26
26.01	RHC II		4.04						26.01
27	Total (sum of lines 14-26)		173.89						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

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

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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	
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
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 catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-8542** **WORKSHEET S-8**
STATISTICAL DATA

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

Clinic Address and Identification:

1	Street: 602 W. SHAWN. T	1
2	City: STEELEVILLE State: IL ZIP Code: 62288 County: RANDOLPH	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

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

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

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)	0.500097	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	840,717	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	158,046	5
6	Medicaid charges	4,588,632	6
7	Medicaid cost (line 1 times line 6)	2,294,761	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.	1,295,998	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,295,998	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	256,380		256,380	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	128,215		128,215	21
22	Partial payment by patients approved for charity care	32,450		32,450	22
23	Cost of charity care (line 21 minus line 22)	95,765		95,765	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)	2,338,803	26
27	Medicare bad debts for the entire hospital complex (see instructions)	213,666	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,125,137	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,062,775	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,158,540	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,454,538	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,315,915	1,315,915	-943,463	372,452		372,452	1
2	00200	Cap Rel Costs-Mvble Equip				1,129,530	1,129,530	-183,954	945,576	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	165,201	2,939,122	3,104,323		3,104,323		3,104,323	4
5	00500	Administrative & General	1,395,051	1,157,185	2,552,236	-47,511	2,504,725	-214,185	2,290,540	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	301,022	503,162	804,184	-25	804,159		804,159	7
8	00800	Laundry & Linen Service	56,624	57,671	114,295		114,295		114,295	8
9	00900	Housekeeping	256,458	56,240	312,698		312,698		312,698	9
10	01000	Dietary	343,584	228,164	571,748	-465,229	106,519		106,519	10
11	01100	Cafeteria				452,310	452,310	-55,936	396,374	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	268,572	21,515	290,087		290,087		290,087	13
14	01400	Central Services & Supply	56,605	613,376	669,981	-611,693	58,288		58,288	14
15	01500	Pharmacy	293,175	520,676	813,851	-366,247	447,604		447,604	15
16	01600	Medical Records & Library	343,122	79,442	422,564		422,564	-21,971	400,593	16
17	01700	Social Service	53,040	5,074	58,114		58,114		58,114	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,596,327	66,506	1,662,833		1,662,833		1,662,833	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	583,625	207,172	790,797	-66,000	724,797		724,797	50
54	05400	Radiology-Diagnostic	684,887	638,084	1,322,971	-150	1,322,821	-1,500	1,321,321	54
60	06000	Laboratory	580,462	720,118	1,300,580	-14,362	1,286,218		1,286,218	60
62	06200	Whole Blood & Packed Red Blood Cells	30,763	143,928	174,691		174,691		174,691	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	201,347	39,522	240,869	-540	240,329	-14,852	225,477	65
66	06600	Physical Therapy		380,449	380,449		380,449		380,449	66
67	06700	Occupational Therapy		30,558	30,558		30,558		30,558	67
68	06800	Speech Pathology		37,397	37,397		37,397		37,397	68
71	07100	Medical Supplies Charged to Patients				388,117	388,117	-824	387,293	71
72	07200	Impl. Dev. Charged to Patients				223,576	223,576		223,576	72
73	07300	Drugs Charged to Patients				239,945	239,945	-65,407	174,538	73
76	03950	CARDIAC REHAB		20,772	20,772	-23,274	-2,502		-2,502	76
76.01	03951	CHEMOTHERAPY	156,959	834,043	991,002	82,562	1,073,564	-59,251	1,014,313	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	61,180	22,440	83,620		83,620		83,620	88
88.01	08801	RHC II	208,125	91,668	299,793	-13,739	286,054	-37,583	248,471	88.01
90	09000	Clinic	119,123	3,402	122,525	12,919	135,444		135,444	90
91	09100	Emergency	598,031	1,471,557	2,069,588		2,069,588	-994,351	1,075,237	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	8,353,283	12,205,158	20,558,441	-23,274	20,535,167	-1,649,814	18,885,353	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	3,696	132	3,828		3,828		3,828	190
192	19200	Physicians' Private Offices	13,601	1,651	15,252		15,252		15,252	192
193.01	19301	RHC				23,274	23,274		23,274	193.01
194	07950	NON-ALLOWABLE COSTS								194
200		TOTAL (sum of lines 118-199)	8,370,580	12,206,941	20,577,521		20,577,521	-1,649,814	18,927,707	200

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		239,945	1
500	Total reclassifications					239,945	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		388,117	1
2	RECLASS MEDICAL SUPPLIES	C	Impl. Dev. Charged to Patient	72		223,576	2
500	Total reclassifications					611,693	500
	Code Letter - C						
1	RECLASS IV THERAPY	D	CHEMOTHERAPY	76.01		82,562	1
500	Total reclassifications					82,562	500
	Code Letter - D						
1	CARDIAC REHAB	E	RHC	193.01		23,274	1
500	Total reclassifications					23,274	500
	Code Letter - E						
1	CAFETRIA	F	Cafeteria	11	278,093	174,217	1
2			Clinic	90		12,919	2
500	Total reclassifications				278,093	187,136	500
	Code Letter - F						
1	MALPRACTICE INSURANCE	G	Administrative & General	5		13,739	1
500	Total reclassifications					13,739	500
	Code Letter - G						
1	LEASE/RENTAL	H	Cap Rel Costs-Mvble Equip	2		127,949	1
2							2
3							3
4							4
5							5
6							6
7							7
500	Total reclassifications					127,949	500
	Code Letter - H						
1	RECLASS PROPERTY INSURANCE	L	Cap Rel Costs-Bldg & Fixt	1		58,118	1
500	Total reclassifications					58,118	500
	Code Letter - L						
	GRAND TOTAL (Increases)				278,093	2,345,997	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS DRUG COST	A	Pharmacy	15		239,945		1
500	Total reclassifications					239,945		500
	Code letter - A							
1	RECLASS DEPRECIATION	B	Cap Rel Costs-Bldg & Fixt	1		1,001,581	9	1
500	Total reclassifications					1,001,581		500
	Code letter - B							
1	RECLASS MEDICAL SUPPLIES	C	Central Services & Supply	14		611,693		1
2	RECLASS MEDICAL SUPPLIES	C						2
500	Total reclassifications					611,693		500
	Code letter - C							
1	RECLASS IV THERAPY	D	Pharmacy	15		82,562		1
500	Total reclassifications					82,562		500
	Code letter - D							
1	CARDIAC REHAB	E	CARDIAC REHAB	76		23,274		1
500	Total reclassifications					23,274		500
	Code letter - E							
1	CAFETRIA	F	Dietary	10	278,093	174,217		1
2			Dietary	10		12,919		2
500	Total reclassifications				278,093	187,136		500
	Code letter - F							
1	MALPRACTICE INSURANCE	G	RHC II	88.01		13,739		1
500	Total reclassifications					13,739		500
	Code letter - G							
1	LEASE/RENTAL	H	Administrative & General	5		3,132	10	1
2			Operation of Plant	7		25	10	2
3			Pharmacy	15		43,740	10	3
4			Operating Room	50		66,000	10	4
5			Radiology-Diagnostic	54		150	10	5
6			Laboratory	60		14,362	10	6
7			Respiratory Therapy	65		540	10	7
500	Total reclassifications					127,949		500
	Code letter - H							
1	RECLASS PROPERTY INSURANCE	L	Administrative & General	5		58,118	12	1
500	Total reclassifications					58,118		500
	Code letter - L							
	GRAND TOTAL (Decreases)				278,093	2,345,997		

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

RECONCILIATION OF CAPITAL COST CENTERS **WORKSHEET A-7**
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	237,440					237,440		1
2	Land Improvements	501,866	28,534		28,534		530,400		2
3	Buildings and Fixtures	14,654,409	163,703		163,703	933	14,817,179		3
4	Building Improvements								4
5	Fixed Equipment	885,814				284	885,530		5
6	Movable Equipment	9,995,565	518,455		518,455	472,995	10,041,025		6
7	HIT-designated Assets	1,560,155					1,560,155		7
8	Subtotal (sum of lines 1-7)	27,835,249	710,692		710,692	474,212	28,071,729		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	27,835,249	710,692		710,692	474,212	28,071,729		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,315,915						1,315,915	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	1,315,915						1,315,915	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	314,334			58,118			372,452	1
2	Cap Rel Costs-Mvble Equip	817,627	127,949					945,576	2
3	Total (sum of lines 1-2)	1,131,961	127,949		58,118			1,318,028	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.)

				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	-824	Medical Supplies Charged to Patients	71		4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-7,631	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	-1,068,454				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-55,936	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-21,971	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-183,954	Cap Rel Costs-Mvble Equip	2	9	32
33	RHC CRNA EXPENSE	A	-37,583	RHC II	88.01		33
34							34
35							35
35.50	REBATES	B	-65,407	Drugs Charged to Patients	73		35.50
36							36
36.03	ADMINISTRATIVE & GENERAL - MISC	B	-396	Administrative & General	5		36.03
37							37
38	NON ALLOWABLE SALARIES	A	-53,003	Administrative & General	5		38
39	NON ALLOWABLE OTHER	A	-103,376	Administrative & General	5		39
40	CRNA AND MD BILLING EXPENSE	A	-41,232	Administrative & General	5		40
41							41
42							42
43	MISC INC ANALYSIS 5010-0220	B	-7,224	Administrative & General	5		43
44	MED TECH FEES FROM CMG	B	-1,323	Administrative & General	5		44
45							45
45.02	MISC REV PET SCANNER	B	-1,500	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)		-1,649,814				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

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	

(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

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

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

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

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

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

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

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

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2	60	Laboratory AGGREGATE	20,400		20,400					2
3	65	Respiratory Therapy AGGREGATE	14,852	14,852						3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE	59,251	59,251						5
6	91	Emergency AGGREGATE	1,443,259	994,351	448,908					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	1,537,762	1,068,454	469,308					200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE							14,852	3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE							59,251	5
6	91	Emergency AGGREGATE							994,351	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							1,068,454	200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

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

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)	52	1
2	Line 1 multiplied by 15 hours per week	780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)		6
7	Standard travel expense rate		7
8	Optional travel expense rate		8

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	2,245.00	902.00	90.00			9
10	AHSEA (see instructions)	70.63	70.63	55.90			10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.32	35.32	27.95			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	158,564	14
15	Therapists (column 2, line 9 times column 2, line 10)	63,708	15
16	Assistants (column 3, line 9 times column 3, line 10)	5,031	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	227,303	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)	227,303	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	227,303	23

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

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

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

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	227,303	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)	227,303	63
64	Total cost of outside supplier services (from provider records)	30,558	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

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

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	345.00	3,496.00	5,212.00	2,157.00		9
10	AHSEA (see instructions)	74.53	74.53	55.90	37.27		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.27	37.27	27.95			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	25,713	14
15	Therapists (column 2, line 9 times column 2, line 10)	260,557	15
16	Assistants (column 3, line 9 times column 3, line 10)	291,351	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	577,621	17
18	Aides (column 4, line 9 times column 4, line 10)	80,391	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)	658,012	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	658,012	23

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

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

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

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	658,012	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)	658,012	63
64	Total cost of outside supplier services (from provider records)	372,266	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	372,452	372,452					1
2	Cap Rel Costs-Mvble Equip	945,576		945,576				2
4	Employee Benefits Department	3,104,323	7,140	18,127	3,129,590			4
5	Administrative & General	2,290,540	44,251	132,075	532,082	2,998,948	2,998,948	5
6	Maintenance & Repairs							6
7	Operation of Plant	804,159	54,168	137,517	114,812	1,110,656	209,073	7
8	Laundry & Linen Service	114,295	3,021	7,670	21,597	146,583	27,593	8
9	Housekeeping	312,698	5,432	13,792	97,815	429,737	80,895	9
10	Dietary	106,519	4,636	11,769	24,979	147,903	27,842	10
11	Cafeteria	396,374	7,776	19,741	106,067	529,958	99,761	11
12	Maintenance of Personnel							12
13	Nursing Administration	290,087	7,123	18,084	102,435	417,729	78,635	13
14	Central Services & Supply	58,288	5,085	12,909	21,590	97,872	18,424	14
15	Pharmacy	447,604	4,742	12,038	111,819	576,203	108,466	15
16	Medical Records & Library	400,593	15,661	39,761	130,869	586,884	110,477	16
17	Social Service	58,114	1,555	3,948	20,230	83,847	15,784	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	1,662,833	40,116	96,703	608,851	2,408,503	453,381	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	724,797	29,662	75,305	222,599	1,052,363	198,100	50
54	Radiology-Diagnostic	1,321,321	25,958	65,903	261,221	1,674,403	315,195	54
60	Laboratory	1,286,218	10,424	26,464	221,392	1,544,498	290,741	60
62	Whole Blood & Packed Red Blood Cells	174,691	610	1,549	11,733	188,583	35,499	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	225,477	7,267	18,450	76,795	327,989	61,742	65
66	Physical Therapy	380,449	39,603	98,446		518,498	97,604	66
67	Occupational Therapy	30,558	1,496	3,798		35,852	6,749	67
68	Speech Pathology	37,397				37,397	7,040	68
71	Medical Supplies Charged to Patients	387,293				387,293	72,905	71
72	Impl. Dev. Charged to Patients	223,576				223,576	42,087	72
73	Drugs Charged to Patients	174,538				174,538	32,856	73
76	CARDIAC REHAB	-2,502				-2,502		76
76.01	CHEMOTHERAPY	1,014,313	10,352	26,282	59,865	1,110,812	209,103	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	83,620			23,334	106,954	20,133	88
88.01	RHC II	248,471			79,380	327,851	61,716	88.01
90	Clinic	135,444	7,869	27,293	45,434	216,040	40,668	90
91	Emergency	1,075,237	19,865	50,433	228,093	1,373,628	258,576	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	18,885,353	353,812	918,057	3,122,992	18,832,596	2,981,045	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,828	3,792	9,628	1,410	18,658	3,512	190
192	Physicians' Private Offices	15,252	12,267	11,339	5,188	44,046	8,291	192
193.01	RHC	23,274	2,581	6,552		32,407	6,100	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	18,927,707	372,452	945,576	3,129,590	18,927,707	2,998,948	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,319,729						7
8	Laundry & Linen Service	15,388	189,564					8
9	Housekeeping	27,667		538,299				9
10	Dietary	23,610		9,955	209,310			10
11	Cafeteria	39,602		16,698		686,019		11
12	Maintenance of Personnel							12
13	Nursing Administration	36,278		15,297		31,481	579,420	13
14	Central Services & Supply	25,898		10,920		6,635		14
15	Pharmacy	24,150		10,183		34,365		15
16	Medical Records & Library	79,765		33,632		40,219		16
17	Social Service	7,920		3,340		6,217	10,285	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	193,996	189,564	81,797	209,310	187,115	309,555	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	151,070		63,698		68,410	113,175	50
54	Radiology-Diagnostic	132,208		55,744		80,279		54
60	Laboratory	53,090		22,385		68,039		60
62	Whole Blood & Packed Red Blood Cells	3,108		1,310		3,606		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	37,012		15,606		23,601		65
66	Physical Therapy	197,494		83,270				66
67	Occupational Therapy	7,618		3,212				67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	52,724		22,230		18,398	30,437	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					7,171		88
88.01	RHC II					24,395		88.01
90	Clinic	54,752		23,086		13,963		90
91	Emergency	101,174		42,659		70,098	115,968	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,264,524	189,564	515,022	209,310	683,992	579,420	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	19,315		8,144		433		190
192	Physicians' Private Offices	22,747		9,591		1,594		192
193.01	RHC	13,143		5,542				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,319,729	189,564	538,299	209,310	686,019	579,420	202

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	159,749						14
15	Pharmacy	18,996	772,363					15
16	Medical Records & Library			850,977				16
17	Social Service				127,393			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			56,546	127,393	4,217,160		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			63,283		1,710,099		50
54	Radiology-Diagnostic			219,435		2,477,264		54
60	Laboratory			161,442		2,140,195		60
62	Whole Blood & Packed Red Blood Cells			8,436		240,542		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			42,574		508,524		65
66	Physical Therapy			35,554		932,420		66
67	Occupational Therapy			2,445		55,876		67
68	Speech Pathology			2,110		46,547		68
71	Medical Supplies Charged to Patients	89,312		64,294		613,804		71
72	Impl. Dev. Charged to Patients	51,441		15,841		332,945		72
73	Drugs Charged to Patients		227,297	86,194		520,885		73
76	CARDIAC REHAB					-2,502		76
76.01	CHEMOTHERAPY		545,066	39,217		2,027,987		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			3,261		137,519		88
88.01	RHC II			8,367		422,329		88.01
90	Clinic			7,595		356,104		90
91	Emergency			34,383		1,996,486		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	159,749	772,363	850,977	127,393	18,734,184		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					50,062		190
192	Physicians' Private Offices					86,269		192
193.01	RHC					57,192		193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	159,749	772,363	850,977	127,393	18,927,707		202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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	4,217,160						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,710,099						50
54	Radiology-Diagnostic	2,477,264						54
60	Laboratory	2,140,195						60
62	Whole Blood & Packed Red Blood Cells	240,542						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	508,524						65
66	Physical Therapy	932,420						66
67	Occupational Therapy	55,876						67
68	Speech Pathology	46,547						68
71	Medical Supplies Charged to Patients	613,804						71
72	Impl. Dev. Charged to Patients	332,945						72
73	Drugs Charged to Patients	520,885						73
76	CARDIAC REHAB	-2,502						76
76.01	CHEMOTHERAPY	2,027,987						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	137,519						88
88.01	RHC II	422,329						88.01
90	Clinic	356,104						90
91	Emergency	1,996,486						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	18,734,184						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	50,062						190
192	Physicians' Private Offices	86,269						192
193.01	RHC	57,192						193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	18,927,707						202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		7,140	18,127	25,267	25,267		4
5	Administrative & General		44,251	132,075	176,326	4,295	180,621	5
6	Maintenance & Repairs							6
7	Operation of Plant		54,168	137,517	191,685	927	12,593	7
8	Laundry & Linen Service		3,021	7,670	10,691	174	1,662	8
9	Housekeeping		5,432	13,792	19,224	790	4,872	9
10	Dietary		4,636	11,769	16,405	202	1,677	10
11	Cafeteria		7,776	19,741	27,517	856	6,009	11
12	Maintenance of Personnel							12
13	Nursing Administration		7,123	18,084	25,207	827	4,736	13
14	Central Services & Supply		5,085	12,909	17,994	174	1,110	14
15	Pharmacy		4,742	12,038	16,780	903	6,533	15
16	Medical Records & Library		15,661	39,761	55,422	1,056	6,654	16
17	Social Service		1,555	3,948	5,503	163	951	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		40,116	96,703	136,819	4,919	27,300	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		29,662	75,305	104,967	1,797	11,932	50
54	Radiology-Diagnostic		25,958	65,903	91,861	2,109	18,984	54
60	Laboratory		10,424	26,464	36,888	1,787	17,512	60
62	Whole Blood & Packed Red Blood Cells		610	1,549	2,159	95	2,138	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		7,267	18,450	25,717	620	3,719	65
66	Physical Therapy		39,603	98,446	138,049		5,879	66
67	Occupational Therapy		1,496	3,798	5,294		406	67
68	Speech Pathology						424	68
71	Medical Supplies Charged to Patients						4,391	71
72	Impl. Dev. Charged to Patients						2,535	72
73	Drugs Charged to Patients						1,979	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		10,352	26,282	36,634	483	12,594	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					188	1,213	88
88.01	RHC II					641	3,717	88.01
90	Clinic		7,869	27,293	35,162	367	2,449	90
91	Emergency		19,865	50,433	70,298	1,841	15,574	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		353,812	918,057	1,271,869	25,214	179,543	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3,792	9,628	13,420	11	212	190
192	Physicians' Private Offices		12,267	11,339	23,606	42	499	192
193.01	RHC		2,581	6,552	9,133		367	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		372,452	945,576	1,318,028	25,267	180,621	202

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	205,205						7
8	Laundry & Linen Service	2,393	14,920					8
9	Housekeeping	4,302		29,188				9
10	Dietary	3,671		540	22,495			10
11	Cafeteria	6,158		905		41,445		11
12	Maintenance of Personnel							12
13	Nursing Administration	5,641		829		1,902	39,142	13
14	Central Services & Supply	4,027		592		401		14
15	Pharmacy	3,755		552		2,076		15
16	Medical Records & Library	12,403		1,824		2,430		16
17	Social Service	1,232		181		376	695	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	30,164	14,920	4,435	22,495	11,304	20,912	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	23,490		3,454		4,133	7,645	50
54	Radiology-Diagnostic	20,557		3,023		4,850		54
60	Laboratory	8,255		1,214		4,110		60
62	Whole Blood & Packed Red Blood Cells	483		71		218		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,755		846		1,426		65
66	Physical Therapy	30,707		4,516				66
67	Occupational Therapy	1,185		174				67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	8,198		1,205		1,111	2,056	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					433		88
88.01	RHC II					1,474		88.01
90	Clinic	8,513		1,252		844		90
91	Emergency	15,732		2,313		4,235	7,834	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	196,621	14,920	27,926	22,495	41,323	39,142	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,003		442		26		190
192	Physicians' Private Offices	3,537		520		96		192
193.01	RHC	2,044		300				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	205,205	14,920	29,188	22,495	41,445	39,142	202

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	24,298						14
15	Pharmacy	2,889	33,488					15
16	Medical Records & Library			79,789				16
17	Social Service				9,101			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			5,303	9,101	287,672		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			5,935		163,353		50
54	Radiology-Diagnostic			20,563		161,947		54
60	Laboratory			15,140		84,906		60
62	Whole Blood & Packed Red Blood Cells			791		5,955		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			3,993		42,076		65
66	Physical Therapy			3,334		182,485		66
67	Occupational Therapy			229		7,288		67
68	Speech Pathology			198		622		68
71	Medical Supplies Charged to Patients	13,585		6,029		24,005		71
72	Impl. Dev. Charged to Patients	7,824		1,486		11,845		72
73	Drugs Charged to Patients		9,855	8,083		19,917		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		23,633	3,678		89,592		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			306		2,140		88
88.01	RHC II			785		6,617		88.01
90	Clinic			712		49,299		90
91	Emergency			3,224		121,051		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,298	33,488	79,789	9,101	1,260,770		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					17,114		190
192	Physicians' Private Offices					28,300		192
193.01	RHC					11,844		193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,298	33,488	79,789	9,101	1,318,028		202

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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	287,672						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	163,353						50
54	Radiology-Diagnostic	161,947						54
60	Laboratory	84,906						60
62	Whole Blood & Packed Red Blood Cells	5,955						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	42,076						65
66	Physical Therapy	182,485						66
67	Occupational Therapy	7,288						67
68	Speech Pathology	622						68
71	Medical Supplies Charged to Patients	24,005						71
72	Impl. Dev. Charged to Patients	11,845						72
73	Drugs Charged to Patients	19,917						73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	89,592						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,140						88
88.01	RHC II	6,617						88.01
90	Clinic	49,299						90
91	Emergency	121,051						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,260,770						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	17,114						190
192	Physicians' Private Offices	28,300						192
193.01	RHC	11,844						193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,318,028						202

	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	8,205,379				4
5	Administrative & General	10,443	12,277	1,395,051	-2,998,948	15,931,261		5
6	Maintenance & Repairs							6
7	Operation of Plant	12,783	12,783	301,022		1,110,656	61,151	7
8	Laundry & Linen Service	713	713	56,624		146,583	713	8
9	Housekeeping	1,282	1,282	256,458		429,737	1,282	9
10	Dietary	1,094	1,094	65,491		147,903	1,094	10
11	Cafeteria	1,835	1,835	278,093		529,958	1,835	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,681	1,681	268,572		417,729	1,681	13
14	Central Services & Supply	1,200	1,200	56,605		97,872	1,200	14
15	Pharmacy	1,119	1,119	293,175		576,203	1,119	15
16	Medical Records & Library	3,696	3,696	343,122		586,884	3,696	16
17	Social Service	367	367	53,040		83,847	367	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,467	8,989	1,596,327		2,408,503	8,989	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,000	7,000	583,625		1,052,363	7,000	50
54	Radiology-Diagnostic	6,126	6,126	684,887		1,674,403	6,126	54
60	Laboratory	2,460	2,460	580,462		1,544,498	2,460	60
62	Whole Blood & Packed Red Blood Cells	144	144	30,763		188,583	144	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,715	1,715	201,347		327,989	1,715	65
66	Physical Therapy	9,346	9,151			518,498	9,151	66
67	Occupational Therapy	353	353			35,852	353	67
68	Speech Pathology					37,397		68
71	Medical Supplies Charged to Patients					387,293		71
72	Impl. Dev. Charged to Patients					223,576		72
73	Drugs Charged to Patients					174,538		73
76	CARDIAC REHAB				2,502			76
76.01	CHEMOTHERAPY	2,443	2,443	156,959		1,110,812	2,443	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			61,180		106,954		88
88.01	RHC II			208,125		327,851		88.01
90	Clinic	1,857	2,537	119,123		216,040	2,537	90
91	Emergency	4,688	4,688	598,031		1,373,628	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)	83,497	85,338	8,188,082	-2,996,446	15,836,150	58,593	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	895	895	3,696		18,658	895	190
192	Physicians' Private Offices	2,895	1,054	13,601		44,046	1,054	192
193.01	RHC	609	609			32,407	609	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	372,452	945,576	3,129,590		2,998,948	1,319,729	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.237417	10.757896	0.381407		0.188243	21.581479	203
204	Cost to be allocated (Per Wkst. B, Part II)			25,267		180,621	205,205	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.003079		0.011338	3.355710	205

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

	COST CENTER DESCRIPTIONS	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINI-STRATION SALARIES	CENTRAL SERVICES & SUPPLY COSTED REQUIS	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	1,932						8
9	Housekeeping		59,156					9
10	Dietary		1,094	1,932				10
11	Cafeteria		1,835		5,852,640			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,681		268,572	2,987,982		13
14	Central Services & Supply		1,200		56,605		694,315	14
15	Pharmacy		1,119		293,175		82,562	15
16	Medical Records & Library		3,696		343,122			16
17	Social Service		367		53,040	53,040		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,932	8,989	1,932	1,596,327	1,596,327		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		7,000		583,625	583,625		50
54	Radiology-Diagnostic		6,126		684,887			54
60	Laboratory		2,460		580,462			60
62	Whole Blood & Packed Red Blood Cells		144		30,763			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,715		201,347			65
66	Physical Therapy		9,151					66
67	Occupational Therapy		353					67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						388,177	71
72	Impl. Dev. Charged to Patients						223,576	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		2,443		156,959	156,959		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				61,180			88
88.01	RHC II				208,125			88.01
90	Clinic		2,537		119,123			90
91	Emergency		4,688		598,031	598,031		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,932	56,598	1,932	5,835,343	2,987,982	694,315	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		895		3,696			190
192	Physicians' Private Offices		1,054		13,601			192
193.01	RHC		609					193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	189,564	538,299	209,310	686,019	579,420	159,749	202
203	Unit Cost Multiplier (Wkst. B, Part I)	98.118012	9.099652	108.338509	0.117215	0.193917	0.230081	203
204	Cost to be allocated (Per Wkst. B, Part II)	14,920	29,188	22,495	41,445	39,142	24,298	204
205	Unit Cost Multiplier (Wkst. B, Part II)	7.722567	0.493407	11.643375	0.007081	0.013100	0.034996	205

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS				
		15	16	17				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	1,046,273						15
16	Medical Records & Library		37,466,134					16
17	Social Service			1,932				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		2,489,595	1,932				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,786,195					50
54	Radiology-Diagnostic		9,660,687					54
60	Laboratory		7,107,913					60
62	Whole Blood & Packed Red Blood Cells		371,411					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,874,431					65
66	Physical Therapy		1,565,380					66
67	Occupational Therapy		107,662					67
68	Speech Pathology		92,911					68
71	Medical Supplies Charged to Patients		2,830,721					71
72	Impl. Dev. Charged to Patients		697,447					72
73	Drugs Charged to Patients	307,905	3,794,938					73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	738,368	1,726,642					76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		143,582					88
88.01	RHC II		368,396					88.01
90	Clinic		334,409					90
91	Emergency		1,513,814					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,046,273	37,466,134	1,932				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193.01	RHC							193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	772,363	850,977	127,393				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.738204	0.022713	65.938406				203
204	Cost to be allocated (Per Wkst. B, Part II)	33,488	79,789	9,101				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.032007	0.002130	4.710663				205

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,217,160		4,217,160			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,710,099		1,710,099			50
54	Radiology-Diagnostic	2,477,264		2,477,264			54
60	Laboratory	2,140,195		2,140,195			60
62	Whole Blood & Packed Red Blood Cells	240,542		240,542			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	508,524		508,524			65
66	Physical Therapy	932,420		932,420			66
67	Occupational Therapy	55,876		55,876			67
68	Speech Pathology	46,547		46,547			68
71	Medical Supplies Charged to Patients	613,804		613,804			71
72	Impl. Dev. Charged to Patients	332,945		332,945			72
73	Drugs Charged to Patients	520,885		520,885			73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	2,027,987		2,027,987			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	137,519		137,519			88
88.01	RHC II	422,329		422,329			88.01
90	Clinic	356,104		356,104			90
91	Emergency	1,996,486		1,996,486			91
92	Observation Beds (Non-Distinct Part)	837,444		837,444			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	19,574,130		19,574,130			200
201	Less Observation Beds	837,444		837,444			201
202	Total (line 200 minus line 201)	18,736,686		18,736,686			202

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C**
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	1,916,597		1,916,597				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	331,898	2,454,297	2,786,195	0.613776			50
54	Radiology-Diagnostic	465,005	9,195,682	9,660,687	0.256427			54
60	Laboratory	989,381	6,118,532	7,107,913	0.301100			60
62	Whole Blood & Packed Red Blood Cells	122,248	249,163	371,411	0.647644			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	390,146	1,484,285	1,874,431	0.271295			65
66	Physical Therapy	237,765	1,327,615	1,565,380	0.595651			66
67	Occupational Therapy	48,078	59,584	107,662	0.518995			67
68	Speech Pathology	22,143	70,768	92,911	0.500985			68
71	Medical Supplies Charged to Patients	819,035	2,011,686	2,830,721	0.216837			71
72	Impl. Dev. Charged to Patients	437,623	259,824	697,447	0.477377			72
73	Drugs Charged to Patients	870,806	2,924,132	3,794,938	0.137258			73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	81,330	1,645,312	1,726,642	1.174527			76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		143,582	143,582				88
88.01	RHC II		368,396	368,396				88.01
90	Clinic		334,409	334,409	1.064876			90
91	Emergency	3,075	1,510,739	1,513,814	1.318845			91
92	Observation Beds (Non-Distinct Part)		572,998	572,998	1.461513			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	6,735,130	30,731,004	37,466,134				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	6,735,130	30,731,004	37,466,134				202

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.613776		703,993			432,094		50
54	Radiology-Diagnostic	0.256427		2,950,273			756,530		54
60	Laboratory	0.301100		2,236,097			673,289		60
62	Whole Blood & Packed Red Blood	0.647644		160,964			104,247		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.271295		554,097			150,324		65
66	Physical Therapy	0.595651		396,005			235,881		66
67	Occupational Therapy	0.518995		16,133			8,373		67
68	Speech Pathology	0.500985		28,136			14,096		68
71	Medical Supplies Charged to Pat	0.216837		1,090,257			236,408		71
72	Impl. Dev. Charged to Patients	0.477377		75,157			35,878		72
73	Drugs Charged to Patients	0.137258		267,766			36,753		73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.174527		1,298,092	6,354		1,524,644	7,463	76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
90	Clinic	1.064876		138,832			147,839		90
91	Emergency	1.318845		607,918	2,340		801,750	3,086	91
92	Observation Beds (Non-Distinct	1.461513		200,293			292,731		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			10,724,013	8,694		5,450,837	10,549	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			10,724,013	8,694		5,450,837	10,549	202

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.613776							50
54	Radiology-Diagnostic	0.256427							54
60	Laboratory	0.301100							60
62	Whole Blood & Packed Red Blood	0.647644							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.271295							65
66	Physical Therapy	0.595651							66
67	Occupational Therapy	0.518995							67
68	Speech Pathology	0.500985							68
71	Medical Supplies Charged to Pat	0.216837							71
72	Impl. Dev. Charged to Patients	0.477377							72
73	Drugs Charged to Patients	0.137258							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.174527							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
90	Clinic	1.064876							90
91	Emergency	1.318845							91
92	Observation Beds (Non-Distinct	1.461513							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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	287,672	23,478	264,194	2,465	107.18	140	15,005	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)	287,672		264,194	2,465		140	15,005	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	163,353	2,786,195	0.058629	30,312	1,777	50
54	Radiology-Diagnostic	161,947	9,660,687	0.016764	64,734	1,085	54
60	Laboratory	84,906	7,107,913	0.011945	99,125	1,184	60
62	Whole Blood & Packed Red Blood	5,955	371,411	0.016033	7,386	118	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	42,076	1,874,431	0.022447	18,661	419	65
66	Physical Therapy	182,485	1,565,380	0.116576			66
67	Occupational Therapy	7,288	107,662	0.067693			67
68	Speech Pathology	622	92,911	0.006695			68
71	Medical Supplies Charged to Pat	24,005	2,830,721	0.008480	72,419	614	71
72	Impl. Dev. Charged to Patients	11,845	697,447	0.016983	6,507	111	72
73	Drugs Charged to Patients	19,917	3,794,938	0.005248	79,570	418	73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	89,592	1,726,642	0.051888			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	2,140	143,582	0.014904			88
88.01	RHC II	6,617	368,396	0.017962			88.01
90	Clinic	49,299	334,409	0.147421			90
91	Emergency	121,051	1,513,814	0.079964			91
92	Observation Beds (Non-Distinct	62,203	572,998	0.108557			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,035,301	35,549,537		378,714	5,726	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,465		140		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	2,465		140		200

(A) Worksheet A line numbers

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

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,786,195			30,312				50
54	Radiology-Diagnostic	9,660,687			64,734				54
60	Laboratory	7,107,913			99,125				60
62	Whole Blood & Packed Red Blood	371,411			7,386				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,874,431			18,661				65
66	Physical Therapy	1,565,380							66
67	Occupational Therapy	107,662							67
68	Speech Pathology	92,911							68
71	Medical Supplies Charged to Pat	2,830,721			72,419				71
72	Impl. Dev. Charged to Patients	697,447			6,507				72
73	Drugs Charged to Patients	3,794,938			79,570				73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1,726,642							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	143,582							88
88.01	RHC II	368,396							88.01
90	Clinic	334,409							90
91	Emergency	1,513,814							91
92	Observation Beds (Non-Distinct	572,998							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	35,549,537			378,714				200

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.613776							50
54	Radiology-Diagnostic	0.256427							54
60	Laboratory	0.301100							60
62	Whole Blood & Packed Red Blood	0.647644							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.271295							65
66	Physical Therapy	0.595651							66
67	Occupational Therapy	0.518995							67
68	Speech Pathology	0.500985							68
71	Medical Supplies Charged to Pat	0.216837							71
72	Impl. Dev. Charged to Patients	0.477377							72
73	Drugs Charged to Patients	0.137258							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.174527							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
90	Clinic	1.064876							90
91	Emergency	1.318845							91
92	Observation Beds (Non-Distinct	1.461513							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] 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)	2,784	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,465	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)	1,932	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	105	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)	104	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	55	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	55	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,142	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)	105	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)	104	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.66	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.73	20
21	Total general inpatient routine service cost (see instructions)	4,217,160	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	7,681	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	8,125	25
26	Total swing-bed cost (see instructions)	344,185	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,872,975	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,872,975	37

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,571.19	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,794,299	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)					1,794,299	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					772,924	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,567,223	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					164,975	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					163,404	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					328,379	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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					533	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,571.19	88
89	Observation bed cost (line 87 x line 88) (see instructions)					837,444	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	287,672	3,872,975	0.074277	837,444	62,203	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,784	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,465	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)	1,932	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	105	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)	104	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	55	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	55	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	140	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.66	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.73	20
21	Total general inpatient routine service cost (see instructions)	4,217,160	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	7,681	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	8,125	25
26	Total swing-bed cost (see instructions)	344,185	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,872,975	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,872,975	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,571.19	38
39	Program general inpatient routine service cost (line 9 x line 38)	219,967	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)	219,967	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	104,629	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	324,596	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	15,005	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,726	51
52	Total Program excludable cost (sum of lines 50 and 51)	20,731	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					533	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		969,795		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.613776	155,214	95,267	50
54	Radiology-Diagnostic	0.256427	262,149	67,222	54
60	Laboratory	0.301100	563,165	169,569	60
62	Whole Blood & Packed Red Blood Cells	0.647644	61,408	39,771	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.271295	202,037	54,812	65
66	Physical Therapy	0.595651	80,041	47,677	66
67	Occupational Therapy	0.518995	9,870	5,122	67
68	Speech Pathology	0.500985	12,319	6,172	68
71	Medical Supplies Charged to Patients	0.216837	572,109	124,054	71
72	Impl. Dev. Charged to Patients	0.477377	223,722	106,800	72
73	Drugs Charged to Patients	0.137258	379,668	52,112	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.174527	361	424	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
90	Clinic	1.064876			90
91	Emergency	1.318845	2,974	3,922	91
92	Observation Beds (Non-Distinct Part)	1.461513			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,525,037	772,924	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,525,037		202

(A) Worksheet A line numbers

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.613776			50
54	Radiology-Diagnostic	0.256427	10,504	2,694	54
60	Laboratory	0.301100	37,630	11,330	60
62	Whole Blood & Packed Red Blood Cells	0.647644	2,563	1,660	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.271295	16,113	4,371	65
66	Physical Therapy	0.595651	62,230	37,067	66
67	Occupational Therapy	0.518995	16,246	8,432	67
68	Speech Pathology	0.500985	5,745	2,878	68
71	Medical Supplies Charged to Patients	0.216837	50,935	11,045	71
72	Impl. Dev. Charged to Patients	0.477377			72
73	Drugs Charged to Patients	0.137258	31,542	4,329	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.174527			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
90	Clinic	1.064876			90
91	Emergency	1.318845			91
92	Observation Beds (Non-Distinct Part)	1.461513			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		233,508	83,806	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		233,508		202

(A) Worksheet A line numbers

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		100,038		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.613776	30,312	18,605	50
54	Radiology-Diagnostic	0.256427	64,734	16,600	54
60	Laboratory	0.301100	99,125	29,847	60
62	Whole Blood & Packed Red Blood Cells	0.647644	7,386	4,783	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.271295	18,661	5,063	65
66	Physical Therapy	0.595651			66
67	Occupational Therapy	0.518995			67
68	Speech Pathology	0.500985			68
71	Medical Supplies Charged to Patients	0.216837	72,419	15,703	71
72	Impl. Dev. Charged to Patients	0.477377	6,507	3,106	72
73	Drugs Charged to Patients	0.137258	79,570	10,922	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.174527			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
90	Clinic	1.064876			90
91	Emergency	1.318845			91
92	Observation Beds (Non-Distinct Part)	1.461513			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		378,714	104,629	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		378,714		202

(A) Worksheet A line numbers

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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,461,386			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,461,386			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	5,516,000			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	14,550			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,717,904			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,783,546			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,783,546			30
31	Primary payer payments	90			31
32	Subtotal (line 30 minus line 31)	3,783,456			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)	247,178			34
35	Adjusted reimbursable bad debts (see instructions)	187,855			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	217,472			36
37	Subtotal (see instructions)	3,971,311			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,971,311			40
40.01	Sequestration adjustment (see instructions)	79,426			40.01
41	Interim payments	4,296,970			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-405,085			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,918,955		3,947,114	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				40,650		227,816	2
3	List separately each retroactive lump sum adjustment		.01			02/24/2015	60,426	3.01
	amount based on subsequent revision of the interim		.02			06/23/2015	61,614	3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	02/24/2015	128,673			3.51
		Provider	.52	06/23/2015	100,914			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		-229,587		122,040	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)				2,730,018		4,296,970	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-414,405		-405,085	6.02
7	Total Medicare program liability (see instructions)				2,315,613		3,891,885	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.

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				507,842			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	02/24/2015	23,624			3.50
			.51	06/23/2015	31,908			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		-55,532			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)				452,310			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-44,329			6.02
7	Total Medicare program liability (see instructions)				407,981			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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	567	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,142	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,932	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	37,466,134	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	256,380	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

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

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	331,663		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	84,644		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	209		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	416,307		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	416,307		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	416,307		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			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)	416,307		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	416,307		19
19.01	Sequestration adjustment (see instructions)	8,326		19.01
20	Interim payments	452,310		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-44,329		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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

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

1	Inpatient services	2,567,223	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,567,223	4
5	Primary payer payments	2,200	5
6	Total cost (see instructions)	2,590,695	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,590,695	19
20	Deductibles (exclude professional component)	253,636	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,337,059	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,337,059	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,962	25
26	Adjusted reimbursable bad debts (see instructions)	25,811	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	31,405	27
28	Subtotal (sum of lines 24 and 26)	2,362,870	28
29	Other adjustments (QUESTRATION)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,362,870	30
30.01	Sequestration adjustment (see instructions)	47,257	30.01
31	Interim payments	2,730,018	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-414,405	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	324,596		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	324,596		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	324,596		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	90,936		8
9	Ancillary service charges	378,714		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)	469,650		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	469,650		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	324,596		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	324,596		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)	324,596		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)	324,596		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	324,596		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	324,596		40
41	Interim payments	38,361		41
42	Balance due provider/program (line 40 minus line 41)	286,235		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	5,554,636				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	8,719,312				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-5,441,311				6
7	Inventory	202,593				7
8	Prepaid expenses	320,832				8
9	Other current assets	13,327				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	9,369,389				11
	FIXED ASSETS					
12	Land	237,440				12
13	Land improvements	530,400				13
14	Accumulated depreciation	-454,859				14
15	Buildings	14,304,443				15
16	Accumulated depreciation	-7,658,516				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	1,424,493				19
20	Accumulated depreciation	-833,479				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,435,364				23
24	Accumulated depreciation	-9,980,931				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)	9,004,355				30
	OTHER ASSETS					
31	Investments	21,143,003				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)	21,143,003				35
36	Total assets (sum of lines 11, 30 and 35)	39,516,747				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	778,943				37
38	Salaries, wages and fees payable	1,326,733				38
39	Payroll taxes payable	60,193				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	368,520				44
45	Total current liabilities (sum of lines 37 thru 44)	2,534,389				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)	2,534,389				51
	CAPITAL ACCOUNTS					
52	General fund balance	36,982,358				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	36,982,358				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	39,516,747				60

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		33,239,068			1
2	Net income (loss) (from Worksheet G-3, line 29)		3,743,290			2
3	Total (sum of line 1 and line 2)		36,982,358			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		36,982,358			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,982,358			19

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,883,824		1,883,824	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)	1,883,824		1,883,824	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)	1,883,824		1,883,824	17
18	Ancillary services	4,818,533		4,818,533	18
19	Outpatient services		31,805,813	31,805,813	19
20	Rural Health Clinic (RHC)		143,582	143,582	20
20.01	RHC II		368,396	368,396	20.01
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		62,632	62,632	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	6,702,357	32,380,423	39,082,780	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		20,577,521	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)		20,577,521	43

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	39,082,780	1
2	Less contractual allowances and discounts on patients' accounts	15,320,574	2
3	Net patient revenues (line 1 minus line 2)	23,762,206	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	20,577,521	4
5	Net income from service to patients (line 3 minus line 4)	3,184,685	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	93,499	6
7	Income from investments	366,601	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER NON OPERATING REVENUE)	410,404	24
24.01	Other (OTHER NON OPERATING)	-464,612	24.01
24.02	Other (RHC OTHER AND NON OPERATING)	152,713	24.02
25	Total other income (sum of lines 6-24)	558,605	25
26	Total (line 5 plus line 25)	3,743,290	26
29	Net income (or loss) for the period (line 26 minus line 28)	3,743,290	29

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES **WORKSHEET L-1**
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193.01	RHC							193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

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

COMPONENT CCN: 14-8542

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	30,462		30,462		30,462		30,462	1
2	Physician Assistant	15,586		15,586		15,586		15,586	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	15,132	272	15,404		15,404		15,404	9
10	Subtotal (sum of lines 1 through 9)	61,180	272	61,452		61,452		61,452	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)								21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	61,180	272	61,452		61,452		61,452	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs		22,168	22,168		22,168		22,168	30
31	Total Facility Overhead (sum of lines 29 and 30)		22,168	22,168		22,168		22,168	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	61,180	22,440	83,620		83,620		83,620	32

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8542** **WORKSHEET M-2**

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.05	246	4,200	210		1
2	Physician Assistants	0.08	309	2,100	168		2
3	Nurse Practitioners			2,100			3
4	Subtotal (sum of lines 1 through 3)	0.13	555		378	555	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	0.13	555			555	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	61,452	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	61,452	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	22,168	14
15	Parent provider overhead allocated to facility (see instructions)	53,899	15
16	Total overhead (sum of lines 14 and 15)	76,067	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	76,067	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	76,067	19
20	Total allowable cost of RHC/FQHC sservices(sum of lines 10 and 19)	137,519	20

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8542** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	137,519	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	137,519	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	555	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	555	6
7	Adjusted cost per visit (line 3 divided by line 6)	247.78	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	247.78	247.78	247.78	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		187		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		46,335		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		46,335		16
16.01	Total program charges (see instructions)(from contractor's records)		24,752		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		36,782		16.04
16.05	Total program cost (see instructions)		36,782		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		358		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,878		19
20	Net Medicare cost excluding vaccines (see instructions)		36,782		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				21
22	Total reimbursable Program cost (line 20 plus line 21)		36,782		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		36,782		26
26.01	Sequestration adjustment (see instructions)		736		26.01
27	Interim payments		19,762		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		16,284		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8542** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	61,452	61,452	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	61,452	61,452	6
7	Total overhead (from Wkst. M-2, line 16)	76,067	76,067	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **COMPONENT CCN: 14-8542** **WORKSHEET M-5**

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				19,762	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				19,762	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		16,284	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				36,046	
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

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

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

COMPONENT CCN: 14-8543

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	83,916		83,916		83,916	-37,583	46,333	1
2	Physician Assistant	17,463		17,463		17,463		17,463	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian	7,375	7,756	15,131		15,131		15,131	8
9	Other Facility Health Care Staff Costs	36,629	4,593	41,222		41,222		41,222	9
10	Subtotal (sum of lines 1 through 9)	145,383	12,349	157,732		157,732	-37,583	120,149	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		4,980	4,980		4,980		4,980	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		13,739	13,739	-13,739				18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		18,719	18,719	-13,739	4,980		4,980	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	145,383	31,068	176,451	-13,739	162,712	-37,583	125,129	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	62,742	60,600	123,342		123,342		123,342	30
31	Total Facility Overhead (sum of lines 29 and 30)	62,742	60,600	123,342		123,342		123,342	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	208,125	91,668	299,793	-13,739	286,054	-37,583	248,471	32

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

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

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.15	867	4,200	630		1
2	Physician Assistants	0.11	557	2,100	231		2
3	Nurse Practitioners			2,100			3
4	Subtotal (sum of lines 1 through 3)	0.26	1,424		861	1,424	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	0.26	1,424			1,424	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	125,129	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	125,129	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	123,342	14
15	Parent provider overhead allocated to facility (see instructions)	173,858	15
16	Total overhead (sum of lines 14 and 15)	297,200	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	297,200	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	297,200	19
20	Total allowable cost of RHC/FQHC sservices(sum of lines 10 and 19)	422,329	20

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

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

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

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	422,329	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	422,329	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	1,424	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	1,424	6
7	Adjusted cost per visit (line 3 divided by line 6)	296.58	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	296.58	296.58	296.58	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		396		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		117,446		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		117,446		16
16.01	Total program charges (see instructions)(from contractor's records)		49,198		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		92,682		16.04
16.05	Total program cost (see instructions)		92,682		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		1,594		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,520		19
20	Net Medicare cost excluding vaccines (see instructions)		92,682		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				21
22	Total reimbursable Program cost (line 20 plus line 21)		92,682		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		92,682		26
26.01	Sequestration adjustment (see instructions)		1,854		26.01
27	Interim payments		40,575		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		50,253		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

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

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	120,149	120,149	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	125,129	125,129	6
7	Total overhead (from Wkst. M-2, line 16)	297,200	297,200	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			16

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/27/2015 Run Time: 14:22 Version: 2015.10 (11/24/2015)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **COMPONENT CCN: 14-8543** **WORKSHEET M-5**

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				40,575	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				40,575	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		50,253	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				90,828	
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

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