

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report Date: 11/14/2018 Time: 15:56 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL (14-1338) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

 Title

 Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX	
	TITLE V	PART A	PART B			
	1	2	3	4	5	
1	HOSPITAL	183,088	579,742			1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF	-38,406				5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC		172,270			10
10.01	HEALTH CLINIC - RHC II					10.01
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	144,682	752,012			200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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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:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
	0	1	2	3	4	5	V	XVIII	XIX	
3	Hospital	MEMORIAL HOSPITAL	14-1338	99914	1	09 / 01 / 2004	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MEMORIAL HOSPITAL-SWING BEDS	14-Z338	99914		09 / 01 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CHESTER CLINIC	14-8543	99914		06 / 01 / 2015	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	STEELEVILLE FAMILY PRACTICE	14-8542	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 / 2017	To: 06 / 30 / 2018		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 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.							25

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

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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)(i) or (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)(i) or (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	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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
56	Teaching Hospitals 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 as 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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

Teaching Hospitals that Claim Residents in 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 through 67. (see instructions)	N			63
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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 column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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 Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06

Rural Providers

		1	2	
105	Does this hospital qualify as a 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 elimination 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
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	109

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	N		111

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-L, 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
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance
		321,534		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

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

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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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		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.	N		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 transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2017	06 / 30 / 2018		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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	12/31/2018	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 instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts		Y	
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

		Y/N	
Bed Complement		N	
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	09/20/2018	Y	09/20/2018	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 Report 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

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

Capital Related Cost		
22	Have assets been relined 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.	N 33

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

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

Cost Report Preparer Contact Information			
41	First name: RAJ	Last name: SHAH	Title: MANAGER 41
42	Employer: STRATEGIC REIMBURSEMENT GROUP, LLC		42
43	Phone number: 630-530-7100 X 107	E-mail Address: RAJ.SHAH@SRGROUPLLC.COM 43	

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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	41,976.00		776	75	1,749	1
2	HMO and other (see instructions)						147	5		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						138		138	5
6	Hospital Adults & Peds. Swing Bed NF								171	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	41,976.00		914	75	2,058	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	41,976.00		914	75	2,058	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					5,448		23,243	26
26.01	RHC II	88.01								26.01
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								187	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
33.01	LTCH site neutral days and discharges									33.01

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

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					213	26	492	1
2	HMO and other (see instructions)					40	2		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)		196.91			213	26	492	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		48.10						26
26.01	RHC II								26.01
27	Total (sum of lines 14-26)		245.01						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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

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

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

SNF SERVICES

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

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

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

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-8543

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

1	Street: 2319 OLD PLANK	1
2	City: CHESTER State: IL ZIP Code: 62223 County: RANDOLPH	2
3	HOSPITAL-BASED 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 a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

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

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

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	Y	2	13
14	RHC/FQHC name: MEMORIAL HOSPITAL, RHC CCN number: 14-8542			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

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

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.530170	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,006,181	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	3,152,258	6
7	Medicaid cost (line 1 times line 6)	1,671,233	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.	665,052	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng 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)	665,052	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	50,160	75,842	126,002	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	26,593	75,842	102,435	21
22	Payments received from patients for amounts previously written off as charity care	1,198	740	1,938	22
23	Cost of charity care (line 21 minus line 22)	25,395	75,102	100,497	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,605,000	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	193,222	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	297,264	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,307,736	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	797,364	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	897,861	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,562,913	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		991,748	991,748	-476,271	515,477		515,477	1
2	00200	Cap Rel Costs-Mvble Equip				662,149	662,149	-4,260	657,889	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	166,100	2,643,795	2,809,895		2,809,895		2,809,895	4
5	00500	Administrative & General	1,424,319	1,581,175	3,005,494	601,129	3,606,623	-87,417	3,519,206	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	367,990	497,003	864,993	-128	864,865	-3,500	861,365	7
8	00800	Laundry & Linen Service	52,159	49,436	101,595		101,595		101,595	8
9	00900	Housekeeping	274,405	77,769	352,174		352,174		352,174	9
10	01000	Dietary	348,227	215,215	563,442	-362,193	201,249		201,249	10
11	01100	Cafeteria				362,193	362,193	-59,592	302,601	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	397,429	56,640	454,069		454,069		454,069	13
14	01400	Central Services & Supply	65,296	736,389	801,685	-723,834	77,851	-724	77,127	14
15	01500	Pharmacy	339,193	544,842	884,035	-433,754	450,281	-69,104	381,177	15
16	01600	Medical Records & Library	452,932	100,658	553,590		553,590	-12,730	540,860	16
17	01700	Social Service								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	1,928,976	211,555	2,140,531	2,185	2,142,716		2,142,716	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	658,721	205,695	864,416	-66,520	797,896		797,896	50
54	05400	Radiology-Diagnostic	756,308	687,019	1,443,327		1,443,327	-2,532	1,440,795	54
60	06000	Laboratory	680,090	708,301	1,388,391	-25,632	1,362,759		1,362,759	60
62	06200	Whole Blood & Packed Red Blood Cells	30,586	73,101	103,687		103,687		103,687	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy		58,537	58,537	-58,537				64
65	06500	Respiratory Therapy	257,688	104,465	362,153	-359	361,794	-42,420	319,374	65
66	06600	Physical Therapy		364,083	364,083		364,083		364,083	66
67	06700	Occupational Therapy		59,758	59,758		59,758		59,758	67
68	06800	Speech Pathology		38,681	38,681		38,681		38,681	68
71	07100	Medical Supplies Charged to Patients				494,349	494,349	-165,032	329,317	71
72	07200	Impl. Dev. Charged to Patients				281,065	281,065		281,065	72
73	07300	Drugs Charged to Patients				408,239	408,239		408,239	73
76	03950	CARDIAC REHAB								76
76.01	03951	CHEMOTHERAPY	188,387	1,435,889	1,624,276	2,495	1,626,771	-140,750	1,486,021	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	2,986,034	2,220,031	5,206,065	-669,373	4,536,692	-1,030,115	3,506,577	88
90	09000	Clinic	221,341	119,819	341,160		341,160	-75,104	266,056	90
91	09100	Emergency	307,160	1,597,025	1,904,185	2,797	1,906,982	-1,033,270	873,712	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	11,903,341	15,378,629	27,281,970		27,281,970	-2,726,550	24,555,420	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	2,979	232	3,211		3,211		3,211	190
192	19200	Physicians' Private Offices								192
193.01	19301	CARDIAC REHAB		10,935	10,935		10,935		10,935	193.01
194	07950	NON-ALLOWABLE COSTS								194
200		TOTAL (sum of lines 118-199)	11,906,320	15,389,796	27,296,116		27,296,116	-2,726,550	24,569,566	200

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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS DRUG COST	A	Drugs Charged to Patients	73		408,239	1
500	Total reclassifications					408,239	500
	Code Letter - A						
1	RECLASS DEPRECIATION	B	Cap Rel Costs-Mvble Equip	2		543,225	1
500	Total reclassifications					543,225	500
	Code Letter - B						
1	RECLASS MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		494,349	1
2	RECLASS MEDICAL SUPPLIES	C	Impl. Dev. Charged to Patient	72		281,065	2
3							3
500	Total reclassifications					775,414	500
	Code Letter - C						
1	CAFETERIA	F	Cafeteria	11	223,848	138,345	1
500	Total reclassifications				223,848	138,345	500
	Code Letter - F						
1	RHC MALPRACTICE	G	Administrative & General	5		60,451	1
500	Total reclassifications					60,451	500
	Code Letter - G						
1	LEASE/RENTAL	H	Cap Rel Costs-Mvble Equip	2		118,924	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					118,924	500
	Code Letter - H						
1	RHC ADMINISTRATION	I	Administrative & General	5	402,719	206,203	1
500	Total reclassifications				402,719	206,203	500
	Code Letter - I						
1	I V THERAPY	J	Adults & Pediatrics	30		2,185	1
2			Emergency	91		2,797	2
3			CHEMOTHERAPY	76.01		2,495	3
4			Operating Room	50		226	4
500	Total reclassifications					7,703	500
	Code Letter - J						
1	RECLASS PROPERTY INSURANCE	L	Cap Rel Costs-Bldg & Fixt	1		66,954	1
500	Total reclassifications					66,954	500
	Code Letter - L						
	GRAND TOTAL (Increases)				626,567	2,325,458	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS DRUG COST	A	Pharmacy	15		408,239		1
500	Total reclassifications					408,239		500
	Code letter - A							
1	RECLASS DEPRECIATION	B	Cap Rel Costs-Bldg & Fixt	1		543,225	9	1
500	Total reclassifications					543,225		500
	Code letter - B							
1	RECLASS MEDICAL SUPPLIES	C	Central Services & Supply	14		723,834		1
2	RECLASS MEDICAL SUPPLIES	C	Operating Room	50		746		2
3			Intravenous Therapy	64		50,834		3
500	Total reclassifications					775,414		500
	Code letter - C							
1	CAFETRIA	F	Dietary	10	223,848	138,345		1
500	Total reclassifications				223,848	138,345		500
	Code letter - F							
1	RHC MALPRACTICE	G	Rural Health Clinic	88		60,451		1
500	Total reclassifications					60,451		500
	Code letter - G							
1	LEASE/RENTAL	H	Administrative & General	5		1,290	10	1
2			Operation of Plant	7		128	10	2
3			Pharmacy	15		25,515	10	3
4			Operating Room	50		66,000	10	4
5			Laboratory	60		25,632	10	5
6			Respiratory Therapy	65		359	10	6
500	Total reclassifications					118,924		500
	Code letter - H							
1	RHC ADMINISTRATION	I	Rural Health Clinic	88	402,719	206,203		1
500	Total reclassifications				402,719	206,203		500
	Code letter - I							
1	I V THERAPY	J	Intravenous Therapy	64		7,703		1
2								2
3								3
4								4
500	Total reclassifications					7,703		500
	Code letter - J							
1	RECLASS PROPERTY INSURANCE	L	Administrative & General	5		66,954	12	1
500	Total reclassifications					66,954		500
	Code letter - L							
	GRAND TOTAL (Decreases)				626,567	2,325,458		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Acquisitions				Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Beginning Balances	Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	237,440				4,456	232,984		1
2	Land Improvements	571,456	23,420	4,456	27,876		599,332		2
3	Buildings and Fixtures	16,700,725	1,126,691		1,126,691	1,746,053	16,081,363		3
4	Building Improvements								4
5	Fixed Equipment	928,850	35,964		35,964		964,814		5
6	Movable Equipment	9,697,902	1,902,115		1,902,115	170,712	11,429,305		6
7	HIT-designated Assets	1,687,027					1,687,027		7
8	Subtotal (sum of lines 1-7)	29,823,400	3,088,190	4,456	3,092,646	1,921,221	30,994,825		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	29,823,400	3,088,190	4,456	3,092,646	1,921,221	30,994,825		10

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

	Description	SUMMARY OF CAPITAL							
		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	991,748						991,748	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	991,748						991,748	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see 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	16,758,893		16,758,893	0.560963					1
2	Cap Rel Costs-Mvble Equip	13,116,331		13,116,331	0.439037					2
3	Total (sum of lines 1-2)	29,875,224		29,875,224	1.000000					3

	Description	SUMMARY OF CAPITAL							
		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	448,523			66,954			515,477	1
2	Cap Rel Costs-Mvble Equip	538,965	118,924					657,889	2
3	Total (sum of lines 1-2)	987,488	118,924		66,954			1,173,366	3

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

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		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	31	Administrative & General	5		4
5	Refunds and rebates of expenses (chapter 8)	B	-69,104	Pharmacy	15		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-2,281	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	-1,291,544				10
11	Sale of scrap, waste, etc. (chapter 23)	A	-3,500	Operation of Plant	7		11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-57,432	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	A	-165,032	Medical Supplies Charged to Patients	71		17
18	Sale of medical records and abstracts	B	-12,730	Medical Records & Library	16		18
19	Nursing and allied health education (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	-4,260	Cap Rel Costs-Mvble Equip	2	9	32
33							33
34							34
35							35
35.01	NON ALLOW SALARY	A	-5,137	Administrative & General	5		35.01
35.02	NON ALLOW OTHER	A	-73,822	Administrative & General	5		35.02
36							36
37							37
38							38
39							39
40	CRNA AND SURGEON BILLING EXPENSE	A	-166,048	Rural Health Clinic	88		40
41	RHC CRNA EXPENSE	A	-461,211	Rural Health Clinic	88		41
42	RHC SURGEON	A	-402,244	Rural Health Clinic	88		42
42.01	RHC-CHESTER CLINIC PHY CONTRACT	A	-192	Rural Health Clinic	88		42.01
43							43
44	RHC-NON ALLOW EXP	A	-420	Rural Health Clinic	88		44
45							45
45.02	MISC REV PET SCANNER	B	-900	Radiology-Diagnostic	54		45.02
45.03	NON OP REV	B	-6,208	Administrative & General	5		45.03
45.04	NON OP REV	B	-2,160	Cafeteria	11		45.04
45.05	NON OP REV	B	-724	Central Services & Supply	14		45.05
45.06	NON OP REV	B	-1,632	Radiology-Diagnostic	54		45.06
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,726,550				50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				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

(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.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2	90	Clinic AGGREGATE	75,104	75,104						2
3	91	Emergency AGGREGATE	1,537,887	1,033,270	504,617					3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE	140,750	140,750						5
6	60	Laboratory AGGREGATE	22,100		22,100					6
7										7
8	65	Respiratory Therapy AGGREGATE	42,420	42,420						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	1,818,261	1,291,544	526,717					200

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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	90	Clinic AGGREGATE							75,104	2
3	91	Emergency AGGREGATE							1,033,270	3
4										4
5	76.01	CHEMOTHERAPY AGGREGATE							140,750	5
6	60	Laboratory AGGREGATE								6
7										7
8	65	Respiratory Therapy AGGREGATE							42,420	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							1,291,544	200

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MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS**WORKSHEET A-8-3
PARTS I-IV**

Check applicable box: ☒ **Occupational** ☐ **Physical** ☐ **Respiratory** ☐ **Speech Pathology**

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	1,712.00	851.00	18.00	298.00		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)	120,919	14
15	Therapists (column 2, line 9 times column 2, line 10)	60,106	15
16	Assistants (column 3, line 9 times column 3, line 10)	1,006	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	182,031	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)	182,031	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)	182,031	23

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

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

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

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

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

Check applicable box: ☒ **Occupational** ☐ **Physical** ☐ **Respiratory** ☐ **Speech Pathology**

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	182,031	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)	182,031	63
64	Total cost of outside supplier services (from provider records)	59,758	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS**WORKSHEET A-8-3
PARTS I-IV**Check applicable box: ☐ Occupational ☒ 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	3,371.00	3,455.00	7,282.00	3,731.00		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)	251,241	14
15	Therapists (column 2, line 9 times column 2, line 10)	257,501	15
16	Assistants (column 3, line 9 times column 3, line 10)	407,064	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	915,806	17
18	Aides (column 4, line 9 times column 4, line 10)	139,054	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)	1,054,860	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)	1,054,860	23

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

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

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

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

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

Check applicable box: ☐ Occupational ☒ Physical ☐ Respiratory ☐ Speech Pathology

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	1,054,860	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)	1,054,860	63
64	Total cost of outside supplier services (from provider records)	357,633	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS**WORKSHEET A-8-3
PARTS I-IV**Check applicable box: ☐ Occupational ☐ 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		768.00				9
10	AHSEA (see instructions)		74.53				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				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	57,239	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	57,239	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)	57,239	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)	74.53	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	58,133	22
23	Total salary equivalency (see instructions)	58,133	23

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

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

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

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

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

Check applicable box: ☐ Occupational ☐ Physical ☐ Respiratory ☒ Speech Pathology

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	58,133	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)	58,133	63
64	Total cost of outside supplier services (from provider records)	15,986	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	515,477	515,477					1
2	Cap Rel Costs-Mvble Equip	657,889		657,889				2
4	Employee Benefits Department	2,809,895	10,140	12,941	2,832,976			4
5	Administrative & General	3,519,206	89,991	114,853	460,930	4,184,980	4,184,980	5
6	Maintenance & Repairs							6
7	Operation of Plant	861,365	74,591	95,199	119,087	1,150,242	236,146	7
8	Laundry & Linen Service	101,595	4,181	5,337	16,879	127,992	26,277	8
9	Housekeeping	352,174	6,134	7,829	88,801	454,938	93,399	9
10	Dietary	201,249	2,528	3,226	40,251	247,254	50,761	10
11	Cafeteria	302,601	14,345	18,308	72,440	407,694	83,700	11
12	Maintenance of Personnel							12
13	Nursing Administration	454,069	6,005	7,664	128,614	596,352	122,432	13
14	Central Services & Supply	77,127	7,037	8,982	21,131	114,277	23,461	14
15	Pharmacy	381,177	4,627	5,905	109,768	501,477	102,954	15
16	Medical Records & Library	540,860	21,089	26,915	146,575	735,439	150,986	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	2,142,716	45,181	57,663	624,242	2,869,802	589,173	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	797,896	50,365	64,279	213,171	1,125,711	231,110	50
54	Radiology-Diagnostic	1,440,795	29,540	37,701	244,752	1,752,788	359,849	54
60	Laboratory	1,362,759	16,790	21,429	220,087	1,621,065	332,806	60
62	Whole Blood & Packed Red Blood Cells	103,687	844	1,078	9,898	115,507	23,714	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	319,374	8,838	11,280	83,391	422,883	86,818	65
66	Physical Therapy	364,083	56,212	71,742		492,037	101,016	66
67	Occupational Therapy	59,758				59,758	12,268	67
68	Speech Pathology	38,681				38,681	7,941	68
71	Medical Supplies Charged to Patients	329,317				329,317	67,609	71
72	Impl. Dev. Charged to Patients	281,065				281,065	57,703	72
73	Drugs Charged to Patients	408,239				408,239	83,812	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,486,021	14,204	18,128	60,965	1,579,318	324,236	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	3,506,577				3,506,577	719,908	88
90	Clinic	266,056	17,394	22,200	71,629	377,279	77,456	90
91	Emergency	873,712	24,743	31,578	99,401	1,029,434	211,344	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,555,420	504,779	644,237	2,832,012	24,530,106	4,176,879	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,211	5,114	6,527	964	15,816	3,247	190
192	Physicians' Private Offices		2,012	2,567		4,579	940	192
193.01	CARDIAC REHAB	10,935	3,572	4,558		19,065	3,914	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,569,566	515,477	657,889	2,832,976	24,569,566	4,184,980	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING 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	1,386,388						7
8	Laundry & Linen Service	17,013	171,282					8
9	Housekeeping	24,958		573,295				9
10	Dietary	10,284		4,385	312,684			10
11	Cafeteria	58,363		24,887		574,644		11
12	Maintenance of Personnel							12
13	Nursing Administration	24,433		10,419		36,325	789,961	13
14	Central Services & Supply	28,633		12,210		5,968		14
15	Pharmacy	18,826		8,028		31,003		15
16	Medical Records & Library	85,802		36,588		41,398		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	183,821	171,282	78,386	312,684	176,308	467,319	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	204,914		87,381		60,208	169,168	50
54	Radiology-Diagnostic	120,185		51,250		69,127		54
60	Laboratory	68,312		29,130		62,161		60
62	Whole Blood & Packed Red Blood Cells	3,436		1,465		2,796		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	35,958		15,333		23,553		65
66	Physical Therapy	228,702		97,527				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	57,790		24,643		17,219	46,199	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	70,770		30,178		20,231		90
91	Emergency	100,667		42,927		28,075	107,275	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,342,867	171,282	554,737	312,684	574,372	789,961	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	20,806		8,872		272		190
192	Physicians' Private Offices	8,184		3,490				192
193.01	CARDIAC REHAB	14,531		6,196				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,386,388	171,282	573,295	312,684	574,644	789,961	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		14	15	16	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	184,549						14
15	Pharmacy		662,288					15
16	Medical Records & Library			1,050,213				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	3,258		61,303	4,913,336		4,913,336	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,742		72,166	1,955,400		1,955,400	50
54	Radiology-Diagnostic			231,106	2,584,305		2,584,305	54
60	Laboratory			231,472	2,344,946		2,344,946	60
62	Whole Blood & Packed Red Blood Cells			6,972	153,890		153,890	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	1,623		46,664	632,832		632,832	65
66	Physical Therapy	40		43,687	963,009		963,009	66
67	Occupational Therapy			6,305	78,331		78,331	67
68	Speech Pathology			3,260	49,882		49,882	68
71	Medical Supplies Charged to Patients	106,155		136,141	639,222		639,222	71
72	Impl. Dev. Charged to Patients	60,354		19,567	418,689		418,689	72
73	Drugs Charged to Patients		146,020	61,581	699,652		699,652	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	630	451,730	51,507	2,553,272		2,553,272	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	3,211	64,538		4,294,234		4,294,234	88
90	Clinic	2,535		10,755	589,204		589,204	90
91	Emergency	2,001		67,727	1,589,450		1,589,450	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	184,549	662,288	1,050,213	24,459,654		24,459,654	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				49,013		49,013	190
192	Physicians' Private Offices				17,193		17,193	192
193.01	CARDIAC REHAB				43,706		43,706	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	184,549	662,288	1,050,213	24,569,566		24,569,566	202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		10,140	12,941	23,081	23,081		4
5	Administrative & General		89,991	114,853	204,844	3,756	208,600	5
6	Maintenance & Repairs							6
7	Operation of Plant		74,591	95,199	169,790	970	11,770	7
8	Laundry & Linen Service		4,181	5,337	9,518	138	1,310	8
9	Housekeeping		6,134	7,829	13,963	724	4,655	9
10	Dietary		2,528	3,226	5,754	328	2,530	10
11	Cafeteria		14,345	18,308	32,653	590	4,172	11
12	Maintenance of Personnel							12
13	Nursing Administration		6,005	7,664	13,669	1,048	6,102	13
14	Central Services & Supply		7,037	8,982	16,019	172	1,169	14
15	Pharmacy		4,627	5,905	10,532	894	5,132	15
16	Medical Records & Library		21,089	26,915	48,004	1,194	7,526	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		45,181	57,663	102,844	5,083	29,367	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		50,365	64,279	114,644	1,737	11,519	50
54	Radiology-Diagnostic		29,540	37,701	67,241	1,994	17,936	54
60	Laboratory		16,790	21,429	38,219	1,793	16,588	60
62	Whole Blood & Packed Red Blood Cells		844	1,078	1,922	81	1,182	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy		8,838	11,280	20,118	680	4,327	65
66	Physical Therapy		56,212	71,742	127,954		5,035	66
67	Occupational Therapy						612	67
68	Speech Pathology						396	68
71	Medical Supplies Charged to Patients						3,370	71
72	Impl. Dev. Charged to Patients						2,876	72
73	Drugs Charged to Patients						4,178	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		14,204	18,128	32,332	497	16,161	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						35,888	88
90	Clinic		17,394	22,200	39,594	584	3,861	90
91	Emergency		24,743	31,578	56,321	810	10,534	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		504,779	644,237	1,149,016	23,073	208,196	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,114	6,527	11,641	8	162	190
192	Physicians' Private Offices		2,012	2,567	4,579		47	192
193.01	CARDIAC REHAB		3,572	4,558	8,130		195	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		515,477	657,889	1,173,366	23,081	208,600	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	182,530						7
8	Laundry & Linen Service	2,240	13,206					8
9	Housekeeping	3,286		22,628				9
10	Dietary	1,354		173	10,139			10
11	Cafeteria	7,684		982		46,081		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,217		411		2,913	27,360	13
14	Central Services & Supply	3,770		482		479		14
15	Pharmacy	2,479		317		2,486		15
16	Medical Records & Library	11,297		1,444		3,320		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	24,202	13,206	3,094	10,139	14,139	16,186	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	26,979		3,449		4,828	5,859	50
54	Radiology-Diagnostic	15,823		2,023		5,543		54
60	Laboratory	8,994		1,150		4,984		60
62	Whole Blood & Packed Red Blood Cells	452		58		224		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	4,734		605		1,889		65
66	Physical Therapy	30,109		3,849				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	7,609		973		1,381	1,600	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	9,317		1,191		1,622		90
91	Emergency	13,254		1,694		2,251	3,715	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	176,800	13,206	21,895	10,139	46,059	27,360	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,739		350		22		190
192	Physicians' Private Offices	1,078		138				192
193.01	CARDIAC REHAB	1,913		245				193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	182,530	13,206	22,628	10,139	46,081	27,360	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		14	15	16	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	22,091						14
15	Pharmacy		21,840					15
16	Medical Records & Library			72,785				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	390		4,250	222,900		222,900	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	568		5,003	174,586		174,586	50
54	Radiology-Diagnostic			16,021	126,581		126,581	54
60	Laboratory			16,027	87,755		87,755	60
62	Whole Blood & Packed Red Blood Cells			483	4,402		4,402	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	194		3,235	35,782		35,782	65
66	Physical Therapy	5		3,028	169,980		169,980	66
67	Occupational Therapy			437	1,049		1,049	67
68	Speech Pathology			226	622		622	68
71	Medical Supplies Charged to Patients	12,708		9,438	25,516		25,516	71
72	Impl. Dev. Charged to Patients	7,224		1,356	11,456		11,456	72
73	Drugs Charged to Patients		4,815	4,269	13,262		13,262	73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	75	14,897	3,571	79,096		79,096	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	384	2,128		38,400		38,400	88
90	Clinic	303		746	57,218		57,218	90
91	Emergency	240		4,695	93,514		93,514	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	22,091	21,840	72,785	1,142,119		1,142,119	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				14,922		14,922	190
192	Physicians' Private Offices				5,842		5,842	192
193.01	CARDIAC REHAB				10,483		10,483	193.01
194	NON-ALLOWABLE COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,091	21,840	72,785	1,173,366		1,173,366	202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP- REL COSTS BLDG&FIXT SQ FEET	NEW CAP- REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	87,897						1
2	Cap Rel Costs-Mvble Equip		87,897					2
4	Employee Benefits Department	1,729	1,729	8,754,187				4
5	Administrative & General	15,345	15,345	1,424,320	-4,184,980	20,384,586		5
6	Maintenance & Repairs							6
7	Operation of Plant	12,719	12,719	367,990		1,150,242	58,104	7
8	Laundry & Linen Service	713	713	52,159		127,992	713	8
9	Housekeeping	1,046	1,046	274,405		454,938	1,046	9
10	Dietary	431	431	124,379		247,254	431	10
11	Cafeteria	2,446	2,446	223,848		407,694	2,446	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,024	1,024	397,429		596,352	1,024	13
14	Central Services & Supply	1,200	1,200	65,296		114,277	1,200	14
15	Pharmacy	789	789	339,193		501,477	789	15
16	Medical Records & Library	3,596	3,596	452,932		735,439	3,596	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	7,704	7,704	1,928,976		2,869,802	7,704	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,588	8,588	658,721		1,125,711	8,588	50
54	Radiology-Diagnostic	5,037	5,037	756,308		1,752,788	5,037	54
60	Laboratory	2,863	2,863	680,090		1,621,065	2,863	60
62	Whole Blood & Packed Red Blood Cells	144	144	30,586		115,507	144	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	1,507	1,507	257,688		422,883	1,507	65
66	Physical Therapy	9,585	9,585			492,037	9,585	66
67	Occupational Therapy					59,758		67
68	Speech Pathology					38,681		68
71	Medical Supplies Charged to Patients					329,317		71
72	Impl. Dev. Charged to Patients					281,065		72
73	Drugs Charged to Patients					408,239		73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	2,422	2,422	188,387		1,579,318	2,422	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					3,506,577		88
90	Clinic	2,966	2,966	221,341		377,279	2,966	90
91	Emergency	4,219	4,219	307,160		1,029,434	4,219	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	86,073	86,073	8,751,208	-4,184,980	20,345,126	56,280	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	872	872	2,979		15,816	872	190
192	Physicians' Private Offices	343	343			4,579	343	192
193.01	CARDIAC REHAB	609	609			19,065	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)	515,477	657,889	2,832,976		4,184,980	1,386,388	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.864557	7.484772	0.323614		0.205301	23.860457	203
204	Cost to be allocated (Per Wkst. B, Part II)			23,081		208,600	182,530	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.002637		0.010233	3.141436	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING 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	1,749						8
9	Housekeeping		56,345					9
10	Dietary		431	1,749				10
11	Cafeteria		2,446		6,287,086			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,024		397,429	2,442,651		13
14	Central Services & Supply		1,200		65,296		859,425	14
15	Pharmacy		789		339,193			15
16	Medical Records & Library		3,596		452,932			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	1,749	7,704	1,749	1,928,976	1,445,006	15,170	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		8,588		658,721	523,086	22,084	50
54	Radiology-Diagnostic		5,037		756,308			54
60	Laboratory		2,863		680,090			60
62	Whole Blood & Packed Red Blood Cells		144		30,586			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy		1,507		257,688		7,560	65
66	Physical Therapy		9,585				184	66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						494,349	71
72	Impl. Dev. Charged to Patients						281,065	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY		2,422		188,387	142,852	2,936	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						14,954	88
90	Clinic		2,966		221,341			90
91	Emergency		4,219		307,160	331,707	9,319	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,749	54,521	1,749	6,284,107	2,442,651	859,425	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		872		2,979			190
192	Physicians' Private Offices		343					192
193.01	CARDIAC REHAB		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)	171,282	573,295	312,684	574,644	789,961	184,549	202
203	Unit Cost Multiplier (Wkst. B, Part I)	97.931389	10.174727	178.778731	0.091401	0.323403	0.214735	203
204	Cost to be allocated (Per Wkst. B, Part II)	13,206	22,628	10,139	46,081	27,360	22,091	204
205	Unit Cost Multiplier (Wkst. B, Part II)	7.550600	0.401597	5.797027	0.007329	0.011201	0.025704	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS	MEDICAL RECORDS + LIBRARY GROSS REVENUE					
		15	16					

	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	1,851,605						15
16	Medical Records & Library		41,179,029					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		2,403,645					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,829,604					50
54	Radiology-Diagnostic		9,061,551					54
60	Laboratory		9,076,599					60
62	Whole Blood & Packed Red Blood Cells		273,371					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy		1,829,666					65
66	Physical Therapy		1,712,952					66
67	Occupational Therapy		247,226					67
68	Speech Pathology		127,812					68
71	Medical Supplies Charged to Patients		5,338,042					71
72	Impl. Dev. Charged to Patients		767,210					72
73	Drugs Charged to Patients	408,239	2,414,574					73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	1,262,932	2,019,550					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	180,434						88
90	Clinic		421,702					90
91	Emergency		2,655,525					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,851,605	41,179,029					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193.01	CARDIAC REHAB							193.01
194	NON-ALLOWABLE COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	662,288	1,050,213					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.357683	0.025504					203
204	Cost to be allocated (Per Wkst. B, Part II)	21,840	72,785					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.011795	0.001768					205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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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	4,913,336		4,913,336			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,955,400		1,955,400			50
54	Radiology-Diagnostic	2,584,305		2,584,305			54
60	Laboratory	2,344,946		2,344,946			60
62	Whole Blood & Packed Red Blood Cells	153,890		153,890			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy						64
65	Respiratory Therapy	632,832		632,832			65
66	Physical Therapy	963,009		963,009			66
67	Occupational Therapy	78,331		78,331			67
68	Speech Pathology	49,882		49,882			68
71	Medical Supplies Charged to Patients	639,222		639,222			71
72	Impl. Dev. Charged to Patients	418,689		418,689			72
73	Drugs Charged to Patients	699,652		699,652			73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	2,553,272		2,553,272			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	4,294,234		4,294,234			88
90	Clinic	589,204		589,204			90
91	Emergency	1,589,450		1,589,450			91
92	Observation Beds (Non-Distinct Part)	440,645		440,645			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	24,900,299		24,900,299			200
201	Less Observation Beds	440,645		440,645			201
202	Total (line 200 minus line 201)	24,459,654		24,459,654			202

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MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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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	2,142,818		2,142,818				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	441,099	2,388,505	2,829,604	0.691051			50
54	Radiology-Diagnostic	477,851	8,583,700	9,061,551	0.285195			54
60	Laboratory	1,048,238	8,028,361	9,076,599	0.258351			60
62	Whole Blood & Packed Red Blood Cells	110,064	163,307	273,371	0.562935			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	303,190	1,526,476	1,829,666	0.345873			65
66	Physical Therapy	237,122	1,475,830	1,712,952	0.562193			66
67	Occupational Therapy	83,740	163,486	247,226	0.316840			67
68	Speech Pathology	15,375	112,437	127,812	0.390276			68
71	Medical Supplies Charged to Patients	1,416,776	3,921,266	5,338,042	0.119748			71
72	Impl. Dev. Charged to Patients	508,409	258,801	767,210	0.545729			72
73	Drugs Charged to Patients	643,378	1,771,196	2,414,574	0.289762			73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	30,275	1,989,275	2,019,550	1.264278			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		4,956,462	4,956,462				88
90	Clinic	509	421,193	421,702	1.397205			90
91	Emergency	29,431	2,626,094	2,655,525	0.598545			91
92	Observation Beds (Non-Distinct Part)		260,827	260,827	1.689415			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	7,488,275	38,647,216	46,135,491				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,488,275	38,647,216	46,135,491				202

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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,913,336		4,913,336		4,913,336	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,955,400		1,955,400		1,955,400	50
54	Radiology-Diagnostic	2,584,305		2,584,305		2,584,305	54
60	Laboratory	2,344,946		2,344,946		2,344,946	60
62	Whole Blood & Packed Red Blood Cells	153,890		153,890		153,890	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy						64
65	Respiratory Therapy	632,832		632,832		632,832	65
66	Physical Therapy	963,009		963,009		963,009	66
67	Occupational Therapy	78,331		78,331		78,331	67
68	Speech Pathology	49,882		49,882		49,882	68
71	Medical Supplies Charged to Patients	639,222		639,222		639,222	71
72	Impl. Dev. Charged to Patients	418,689		418,689		418,689	72
73	Drugs Charged to Patients	699,652		699,652		699,652	73
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	2,553,272		2,553,272		2,553,272	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	4,294,234		4,294,234		4,294,234	88
90	Clinic	589,204		589,204		589,204	90
91	Emergency	1,589,450		1,589,450		1,589,450	91
92	Observation Beds (Non-Distinct Part)	440,645		440,645			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	24,900,299		24,900,299		24,459,654	200
201	Less Observation Beds	440,645		440,645			201
202	Total (line 200 minus line 201)	24,459,654		24,459,654		24,459,654	202

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**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	2,142,818		2,142,818				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	441,099	2,388,505	2,829,604	0.691051			50
54	Radiology-Diagnostic	477,851	8,583,700	9,061,551	0.285195			54
60	Laboratory	1,048,238	8,028,361	9,076,599	0.258351			60
62	Whole Blood & Packed Red Blood Cells	110,064	163,307	273,371	0.562935			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	303,190	1,526,476	1,829,666	0.345873			65
66	Physical Therapy	237,122	1,475,830	1,712,952	0.562193			66
67	Occupational Therapy	83,740	163,486	247,226	0.316840			67
68	Speech Pathology	15,375	112,437	127,812	0.390276			68
71	Medical Supplies Charged to Patients	1,416,776	3,921,266	5,338,042	0.119748			71
72	Impl. Dev. Charged to Patients	508,409	258,801	767,210	0.545729			72
73	Drugs Charged to Patients	643,378	1,771,196	2,414,574	0.289762			73
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	30,275	1,989,275	2,019,550	1.264278			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		4,956,462	4,956,462				88
90	Clinic	509	421,193	421,702	1.397205			90
91	Emergency	29,431	2,626,094	2,655,525	0.598545			91
92	Observation Beds (Non-Distinct Part)		260,827	260,827	1.689415			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	7,488,275	38,647,216	46,135,491				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,488,275	38,647,216	46,135,491				202

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	1,955,400	174,586	1,780,814		50
54	Radiology-Diagnostic	2,584,305	126,581	2,457,724		54
60	Laboratory	2,344,946	87,755	2,257,191		60
62	Whole Blood & Packed Red Blood Cells	153,890	4,402	149,488		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	Intravenous Therapy					64
65	Respiratory Therapy	632,832	35,782	597,050		65
66	Physical Therapy	963,009	169,980	793,029		66
67	Occupational Therapy	78,331	1,049	77,282		67
68	Speech Pathology	49,882	622	49,260		68
71	Medical Supplies Charged to Patients	639,222	25,516	613,706		71
72	Impl. Dev. Charged to Patients	418,689	11,456	407,233		72
73	Drugs Charged to Patients	699,652	13,262	686,390		73
76	CARDIAC REHAB					76
76.01	CHEMOTHERAPY	2,553,272	79,096	2,474,176		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	4,294,234	38,400	4,255,834		88
90	Clinic	589,204	57,218	531,986		90
91	Emergency	1,589,450	93,514	1,495,936		91
92	Observation Beds (Non-Distinct Part)	440,645	19,990	420,655		92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	19,986,963	939,209	19,047,754		200
201	Less Observation Beds	440,645	19,990	420,655		201
202	Total	19,546,318	919,219	18,627,099		202

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		1,955,400	2,829,604	0.691051	50
54	Radiology-Diagnostic		2,584,305	9,061,551	0.285195	54
60	Laboratory		2,344,946	9,076,599	0.258351	60
62	Whole Blood & Packed Red Blood Cells		153,890	273,371	0.562935	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	Intravenous Therapy					64
65	Respiratory Therapy		632,832	1,829,666	0.345873	65
66	Physical Therapy		963,009	1,712,952	0.562193	66
67	Occupational Therapy		78,331	247,226	0.316840	67
68	Speech Pathology		49,882	127,812	0.390276	68
71	Medical Supplies Charged to Patients		639,222	5,338,042	0.119748	71
72	Impl. Dev. Charged to Patients		418,689	767,210	0.545729	72
73	Drugs Charged to Patients		699,652	2,414,574	0.289762	73
76	CARDIAC REHAB					76
76.01	CHEMOTHERAPY		2,553,272	2,019,550	1.264278	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		4,294,234	4,956,462	0.866391	88
90	Clinic		589,204	421,702	1.397205	90
91	Emergency		1,589,450	2,655,525	0.598545	91
92	Observation Beds (Non-Distinct Part)		440,645	260,827	1.689415	92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		19,986,963	43,992,673		200
201	Less Observation Beds		440,645	260,827		201
202	Total		19,546,318	43,731,846		202

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1338

WORKSHEET D PART V

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

(A)	Cost Center Description	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	0.691051		641,825			443,534		50
54	Radiology-Diagnostic	0.285195		2,692,299			767,830		54
60	Laboratory	0.258351		2,823,449			729,441		60
62	Whole Blood & Packed Red Blood	0.562935		70,212			39,525		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy								64
65	Respiratory Therapy	0.345873		559,574			193,542		65
66	Physical Therapy	0.562193		483,315			271,716		66
67	Occupational Therapy	0.316840		58,662			18,586		67
68	Speech Pathology	0.390276		14,562			5,683		68
71	Medical Supplies Charged to Pat	0.119748		1,084,408			129,856		71
72	Impl. Dev. Charged to Patients	0.545729		74,743			40,789		72
73	Drugs Charged to Patients	0.289762		639,993	888		185,446	257	73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.264278		1,228,682			1,553,396		76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.397205		167,581	518		234,145	724	90
91	Emergency	0.598545		668,646			400,215		91
92	Observation Beds (Non-Distinct	1.689415		114,643			193,680		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			11,322,594	1,406		5,207,384	981	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			11,322,594	1,406		5,207,384	981	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS
COMPONENT CCN: 14-Z338
**WORKSHEET D
PART V**

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

(A)	Cost Center Description	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	0.691051							50
54	Radiology-Diagnostic	0.285195							54
60	Laboratory	0.258351							60
62	Whole Blood & Packed Red Blood	0.562935							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy								64
65	Respiratory Therapy	0.345873							65
66	Physical Therapy	0.562193							66
67	Occupational Therapy	0.316840							67
68	Speech Pathology	0.390276							68
71	Medical Supplies Charged to Pat	0.119748							71
72	Impl. Dev. Charged to Patients	0.545729							72
73	Drugs Charged to Patients	0.289762							73
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1.264278							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.397205							90
91	Emergency	0.598545							91
92	Observation Beds (Non-Distinct	1.689415							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

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1338****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,245	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,936	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)	1,749	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	69	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)	69	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	85	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)	86	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	776	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)	69	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)	69	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	151.18	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.11	20
21	Total general inpatient routine service cost (see instructions)	4,913,336	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)	12,850	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	13,339	25
26	Total swing-bed cost (see instructions)	351,371	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,561,965	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,561,965	37

KPMG LLP Compu-Max 2552-10

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

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
Boxes: ☐ Title XIX - I/P ☐ IRF ☒ 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)						2,356.39 38
39	Program general inpatient routine service cost (line 9 x line 38)						1,828,559 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)						1,828,559 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)					653,807	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,482,366	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 enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					162,591	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					162,591	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					325,182	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

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1338

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					187	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,356.39	88
89	Observation bed cost (line 87 x line 88) (see instructions)					440,645	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	222,900	4,913,336	0.045366	440,645	19,990	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1338

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		754,009		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.691051	161,656	111,713	50
54	Radiology-Diagnostic	0.285195	192,330	54,852	54
60	Laboratory	0.258351	423,770	109,481	60
62	Whole Blood & Packed Red Blood Cells	0.562935	44,165	24,862	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy				64
65	Respiratory Therapy	0.345873	135,358	46,817	65
66	Physical Therapy	0.562193	81,611	45,881	66
67	Occupational Therapy	0.316840	24,489	7,759	67
68	Speech Pathology	0.390276	4,503	1,757	68
71	Medical Supplies Charged to Patients	0.119748	489,707	58,641	71
72	Impl. Dev. Charged to Patients	0.545729	222,165	121,242	72
73	Drugs Charged to Patients	0.289762	238,807	69,197	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.264278			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.397205			90
91	Emergency	0.598545	2,681	1,605	91
92	Observation Beds (Non-Distinct Part)	1.689415			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,021,242	653,807	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,021,242		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z338

WORKSHEET D-3

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ Swing Bed SNF ☐ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☒ 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	0.691051	468	323	50
54	Radiology-Diagnostic	0.285195	4,822	1,375	54
60	Laboratory	0.258351	29,022	7,498	60
62	Whole Blood & Packed Red Blood Cells	0.562935			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy				64
65	Respiratory Therapy	0.345873	8,201	2,837	65
66	Physical Therapy	0.562193	34,788	19,558	66
67	Occupational Therapy	0.316840	14,540	4,607	67
68	Speech Pathology	0.390276	2,745	1,071	68
71	Medical Supplies Charged to Patients	0.119748	33,328	3,991	71
72	Impl. Dev. Charged to Patients	0.545729			72
73	Drugs Charged to Patients	0.289762	66,125	19,161	73
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	1.264278			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.397205			90
91	Emergency	0.598545			91
92	Observation Beds (Non-Distinct Part)	1.689415			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		194,039	60,421	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		194,039		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-1338****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,208,365			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	5,208,365			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 reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	5,260,449			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, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,720,722			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)	3,539,727			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)	3,539,727			30
31	Primary payer payments	1,385			31
32	Subtotal (line 30 minus line 31)	3,538,342			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)	234,010			34
35	Adjusted reimbursable bad debts (see instructions)	152,107			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	177,624			36
37	Subtotal (see instructions)	3,690,449			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)	3,690,449			40
40.01	Sequestration adjustment (see instructions)	73,809			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	3,036,898			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	579,742			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 (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-1338****WORKSHEET E-1
PART I**

Check ☒ Hospital ☐ SUB (Other)
Applicable ☐ IPF ☐ SNF
Boxes: ☐ IRF ☐ Swing Bed SNF

			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			1,944,437		3,243,943
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero			26,846		
3	List separately each retroactive lump sum adjustment	.01	01/04/2018	209,979		3.01
	amount based on subsequent revision of the interim	.02				3.02
	rate for the cost reporting period. Also show date of	Program				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to				3.04
		Provider				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51	06/20/2018	79,159	01/04/2018	86,717
		Provider			06/20/2018	120,328
		to				3.53
		Program				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		130,820		-207,045
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)			2,102,103		3,036,898
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				5.03
		to				5.04
		Provider				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		Provider				5.52
		to				5.53
		Program				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		183,088		579,742
		.02				
7	Total Medicare program liability (see instructions)			2,285,191		3,616,640
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z338

WORKSHEET E-1
PART I

Check ☐ Hospital ☐ SUB (Other)
Applicable ☐ IPF ☐ SNF
Boxes: ☐ IRF ☒ 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			317,623		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment		01/04/2018	43,711		3.01
	amount based on subsequent revision of the interim		06/20/2018	58,419		3.02
	rate for the cost reporting period. Also show date of	Program				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to				3.04
		Provider				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		Provider				3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			102,130		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)			419,753		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment					5.01
	after desk review. Also show date of each payment.					5.02
	If none, write 'NONE' or enter a zero. (1)	Program				5.03
		to				5.04
		Provider				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		Provider				5.52
		to				5.53
		Program				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due)					6.01
	based on the cost report (1)			-38,406		6.02
7	Total Medicare program liability (see instructions)			381,347		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.

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z338

WORKSHEET E-2

Check ☐ Title V ☒ Swing Bed - SNF
Applicable ☒ Title XVIII ☐ Swing Bed - NF
Boxes: ☐ Title XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	328,434		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)	61,025		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	138		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)	389,459		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	389,459		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	389,459		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	329		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)	389,130		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)	389,130		19
19.01	Sequestration adjustment (see instructions)	7,783		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	419,753		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	-38,406		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART V****PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT**

1	Inpatient services	2,482,366	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,482,366	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,507,190	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)	2,507,190	19
20	Deductibles (exclude professional component)	201,592	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,305,598	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,305,598	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	40,354	25
26	Adjusted reimbursable bad debts (see instructions)	26,230	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,676	27
28	Subtotal (sum of lines 24 and 26)	2,331,828	28
29	Other adjustments (QUESTRATION)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,331,828	30
30.01	Sequestration adjustment (see instructions)	46,637	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	2,102,103	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	183,088	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,498,436				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	19,120,732				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-12,011,078				6
7	Inventory	1,325,902				7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	12,933,992				11
	FIXED ASSETS					
12	Land	232,983				12
13	Land improvements	599,332				13
14	Accumulated depreciation	-514,559				14
15	Buildings	16,081,363				15
16	Accumulated depreciation	-9,091,180				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	964,814				19
20	Accumulated depreciation	-845,339				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	13,116,331				23
24	Accumulated depreciation	-10,175,518				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)	10,368,227				30
	OTHER ASSETS					
31	Investments	26,867,800				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)	26,867,800				35
36	Total assets (sum of lines 11, 30 and 35)	50,170,019				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,172,994				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					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	2,618,623				44
45	Total current liabilities (sum of lines 37 thru 44)	3,791,617				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)	3,791,617				51
	CAPITAL ACCOUNTS					
52	General fund balance	46,378,402				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	46,378,402				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	50,170,019				60

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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STATEMENT OF CHANGES IN FUND BALANCES**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		42,405,026		1
2	Net income (loss) (from Worksheet G-3, line 29)		3,973,376		2
3	Total (sum of line 1 and line 2)		46,378,402		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)		46,378,402		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)		46,378,402		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

KPMG LLP Compu-Max 2552-10

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,952,870		1,952,870	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)	1,952,870		1,952,870	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)	1,952,870		1,952,870	17
18	Ancillary services	6,093,485		6,093,485	18
19	Outpatient services		41,252,147	41,252,147	19
20	Rural Health Clinic (RHC)				20
20.01	RHC II				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 (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	8,046,355	41,252,147	49,298,502	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		27,296,116	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)		27,296,116	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	49,298,502	1
2	Less contractual allowances and discounts on patients' accounts	21,785,233	2
3	Net patient revenues (line 1 minus line 2)	27,513,269	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	27,296,116	4
5	Net income from service to patients (line 3 minus line 4)	217,153	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	490,437	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	57,432	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	218	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 (specify)		24
24.01	Other (340B NET REVENUE)	1,698,980	24.01
24.02	Other (REBATE)	69,104	24.02
24.03	Other (HPSA AND OTHER INCENTIVE PYMT)	13,330	24.03
24.04	Other (AR ACCT FOR ACCU. INTEREST)	548,148	24.04
24.05	Other (SALE OF DRUGS TO EMPLOYYES)	165,032	24.05
24.06	Other (RENTAL INCOME)	57,744	24.06
24.07	Other (OTHER INCOME)	655,798	24.07
25	Total other income (sum of lines 6-24)	3,756,223	25
26	Total (line 5 plus line 25)	3,973,376	26
29	Net income (or loss) for the period (line 26 minus line 28)	3,973,376	29

KPMG LLP Compu-Max 2552-10

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

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

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**ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS****COMPONENT CCN: 14-8543****WORKSHEET M-1**Check applicable box: ☒ 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	1,370,225	252,906	1,623,131		1,623,131		1,623,131	1
2	Physician Assistant	194,744	35,944	230,688		230,688		230,688	2
3	Nurse Practitioner	105,417	19,457	124,874		124,874		124,874	3
4	Visiting Nurse								4
5	Other Nurse	472,141	87,144	559,285		559,285		559,285	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician		127,425	127,425		127,425		127,425	8
9	Other Facility Health Care Staff Costs	453,234	83,655	536,889		536,889		536,889	9
10	Subtotal (sum of lines 1 through 9)	2,595,761	606,531	3,202,292		3,202,292		3,202,292	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		863,647	863,647		863,647	-863,647		11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)		863,647	863,647		863,647	-863,647		14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		21,036	21,036		21,036		21,036	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance		60,451	60,451	-60,451				18
19	Other Health Care Costs		180,848	180,848		180,848		180,848	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		262,335	262,335	-60,451	201,884		201,884	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,595,761	1,732,513	4,328,274	-60,451	4,267,823	-863,647	3,404,176	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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		140,250	140,250		140,250		140,250	29
30	Administrative Costs	390,273	347,268	737,541	-608,922	128,619	-166,468	-37,849	30
31	Total Facility Overhead (sum of lines 29 and 30)	390,273	487,518	877,791	-608,922	268,869	-166,468	102,401	31
32	Total facility costs (sum of lines 22, 28 and 31)	2,986,034	2,220,031	5,206,065	-669,373	4,536,692	-1,030,115	3,506,577	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.

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-8543

WORKSHEET M-2

Check applicable box: ☒ RHC ☐ 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	4.85	16,218	4,200	20,370		1
2	Physician Assistants	1.72	4,381	2,100	3,612		2
3	Nurse Practitioners	1.00	2,644	2,100	2,100		3
4	Subtotal (sum of lines 1 through 3)	7.57	23,243		26,082	26,082	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)	7.57	23,243			26,082	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)	3,404,176	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)	3,404,176	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)	102,401	14
15	Parent provider overhead allocated to facility (see instructions)	787,657	15
16	Total overhead (sum of lines 14 and 15)	890,058	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	890,058	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	890,058	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	4,294,234	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 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

KPMG LLP Compu-Max 2552-10

MEMORIAL HOSPITAL Provider CCN: 14-1338	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/14/2018 Run Time: 15:56 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES**COMPONENT CCN: 14-8543****WORKSHEET M-3**

Check applicable boxes: ☒ RHC I ☐ Title V ☐ Title XIX
☐ FQHC ☒ Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	4,294,234	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	146,170	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	4,148,064	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	26,082	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	26,082	6
7	Adjusted cost per visit (line 3 divided by line 6)	159.04	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)	82.30	83.45		8
9	Rate for program covered visits (see instructions)	159.04	159.04	159.04	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)	2,724	2,724		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	433,225	433,225		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)		866,450		16
16.01	Total program charges (see instructions)(from contractor's records)		710,822		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,972		16.02
16.03	Total program preventive costs (see instructions)		3,623		16.03
16.04	Total program non-preventive costs (see instructions)		625,831		16.04
16.05	Total program cost (see instructions)		629,454		16.05
17	Primary payer payments		86		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		80,538		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		126,057		19
20	Net Medicare cost excluding vaccines (see instructions)		629,368		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		56,134		21
22	Total reimbursable Program cost (line 20 plus line 21)		685,502		22
23	Allowable bad debts (see instructions)		22,900		23
23.01	Adjusted reimbursable bad debts (see instructions)		14,885		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		22,900		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		700,387		26
26.01	Sequestration adjustment (see instructions)		14,008		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		514,109		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		172,270		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.

KPMG LLP Compu-Max 2552-10

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

Check applicable boxes: ☒ RHC I ☐ Title V ☐ Title XIX
☐ FQHC ☒ Title XVIII

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,202,292	3,202,292	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.009761	0.001694	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	31,258	5,425	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	36,815	42,376	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	68,073	47,801	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	3,404,176	3,404,176	6
7	Total overhead (from Wkst. M-2, line 16)	890,058	890,058	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.019997	0.014042	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	17,798	12,498	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	85,871	60,299	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	216	1,245	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	397.55	48.43	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	77	527	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	30,611	25,523	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)		146,170	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)		56,134	16

KPMG LLP Compu-Max 2552-10

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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: ☒ RHC I ☐ FQHC

				Part B		
DESCRIPTION				mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider				546,551	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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)		.01			3.01
			.02			3.02
		Program	.03			3.03
		to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51	01/04/2018	11,444	3.51
		Provider	.52	06/20/2018	20,998	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		-32,442	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				514,109	
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)		.01			5.01
			.02			5.02
		Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)		.01		172,270	6.01
			.02			6.02
7	Total Medicare program liability (see instructions)				686,379	
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.