Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0115 Worksheet S Peri od From 07/01/2020 Parts I-III AND SETTLEMENT SUMMARY 06/30/2021 Date/Time Prepared: То 11/30/2021 2:40 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/30/2021 Time: 2:40 pm] Manually prepared cost report use only 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF 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 HOSP & HEALTH CARE CTR (15-0115) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 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.

(Si aned)

Officer or Administrator of Provider(s)

Δ

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 399, 761	118, 320	0	0	1.00
2.00	Subprovider - IPF	0	47, 499	0		0	2.00
3.00	Subprovider - IRF	0	-9, 108	1		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	2, 452	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		13, 333		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		18, 895		0	10. 01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	1, 440, 604	150, 548	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time data interest, and complete and rever the information correction. If you have any comments concerning the accuracy of the time data interest, and complete and rever the information correction. Type and the set in the set 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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	MEMORIAL HOSP & H IDENTIFICATION DATA		der CCN: 1	15-0115	Period: From 07/01/ To 06/30/		<u>of</u> For Workshe Part I Date/Ti 11/30/2	et S-2 me Pre	2 epared
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00 00	Street: 800 WEST 9TH STREET City: JASPER	PO Box: State: IN	Zin Cod	e: 47546	Count	ty: DUBOIS				1.
		Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified		0, or		-
		1.00	2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Componer		2.00	0.00	1 4.00	0.00	0.00	17.00	0.00	
00	Hospi tal	MEMORIAL HOSP & HEALTH	150115	99915	1	07/01/1966	Ν	Р	0	3.
00	Subprovider - IPF	CARE CTR MEMORIAL HOSP & HCC	15S115	99915	4	07/01/1985	Ν	Р	0	4.
00	Subprovider - IRF	(PSYCH) MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	Ν	P	0	5.
00	Subprovider - (Other)	(KLIAD)								6.
00	Swing Beds - SNF									7.
00	Swing Beds - NF		155205	00015		00/04/1007	N			8.
00	Hospital-Based SNF	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	Ν	P	0	9.
. 00	Hospital-Based NF									10.
. 00	Hospital-Based OLTC		457000	00015		00 (00 (1001				11.
. 00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	Ν	P	N	12
. 00	Separately Certified ASC									13
. 00	Hospital -Based Hospice		4505				•.			14
. 00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	Ν	0	N	15
01	Hospital-Based Health Clinic - RHC	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	Ν	0	N	15
00	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
00	Renal Dialysis Other									18
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. 01	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portior er October 1. (see instr requires final uncomper port settlement? (see ir " for no, for the portic er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statist column 1, "Y" for yes or	th 42 CFf this endment is for thi for no f October of the cuctions) nof the "Y" for on of the "Y" for on of the "Y" for a urban to stical an "" for the cost uctions) 9 beds (a 3, "Y" for a urban to the cost "N" for	s for 1. cost re ns) yes ter o reas no er as or as or as no	Y Y N	N Y N				22
. 01 . 02	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Joes this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2) (Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncomper port settlement? (see ir " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statist column 1, "Y" for yes or g period prior to Octobe no for the portion of th	th 42 CFf this endment s for thi for no 1 October n of the o nof the o structions on of the "Y" for on or aff "N" for the cost stical ar stical area 3, "Y" for a, "Y" for ourban to stical area 3, "Y" for on or aff the cost stical area of the other stical area	s for 1. cost re ns) yes ter o reas no er as or as or as no	Y Y N	N Y N				22
. 01	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft period occurring on or aft adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncomper port settlement? (see in " for no, for the portion er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of the er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statist column 1, "Y" for yes or g period prior to Octobe no for the portion of the er October 1. (see instr	th 42 CFf this endment ts for thi for no 1 October of nof the or uctions) nsated can "N" for on or aff "Y" for on or aff nurban to stical are "N" for cer 1. Enton to stical are of "N" for on or aff nurban to the cost of urban to the cost "N" for or 1. Enton of the or the cost "N" for or 1. Enton the cost "N" for or 1. Enton the cost curctions)	s for 1. cost re ns) yes ter preas no er	Y Y N	N Y N				22
01 02 03	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Joes this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portio" er October 1. (see instr requires final uncomper port settlement? (see ir " for no, for the portic er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statist column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statist column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	th 42 CFf this endment is for thi for no f October of of the of ouctions) issted can instruction on of the "Y" for on or aff nurban to stical an "N" for the cost ouctions) 29 beds (i 3, "Y" for nurban to tical area "N" for tical area "N" for tical area outtons) 29 beds (i 3, "Y" for nurban to tical area outtons) 29 beds (i 3, "Y" for tical area outtons) 29 beds (i 50 to the outtons) 20 beds (i 50 to the outtons) 50 to the outtons 50 to the outton 50 to the outt	s for 1. cost re ns) yes ter o reas no er as no er	Y Y N	N Y N				22

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	CN: 15-0115	Period From (To (07/01	/2020 /2021	Part I Date/T	eet S-2 ime Pre 2021 2:	epared:
			/ 05	1.00		2.00)	3.	00	
	Which method is used to determine Medicaid days on li below? In column 1, enter 1 if date of admission, 2 i if date of discharge. Is the method of identifying th reporting period different from the method used in th reporting period? In column 2, enter "Y" for yes or	f census da ne days in ne prior cos	ays, or 3 this cost st		3	N				23. 0
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-o State Medica eligib unpai	e l id le d	Medica HMO da	ys Me)ther di cai d days	
5. 00	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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,	<u>1.00</u> 309 0	2.00 249 36			0	<u>5.00</u> 1,	47	<u>6. 00</u> 161	25. 0
	out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.				Urb	an/Ru	ral S	Date o	f Geogr	
						1. 00)		00	
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for	rural.		, 0			2			26.0
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	2" for ri cation in d	ural. If ap column 2.	opl i cabl e,			2			35.0
	effect in the cost reporting period.				Be	egi nni		Endi		
5.00	Enter applicable beginning and ending dates of SCH st	atus. Subs	cript line	36 for numb	ber	1.00)	۷.	00	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.					0			37.0
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)									37.0
	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.					× / 1		V	///	38.0
						Y/N 1.00			/N 00	-
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or he mileage	(iii)? Ent requiremen	ter in colum nts in	nn	Y		,	ſ	39. C
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Enter	r"Y" for y			N			í VIV	40.0
							V 1.00	XVIII 2.00		
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	t for disp	coporti opat	te share in	accorda	Ince	N	N	N	45.0
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for e	extraordi na	ary circumst	tances		N	N	N	46.0
. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c	apital? Ei	nter "Y for	r yes or "N'	' for no	0	N	N	N	47.0
	Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic	approved G to column ograms in t	ME programs 1 is "Y", the prior y	s? Enter "Y' or if this year or penu	' for ye hospita ultimate	ıl e	Y	Y	<u> </u>	48. 0 56. 0
	Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	umn 2. Deriod durin yes or "N" th of this of (", complete	ng which re ' for no ir cost report e Worksheet	esidents in n column 1. ting period?	approve If colu ? Enter	ed Imn 1 ''Y"	Y	Y		57.0

	Financial Systems MEMORIAL H AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-0115	Peri od:		Workshe	et S-2	2552-
					From 07/01/ To 06/30/		Part I Date/Ti 11/30/2		
						V	XVIII		
	LE Line I/ is used with this facility alost cost with					1.00	2.00	3.00	50
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	te Wkst. D-5.		as	N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, compi	ete wkst. D-2	NAHE 413.8	5 Workshee	N et A	Pass-Th	l 1rouah	59.
				Y/N	Line	#	Qualific Criterio	cation	
				1.00	2.00		3.0	00	
). 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1 E MA payment	N					60.
		Y/N	IME	Direct GME	IME		Di rect	GME	
	1	1.00	2.00	3.00	4.00		5.0		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care	N				0.00		0.00	61. 61.
. 02	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care								61.
. 03	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care								61.
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or								61.
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary								61.
. 06	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) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary								61.
	care or general surgery. (see instructions)								
		Pro	ogram Name	Program Cod	le Unweighter FTE Cou		Unweig Direct G Cour	GME FTE	
			1.00	2.00	3.00		4.0	00	
. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00		0.00	61.
. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column					0. 00		0. 00	61.
	 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 								
							1.0)0	
00	ACA Provisions Affecting the Health Resources and Ser								10
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct	ti ons)						0.00	
01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	iram. (s	<u>see instructio</u>	• •	o your hospi	tal		0.00	62.
	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se			ost reporting	pori od2 En	tor	Y		63.

Ith Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL	MEMORIAL EX IDENTIFICATION D		CN: 15-0115 P	eriod:	Worksheet S-2	
			FI To	rom 07/01/2020 o 06/30/2021		
			Unwei ghted		Ratio (col. 1/	
			FTES		$(col \cdot 1 + col \cdot$	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Base Year	- FTE Residents in M	Nonprovider Settings				
period that begins on or after Ju	uly 1, 2009 and befo	ore June 30, 2010.				
00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	per of unweighted no tations occurring in number of unweighte ur hospital. Enter i	on-primary care all nonprovider ed non-primary care n column 3 the ratio	0. 00	0.00	0. 000000) 64.0
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col. 3/	1
			FTEs		(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
_			Site			4
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	1 /
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unweighted	Ratio (col. 1/	
			FTĔs Nonprovider Site 1.00		(col. 1 + col. 2)) 3.00	
Section 5504 of the ACA Current	/ear FTF Residents i	n Nonnrovider Setting				
beginning on or after July 1, 20 00 Enter in column 1 the number of u	10		0.00			0 66
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of				
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	/
			FTES		(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
-	1 00	2.00	Si te	4.00	E 00	-
00 Enter in column 1, the program [1.00 FAMILY MEDICINE	2.00	3.00	4.00 6.85	5.00 0.257855	67
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in						

	Financial Systems MEMORIAL HOSP & HEALTH CARE CTR	1	n Lieu	of For	m CMS-	2552-10
HOSPI T	F	eriod: rom 07/01/ o 06/30/	/2020 /2021	Workshe Part I Date/Ti 11/30/2	me Pre	pared:
	Inpatient Psychiatric Facility PPS			2.00	3.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subp Enter "Y" for yes or "N" for no.	provi der?	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for a 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teach program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for a Column 3: If column 2 is Y, indicate which program year began during this cost reporting (see instructions)	no. (see ni ng no.	N	Y	1	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Y			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in "	the most	N	N	0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					
			_	1. C	0	-
	Long Term Care Hospi tal PPS					00.00
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? E	nter	N N		80.00 81.00
	"Y" for yes and "N" for no. TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes of Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		no.	N		85.00 86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			Ν		87.00
		V 1.00		XI 2		
90 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N		N		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N		N		94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0.00 N		0. C N		95.00 96.00
	applicable column.					
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0.00 Y		0. C Y	00	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		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		Ν		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	N		Ν		98.04
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title VIX.	Y		Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.06
10F 00	Rural Providers	N				105.00
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N				105.00
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R					107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded LPF and/or LRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems MEMORIAL HOSP & H	EALTH CARE CTR	2	In Lieu	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO		eriod: com 07/01/2020 o 06/30/2021	Worksheet S- Part I Date/Time Pro 11/30/2021 2	epared:
			V	XI X	
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e2 See 12	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRINA TEE SCHER	Jule: 366 42	IN		108.00
	Physi cal	Occupational	Speech	Respi ratory	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2.00	3.00	4.00	109.00
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. If	yes,	<u>1.00</u> N	110.00
			1.00		_
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	st reporting p lumn 1 is Y, o ticipating in	period? Enter enter the column 2.	1.00 N	2.00	111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? "Y", enter e	N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	N" for po	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	, or E only) 3" percent includes	in in			
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	Y			116. 00
117.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	ance? Enter	Y			117.00
118.00 Is the mal practice insurance a claims-made or occurrence pol lif the policy is claim-made. Enter 2 if the policy is occurr	2	1			118.00
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid losses:		1, 201, 208	0		0118.01
			1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			N		118.02
119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendmen Exter in colump 2. "V" for yos or "N" for po	column 1, "Y alifies for tl	' for yes or ne Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable device	s charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo	or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	ter the certi				126. 00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent		cation date			127.00
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent		cation date			128.00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter		cation date in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		ti fi cati on			130. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	A Provider CCN	: 15-0115	From 07	7/01/2020 5/30/2021	Worksheet S-2 Part I Date/Time Pre 11/30/2021 2:	epared:
					1.00	2.00	-
31.00 If this is a Medicare certified ir	itestinal transplant	center, enter the cer	tificati			2100	131.00
date in column 1 and termination of 32.00 If this is a Medicare certified is in column 1 and termination date,	let transplant cente	r, enter the certific	ation da	te			132.00
33. 00 Removed and reserved	in appricable, in co	rumr z.					133. 0
34.00 If this is an organ procurement or and termination date, if applicabl All Providers		ter the OPO number ir	o column	1			134.00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column	1. If yes, and home c umber. (see instructi	office co		Y		140.00
1.00 If this facility is part of a chai	n organization ente	2.00 r on lines 141 throug	uh 143 th	e name and	3.00 address	of the	-
home office and enter the home off	ice contractor name	and contractor number	<u>.</u>				
41.00 Name: MEMORIAL HOSPITAL AND HEAL CENTER	TH Contractor's Na	me: WPS	Contra	actor's Nu	mber: 0810	1	141.00
42.00 Street: 800 W 9TH STREET	PO Box:						142.00
43.00 City: JASPER	State:	IN	Zip C	ode:	4754	6	143.00
						1.00	-
44.00 Are provider based physicians' cos	ts included in Works	heet A?				Y	144.00
					1 00	0.00	
45.00 If costs for renal services are cl	aimed on Wkst A li	ne 7/ are the costs	for		1.00	2.00	145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	lude Medicare utiliz for no in column 2. y changed from the p column 1. (See CMS)	ation for this cost r reviously filed cost	reporting report?		Ν		146. 0
						1.00	-
47.00Was there a change in the statisti						N	147.0
48.00Was there a change in the order of 49.00Was there a change to the simplifi				for no		N N	148.0
47. oolwas there a change to the shipirn	ed cost finding meth	Part A	Part		itle V	Title XIX	147.0
		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "							
55. 00 Hospi tal		N N	N	<u>D. (300 12</u>	N N	N	155. 0
56.00 Subprovider - IPF		N	N		N	N	156.0
57. 00 Subprovi der – IRF 58. 00 SUBPROVI DER		N	N		Ν	N	157.0 158.0
59. 00 SNF		Ν	Ν		N	N	159.0
60.00 HOME HEALTH AGENCY		Ν	N		N	N	160. 0
61.00 CMHC			N		N	N	161. 0
Multicampus						1.00	-
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that h	as one or more campus	es in di	fferent CB	SAs?	N	165. 0
	Name	County	State	Zip Code	CBSA	FTE/Campus	-
44 00/1 f line 145 is you for each	0	1.00	2.00	3.00	4.00	5.00	144 04
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	0166.0
						1.00	
Health Information Technology (HI)							4/7
67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the H	95 is "Y") and is a m	eaningful user (line			the	Y	167. 0 168. 0
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	iot a meaningful user	, does this provider			shi p		168. 0 ⁻
) and is not a CAH (I					9169.0

Health Financial Systems	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	Period:	Worksheet S-2			
	From 07/01/2020				
			To 06/30/2021	Date/Time Pre	
			-	11/30/2021 2:	<u>40 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provid	der have any days for indi	viduals enrolled in	N	0	171.00
section 1876 Medicare cost plans rep					
"Y" for yes and "N" for no in column	n 1. lfcolumn 1 is yes, e	nter the number of section	1		
1876 Medicare days in column 2. (see	e instructions)				

	Financial Systems MEMORIAL HOSP & H				u of Form CMS-	
IOSPI TA	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0115	Period: From 07/01/2020 To 06/30/2021		
				Y/N	11/30/2021 2: Date	:40 pm
				1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N m/dd/yyyy format.	for all NU re	esponses. Ente	er all dates in t	the	
С	COMPLETED BY ALL HOSPITALS					
00 F	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			1.00
I			Y/N	Date	V/I	
00	· · · · · · · · · · · · · · · · · · ·		1.00	2.00	3.00	0.00
3	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
00 I () ()	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home c or medical supply companies) that are related to the provic officers, medical staff, management personnel, or members c	offices, drug ler or its of the board	N			3.00
	of directors through ownership, control, or family and othe relationships? (see instructions)	er similar				
İ			Y/N	Туре	Date	
	inensial Data and Deports		1.00	2.00	3.00	_
00 0	inancial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		Y	A		4.00
	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	nilable in				
	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.00
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf yoo io th		S N		
	the legal operator of the program?	TT yes, is tr	le provider is			6.00
	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Ν		7.00
0	Nere nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		0	N		8.00
, F	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	IS.		N		9.00
	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.	or renewed in t	the current	N		10.00
	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	Ν		11.00
1	Teaching Program on Worksheet A? If yes, see instructions.					-
					Y/N 1.00	
В	Bad Debts				1.00	
. 00 🛛	Is the provider seeking reimbursement for bad debts? If yes				Y	12.00
, F	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	5 0	0		Ν	13.00
	lfline 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	ryes, see ins	structions.	N	14.00
	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructions.	N	15.00
			rt A		тв	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
P	PS&R Data	1.00	2.00	3.00	4.00	
. 00 V 	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	09/30/2021	Y	09/30/2021	16.00
00 1	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		Ν		17.00
li	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
F	Report data for additional claims that have been billed bout are not included on the PS&R Report used to file this			IN IN		
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		19.00

Health Financial Systems

MEMORIAL HOSP & HEALTH CARE CTR

In Lieu of Form CMS-2552-10

Health Financial Systems MEMORIAL I	HOSP & HE	ALTH CARE CTR	u of Form CMS-2552-1			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA		Provider C	CN: 15-0115	Period: From 07/01/2020 Fo 06/30/2021	Worksheet S Part II Date/Time P	-2 repared:
					11/30/2021	2:40 pm
			ption	Y/N	Y/N	
		()	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS Report data for Other? Describe the other adjustment				N	N	20.00
	15.	Y/N	Date	Y/N	Date	
	-	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider	r's	N	2100	N		21.00
records? If yes, see instructions.						
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONL	LV (EXCEPT	CHILDRENS H	OSPLTALS)		1.00	
Capital Related Cost			001111120)			
22.00 Have assets been relifed for Medicare purposes? If y	ves, see i	instructions				22.00
23.00 Have changes occurred in the Medicare depreciation e	5		als made durir	na the cost		23.00
reporting period? If yes, see instructions.				.g		
24.00 Were new leases and/or amendments to existing leases	s entered	into during	this cost repo	orting period?		24.00
If yes, see instructions		5		5 1		
25.00 Have there been new capitalized leases entered into	during tl	he cost repor	ting period? I	f yes, see		25.00
instructions.						
26.00 Were assets subject to Sec. 2314 of DEFRA acquired du	uring the	cost reporti	ng period? If	yes, see		26.00
instructions.						07.00
27.00 Has the provider's capitalization policy changed dur	ring the o	cost reportin	g period? IT y	es, submit/		27.00
copy. Interest Expense						_
28.00 Were new Loans, mortgage agreements or Letters of cr	rodit onto	ared into dur	ing the cost r	conorting	1	28.00
period? If yes, see instructions.			The cost i	eportring		20.00
29.00 Did the provider have a funded depreciation account	and/or bo	ond funds (De	bt Service Res	serve Fund)		29.00
treated as a funded depreciation account? If yes, se						
30.00 Has existing debt been replaced prior to its schedul			debt? If yes,	see		30.00
instructions.		-	-			
31.00 Has debt been recalled before scheduled maturity wit	thout issu	uance of new	debt? If yes,	see		31.00
instructions.						
Purchased Services					1	
32.00 Have changes or new agreements occurred in patient of			d through cont	tractual		32.00
arrangements with suppliers of services? If yes, see			a to compotiti	vo bidding? If		22.00
33.00 f line 32 is yes, were the requirements of Sec. 213 no, see instructions.	35. Z appi i	red pertainin	g to competiti	ve broarng? IT		33.00
Provi der-Based Physi ci ans						
34.00 Are services furnished at the provider facility under	er an arra	angement with	provi der-base	ed physicians?		34.00
If yes, see instructions.		angomorre in en	protridor buot			01100
35.00 If line 34 is yes, were there new agreements or amer	nded exis [.]	ting agreemen	ts with the pr	rovi der-based		35.00
physicians during the cost reporting period? If yes,	, see ins	tructions.	•			
				Y/N	Date	
				1.00	2.00	_
Home Office Costs					1	24.00
36.00 Were home office costs claimed on the cost report?	boon nr-	oarad by +b-	home office?			36.00
37.00 If line 36 is yes, has a home office cost statement	neeu br.el	pareu by the	nome office?			37.00
<pre>If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the h</pre>	home offi	re different	from that of			38.00
the provider? If yes, enter in column 2 the fiscal y						30.00
39.00 If line 36 is yes, did the provider render services						39.00
see instructions.						
40.00 If line 36 is yes, did the provider render services	to the ho	ome office?	lf yes, see			40.00
instructions.						
		1.	00	2.	00	
Cost Report Preparer Contact Information	1					41.00
41.00 Enter the first name, last name and the title/positi		ERRY		BEJARANO		41.00
held by the cost report preparer in columns 1, 2, ar	nu 3,					
42.00 Enter the employer/company name of the cost report	DL	KD, LLP				42.00
preparer.		NU, LLI				+∠.00
43.00 Enter the telephone number and email address of the	cost (317) 383-4000		KBEJARANO@BKD.	COM	43.00
report preparer in columns 1 and 2, respectively.		, 250 .000				
	1			1		

Heal th	Financial Systems MEMORIAL HOSP &	HEA	ALTH CARE CTR		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0115		eri od:	Worksheet S-2	
				To	rom 07/01/2020 06/30/2021	Part II Date/Time Pre 11/30/2021 2:	pared: 40 pm
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	DH	RECTOR				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	N: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/30/2021 2:4	pared:
	Component	Worksheet A	No. of Beds	Bed Days		I/P Days / O/P Visits / Trips Title V	
		Line Number 1.00	2.00	Avai I abl e 3.00	4,00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00	<u> </u>			1.00
2.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	50.00	70	23, 3,	0.00		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF		70			0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		70	25, 55	50 0.00	0	7.00
8.00	INTENSI VE CARE UNI T	31.00	26	9, 49	90 0.00	0	8.00
9.00	CORONARY CARE UNIT	01.00	20	7, 1		0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		96	35, 04	40 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6, 93	35	0	16.00
17.00	SUBPROVIDER – IRF	41.00	8	2, 92	20	0	17.00
18. 00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44.00	14	5, 11	10	0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	101.00					21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	11/ 00	0		0		23.00
24.00 24.10	HOSPICE HOSPICE (non-distinct part)	116. 00 30. 00	0		0		24.00 24.10
25.00	CMHC - CMHC	30.00					25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88, 01				0	26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)	07100	137				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30. 00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.0

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	:N: 15-0115	Period: From 07/01/20 To 06/30/20		epared:
		I/P Days	/ O/P Visits	/ Trips	Full Tim	e Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interr & Residents		
	1	6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	3, 624	161	8, 65	51		1.00
. 00	for the portion of LDP room available beds) HMO and other (see instructions)	1, 418	2, 086				2.00
. 00	HMO I PF Subprovider	105	0				3.00
. 00	HMO IRF Subprovider	199	83				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
00 00 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	2 (24	0 161	0.45	0		6.00 7.00
. 00 8. 00	beds) (see instructions)	3, 624 1, 924	84	8, 65			8.00
9.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 924	04	4, 05	74		9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		64	1, 37	78		13.00
4.00	Total (see instructions)	5, 548	309	14, 12		35 968.27	
5.00	CAH visits	0	0		0		15.00
6.00	SUBPROVIDER - IPF	884	712	2, 26	6 0.	51 22.56	16.00
7.00	SUBPROVIDER – IRF	517	0	1, 09	97 0.	00 8.05	17.00
8.00	SUBPROVI DER						18.00
9.00	SKILLED NURSING FACILITY	3, 459	100	4, 33	34 0.	20. 43	
0.00	NURSING FACILITY						20.00
1.00	OTHER LONG TERM CARE	10, 100		10.00			21.00
2.00	HOME HEALTH AGENCY	12, 439	0	18, 80	05 0.	32.05	22.00
4.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0	0		0 0.	0.00	
4. 10	HOSPICE (non-distinct part)	0	0	10		0.00	24.00
25.00	CMHC - CMHC				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		25.00
26.00	RURAL HEALTH CLINIC	1, 323	o	4,04	0.	4.78	
6. 01	RURAL HEALTH CLINIC II	1, 446	o	4,44			
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.	0.00	26.25
7.00	Total (sum of lines 14-26)				9.	36 1, 062. 90	27.00
8. 00	Observation Bed Days		45	2, 64	16		28.00
9.00	Ambul ance Trips	0					29.00
0. 00	Employee discount days (see instruction)				0		30.00
1. 00	Employee discount days - IRF				0		31.00
2.00	Labor & delivery days (see instructions)	0	161	36			32.00
2. 01	Total ancillary labor & delivery room				0		32.01
12 00	outpatient days (see instructions)						22.00
3.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.00 33.01

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	MORIAL HOSP & HE		CCN: 15-0115		riod: om 07/01/2020 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/30/2021 2:	pared:
		Full Time		D	i scha	arges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVI	11	Title XIX	Total All Patients	
		11.00	12.00	13.00		14.00	15.00	
1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 21.00 21.00 22.00 23.00 24.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	11.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		0 1,	773 0 773 106 43	14.00 439 0 0 0 0 439 190 0	15.00 3,952 3,952 481 82	15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00
24. 10 25. 00 26. 01 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00 0. 00 0. 00			0			24. 10 25. 00 26. 00 26. 01 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

	Financial Systems AL WAGE INDEX INFORMATION			HEALTH CARE CTR Provider CC	N: 15-0115	Period: From 07/01/2020 To 06/30/2021		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see instructions)	200.00	95, 982, 355	-960, 847	95, 021, 508	8 2, 179, 218. 50	43.60	1. C
2.00	Non-physician anesthetist Part A		C	0	(0.00	0.00	2. C
. 00	Non-physician anesthetist Part		3, 589, 814	. 0	3, 589, 814	4 32, 681. 00	109. 84	3. C
. 00	Physician-Part A - Administrative		232, 475	0	232, 47	5 781.00	297.66	4. C
. 01 . 00	Physicians - Part A - Teaching Physician and Non		887, 599 10, 468, 833		887, 599 10, 468, 833			4. (5. (
. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC services		560, 651	0	560, 65 ⁻	1 15, 814. 00	35. 45	6. (
. 00	Interns & residents (in an	21.00	C	0	(0.00	0.00	7.0
. 01	approved program) Contracted interns and residents (in an approved		832, 537	0	832, 53	7 19, 448. 00	42. 81	7.0
. 00	programs) Home office and/or related organization personnel		C	0	(0.00	0.00	8. (
. 00 0. 00	SNF Excluded area salaries (see instructions)	44.00	1, 279, 191 36, 420, 684		1, 273, 50 36, 151, 22			
1. 00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		2, 174, 043	0	2, 174, 043	3 42, 063. 00	51.69	1 1 1
2. 00	Care Contract Labor: Top Level		2, 1, 1, 010			0.00		
	management and other management and administrative services							
3. 00	Contract Labor: Physician-Part A - Administrative		132, 271		132, 27 ⁻			
4. 00	Home office and/or related organization salaries and wage-related costs		C			0.00		
4.01 4.02	Home office salaries Related organization salaries		11, 287, 484	0	11, 287, 484	4 472, 589. 26 0 0. 00		
5. 00	Home office: Physician Part A - Administrative		C	0	(0.00		
5.00	Home office and Contract Physicians Part A - Teaching		C	0	(0.00	0.00	16.
5. O1	Home office Physicians Part A - Teaching		C	0	(0.00		
6. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	(0.00	0.00	16.
7.00	Wage-related costs (core) (see instructions)		12, 691, 599	0	12, 691, 599	9		17.
3. 00	Wage-related costs (other) (see instructions)							18.
9.00).00	Excluded areas Non-physician anesthetist Part A		7, 087, 570 C	0 0	7, 087, 570 (19. 20.
I. 00	Non-physician anesthetist Part B		303, 311	О	303, 31 ⁻	1		21.
2. 00	Physician Part A - Administrative		8, 253		8, 25			22.
2. 01 8. 00	Physician Part A - Teaching Physician Part B		66, 027 330, 134		66, 02 ⁻ 330, 134			22. 23.
. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		146, 497 C		146, 49			24. 25.
. 50	approved program) Home office wage-related		2, 354, 569	0	2, 354, 56	9		25.
5. 51	(core) Related organization wage-related (core)		C	0	(b		25.
5. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0 0	(C		25.

							u of Form CMS-2	
HOSPII	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2020	Worksheet S-3 Part II	
						To 06/30/2021	Date/Time Pre	pared:
						-	11/30/2021 2:	40 pm
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
24 00	OVERHEAD COSTS - DIRECT SALARIE			0			0.00	
26.00	Employee Benefits Department	4.00	0	-		0 0.00		26.00
27.00	Administrative & General	5.00	3, 718, 443					27.00
28.00	Administrative & General under		946, 309	0	946, 30	9 9, 562. 07	98.96	28.00
20.00	contract (see inst.)	(00	F00 000		F 20, 02	0 / 711 75	70.05	00.00
29.00	Maintenance & Repairs	6.00	529, 923	0	529, 92			29.00
30.00	Operation of Plant	7.00	0	0	004.40	0 0.00		30.00
31.00	Laundry & Linen Service	8.00	296, 807	-2, 706	294, 10			31.00
32.00	Housekeeping	9.00	0	0	4 705 44	0 0.00		32.00
33.00	Housekeeping under contract (see instructions)		1, 735, 413	0	1, 735, 41	3 90, 249. 32	19. 23	33.00
34.00	Dietary	10.00	1,057,642	-839, 005	218, 63	7 12, 603. 70	17.35	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	814, 279	814, 27	9 46, 852.00	17.38	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	858, 516	-13, 697	844, 81	9 21, 943. 85	38. 50	38.00
39.00	Central Services and Supply	14.00	275, 242	-7, 417	267, 82	5 13, 017. 56		39.00
40.00	Pharmacy	15.00	1, 937, 382					40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0	. , ,	0 0.00		41.00
42.00	Social Service	17.00	Ω	n –		0 0.00	0.00	42.00
42.00	Other General Service	17.00	0			0 0.00		42.00

Heal th	Financial Systems	ME	MORIAL HOSP & I	HEALTH CARE CTR	2	In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CC		Period: From 07/01/2020 To 06/30/2021		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		82, 324, 643	-960, 847	81, 363, 79	6 2, 168, 478. 96	37.52	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		37, 699, 875	-275, 145	37, 424, 73	0 792, 401. 45	47.23	2.00
3.00	Subtotal salaries (line 1		44, 624, 768	-685, 702	43, 939, 06	6 1, 376, 077. 51	31.93	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		13, 593, 798	0	13, 593, 79	8 515, 702. 26	26.36	4.00
5.00	Subtotal wage-related costs (see inst.)		15, 054, 421	0	15, 054, 42	1 0.00	34.26	5.00
6.00	Total (sum of lines 3 thru 5)		73, 272, 987	-685, 702	72, 587, 28	5 1, 891, 779. 77	38. 37	6.00
7.00	Total overhead cost (see instructions)		11, 355, 677					7.00

SPI T	AL WAGE RELATED COSTS	ALTH CARE CTR Provider CCN: 15-0115	Period:	Worksheet S-3	-
			From 07/01/2020	Part IV	
			To 06/30/2021	Date/Time Prep 11/30/2021 2:4	
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
00	401K Employer Contributions			1, 557, 372	1.
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	
00	Nonqualified Defined Benefit Plan Cost (see instructions)			-1, 493	3.
00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
00	401K/TSA Plan Administration fees			0	5.
00	Legal/Accounting/Management Fees-Pension Plan			0	6.
00	Employee Managed Care Program Administration Fees			0	7.
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funded)			0	
01	Health Insurance (Self Funded without a Third Party Administr	rator)		0	8
02	Health Insurance (Self Funded with a Third Party Administrate	or)		11, 120, 408	
03	Health Insurance (Purchased)			0	
00	Prescription Drug Plan			0	9
. 00	Dental, Hearing and Vision Plan			0	
. 00	Life Insurance (If employee is owner or beneficiary)			80, 558	11
. 00	Accident Insurance (If employee is owner or beneficiary)			0	12
. 00	Disability Insurance (If employee is owner or beneficiary)			1, 289, 201	13
. 00	Long-Term Care Insurance (If employee is owner or beneficiary	y)		0	14
. 00	'Workers' Compensation Insurance			312, 430	15
. 00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	16
	Non cumulative portion)				1
	TAXES				
. 00	FICA-Employers Portion Only			5, 979, 451	
. 00	Medicare Taxes - Employers Portion Only			0	
. 00	Unemployment Insurance			81, 373	
. 00	State or Federal Unemployment Taxes			0	20
	OTHER				
. 00	Executive Deferred Compensation (Other Than Retirement Cost Finstructions))	Reported on lines 1 throu	igh 4 above. (see	0	21
. 00	Day Care Cost and Allowances			0	22
. 00	5			214, 091	
	Total Wage Related cost (Sum of lines 1 -23)			20, 633, 391	
	Part B - Other than Core Related Cost				1
00	OTHER WAGE RELATED COSTS (SPECIFY)				25

Heal th	Financial Systems	MEMORIAL HOSP & HEAL	TH CARE CTR	In Lieu	of Form CMS-2	2552-10
H0SPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0115	Peri od:	Worksheet S-3	
				From 07/01/2020	Part V	
				To 06/30/2021	Date/Time Pre 11/30/2021 2:	
	Cost Center Description			Contract Labor	Benefit Cost	
	cost center bescription			1.00	2.00	
	PART V - Contract Labor and Benefit Cost			1.00	2.00	
	Hospital and Hospital-Based Component Ide	enti fi cati on:				
1.00	Total facility's contract labor and benef	fit cost		2, 174, 043	20, 633, 391	1.00
2.00	Hospi tal			2, 174, 043	20, 633, 391	2.00
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce			0	0	13.00
14.00	Hospital-Based Health Clinic RHC			0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1			0	0	14.01
15.00	Hospital-Based Health Clinic FQHC			0	0	15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems ME	MORIAL HOSP & F	IEALTH CARE CTI	2	In Lie	u of Form CMS-	2552-10
	IEALTH AGENCY STATI STI CAL DATA		Provider C		Period: From 07/01/2020	Worksheet S-4	
			Component	CCN: 15-7222	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
					Home Health Agency I	PPS	
						0.0	-
0.00	County				1. DUBOI S	00	0.00
		Title V	Title XVIII	Title XIX	Other	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Home Health Aide Hours	0	5, 509	60	794	6, 906	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	722.00				2.00
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal					
				1.00	2.00	2 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	C	,	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40.00			0.00	•
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			1.0		1. 03 4. 81	•
6.00	Direct Nursing Service			12.	0.00	12.77	6.00
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.8		0. 81 5. 90	•
9.00	Physical Therapy Supervisor			0.0		0.00	•
10.00	Occupational Therapy Service			3. (3.07	•
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.0		0. 00 0. 16	•
13.00	Speech Pathology Supervisor			0.0		0.00	•
14.00	Medical Social Service			0.		0.17	•
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.0		0.00 3.32	•
17.00	Home Health Aide Supervisor			0.0	0. 00	0.00	17.00
18.00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18.00
19.00	Enter in column 1 the number of CBSAs where				1		19.00
	you provided services during the cost						
20.00	reporting period. List those CBSA code(s) in column 1 serviced			99915			20.00
	during this cost reporting period (line 20						
	contains the first code).	Full Ep	oi sodes				
			With Outliers	LUPA Epi sode	3	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5.00	
21 00	PPS ACTIVITY DATA	4.004	1 004	1.	22 42	E 202	21 00
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	4, 094 1, 033, 188	1, 084 274, 804		32 12 51 3, 024	5, 322 1, 346, 467	1
23.00	Physical Therapy Visits	2, 169	1, 130		24 2	3, 325	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	584, 920 824	303, 492 906		53 538 8 0	895, 703 1, 738	
26.00	Occupational Therapy Visit Charges	221, 188	243, 077		-	466, 417	
27.00	Speech Pathology Visits	25	48	8		74	•
28.00 29.00	Speech Pathology Visit Charges Medical Social Service Visits	6, 712 22	12, 873 5	20	59 0 0 0	19, 854 27	1
30.00	Medical Social Service Visit Charges	6, 732	1, 530		0 0	8, 262	30.00
31.00 32.00	Home Health Aide Visits Home Health Aide Visit Charges	1, 331 155, 321	617 71, 930		3 2 51 234	1, 953 227, 836	•
33.00	Total visits (sum of lines 21, 23, 25, 27,	8, 465	3, 790		58 16	12, 439	
34.00	29, and 31) Other Charges	0	0		0 0	0	34.00
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	2, 008, 061	907, 706	44, 9	5	0 2, 964, 539	•
36.00	30, 32, and 34) Total Number of Episodes (standard/non	783			93 3	879	
37.00	outlier) Total Number of Outlier Episodes		160		_	160	37.00
37.00 38.00	Total Number of Outrier Episodes Total Non-Routine Medical Supply Charges	94, 519			50 273	114, 828	•

Heal th	Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTI	R	In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-0115	Peri od:	Worksheet S-8	3
			Component		From 07/01/2020 To 06/30/2021		
					RHC I	Cost	
					1	. 00	
1 00	Clinic Address and Identification						1 00
1.00	Street		Ci	ty	522 SOUTH MAPL State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		FRENCH LICK	00		V47432	2.00
			1				
	1					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" forι	1		0	3.00
					t Award	Date	
	Source of Federal Funds				1.00	2.00	-
4.00	Community Health Center (Section 330(d), PHS	Act)				1	4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho	ospital-based I	RHC or FQHC? Er	nter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
		Sur	nday	Mc	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)		1	1			
11.00	CLINIC			08:00	17:00	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	uctivity standa	ard?	N	2.00	12.00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapter enter in colum	-9, section nn 2 the	N	0	13.00
	numbers below.		s or arr provid				
				Provi	der name	CCN number	
				1	I. 00	2.00	
14.00	RHC/FQHC name, CCN number					.	14.00
		Y/N 1.00	V 2.00	XVIII 3.00	4.00	Total Visits 5.00	
15 00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
10.00	GME cost? Enter "Y" for yes or "N" for no in						10.00
	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)						
			Соц	unty			
				00			
2.00	City, State, ZIP Code, County	·	ORANGE				2.00
		Tuesday to		esday		rsday to	
		6.00	from 7.00	to 8.00	from 9.00	to 10.00	
	Facility hours of operations (1)	0.00	7.00	0.00	7.00	10.00	
11.00		16:00	08: 00	12:00	07:00	16: 00	11.00

Health Financial Systems	MEMORIAL HOSP &	HEALTH CARE CT	In Lieu of Form CMS-2552-1			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0115	Peri od:	Worksheet S-8	
		Component	CCN: 15-8507	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	
				RHC I	Cost	
	Fr	i day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	06: 00	15: 00				11.00

Heal th	Financial Systems ME	MORIAL HOSP &	HEALTH CARE CT	R	In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Peri od:	Worksheet S-8	;
			Component		From 07/01/2020 To 06/30/2021		epared: 40 pm
					RHC II	Cost	
					1.	00	
1 00	Clinic Address and Identification				105 000DED 070		1 00
1.00	Street		Ci	ty	105 COOPER STR State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		LOOGOOTEE		IN	47553	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban		0	3.00
				-	t Award	Date	
	Source of Federal Funds			1	1.00	2.00	-
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad	ct)					5.00
6.00	Health Services for the Homeless (Section 340	D(d), PHS Act)					6.00
7.00 8.00	Appalachian Regional Commission Look-Alikes						7.00
9.00	OTHER (SPECIFY)						9.00
10.00	Does this facility operate as other than a ho		RHC or EOHC2 Er	ter "Y" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of a	other operatior	ns in column	, v		10.00
		Sur	nday	Мс	onday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00				08:00	17:00	08:00	11.00
12.00	Have you received an approval for an exception	on to the produ	uctivity standa	ard?	1.00 N	2.00	12.00
	Is this a consolidated cost report as defined				N	0	
	30.8? Enter "Y" for yes or "N" for no in colu						
	number of providers included in this report. numbers below.	List the names	s of all provid	lers and			
	Indilber 3 ber ow.			Provi	der name	CCN number	
				1	1.00	2.00	
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
				inty			
2.00	City, State, ZIP Code, County		4. MARTIN	00			2.00
2.00	ICITY, STATE, ZIF COUE, COUNTY	Tuesday		esday	Thur	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
11.00			00.00	1.7.00	00.00	1.7.00	1 11.00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of						
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0115	Period:	Worksheet S-8	
		Component	CCN: 15-8508	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	13:00				11.00

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR		In Lie	u of Form CMS-2	2552-10	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN:		Period:	Worksheet S-1	0	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:		
					1.00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by line	202 column	8)	0. 246605	1.00	
	Medicaid (see instructions for each line)	3		,			
2.00	Net revenue from Medicaid				10, 649, 705	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		с. н. н.		N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		from Medica	i d?		4.00	
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	om medicald			0 88, 230, 525	5.00	
7.00	Medicaid cost (line 1 times line 6)				21, 758, 089	7.00	
8.00	Difference between net revenue and costs for Medicaid program (íline 7 minus	sum of lin	es 2 and 5: if	11, 108, 384	8.00	
	< zero then enter zero)				,		
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line)					
9.00	Net revenue from stand-al one CHIP				0	9.00	
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00	
	Difference between net revenue and costs for stand-alone CHIP (ling 11 minu	slino 0. i	f < zero then		12.00	
12.00	enter zero)		STILE 7, 1		0	12.00	
	Other state or local government indigent care program (see inst	ructions for	each line)		1		
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00	
14.00	Charges for patients covered under state or local indigent care	e program (No	t included	in lines 6 or	0	14.00	
15.00	10) State on Local indigent care program east (line 1 times line 14				0	15.00	
	State or local indigent care program cost (line 1 times line 14 Difference between net revenue and costs for state or local inc		rogram (lin	a 15 minus lina	0	16.00	
10.00	13; if < zero then enter zero)	ingent care p			0	10.00	
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/	local indig	ent care program	ns (see		
	instructions for each line)				Γ		
	Private grants, donations, or endowment income restricted to fu				0		
	Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines	0 11, 108, 384	18.00 19.00	
19.00	8, 12 and 16)	indigent ca	ne programs	(Sum Of TITIES	11, 100, 304	17.00	
			Uni nsured	Insured	Total (col. 1		
		_	patients	patients	+ col . 2)		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00		
20.00	Charity care charges and uninsured discounts for the entire fac	cility	2, 760, 55	1 1, 417, 910	4, 178, 461	20.00	
	(see instructions)		, ,				
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	680, 76	6 1, 417, 910	2, 098, 676	21.00	
~~~~~	instructions)	66		_			
22.00	Payments received from patients for amounts previously written charity care	OTT as		0 0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)		680, 76	6 1, 417, 910	2, 098, 676	23.00	
20100					2,0,0,0,0	20100	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patier		d a length	of stay limit	N	24.00	
25.00	imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of						
20.00	stay limit	le indigent e	are program	S rength of	0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			10, 039, 632	26.00	
	Medicare reimbursable bad debts for the entire hospital complex				278, 751		
	Medicare allowable bad debts for the entire hospital complex (s	see instructi	ons)		428, 847		
28.00 29.00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	onco (coo in	structions)		9, 610, 785 2, 520, 164		
	Cost of uncompensated care (line 23 column 3 plus line 29)	CISE (SEE III	structruns)		4, 618, 840		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			15, 727, 224		

	Financial Systems MEI SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE ON	MORIAL HOSP & H F EXPENSES	EALTH CARE CTR Provider CC		In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
				F	rom 07/01/2020 o 06/30/2021	Date/Time Pre 11/30/2021 2:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		6, 831, 597 5, 529, 859		0	6, 831, 597 5, 529, 859	1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	О	5, 529, 859 0	5, 529, 659	0	5, 529, 659 0	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 718, 443	2, 112, 883			5, 831, 068	•
6.00 8.00	00600 MAINTENANCE & REPAIRS 00800 LAUNDRY & LINEN SERVICE	529, 923 296, 807	3, 204, 950 68, 920	3, 734, 873 365, 727	0	3, 734, 873 365, 727	6.00 8.00
8.00 9.00	00900 HOUSEKEEPING	290, 807	08, 920	0	0	305,727	9.00
10.00	01000 DI ETARY	1, 057, 642	547, 397	1, 605, 039		363, 368	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 858, 516	0 65, 081	0 923, 597	1, 235, 720 -516	1, 235, 720 923, 081	
14.00	01400 CENTRAL SERVICES & SUPPLY	275, 242	153, 517	428, 759		415, 828	
15.00	01500 PHARMACY	1, 937, 382	18, 821, 943			2, 155, 990	
16.00 21.00	01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	-	0 832, 537	
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	951, 842	867, 277	1, 819, 119		986, 578	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 290, 583 2, 748, 046	674, 365 204, 471	7, 964, 948 2, 952, 517		5, 937, 443 2, 852, 660	
40.00	04000 SUBPROVI DER – I PF	1, 653, 256	49, 641				
41.00	04100 SUBPROVIDER - IRF	637, 847	159, 742			793, 447	
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0 1, 279, 191	0 82, 495	0 1, 361, 686	/	616, 339 1, 331, 502	
44.00	ANCI LLARY SERVICE COST CENTERS	1,277,171	02,473	1, 301, 000	-30, 104	1, 331, 302	44.00
50.00	05000 OPERATING ROOM	4, 817, 996	10, 319, 234				
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 4, 114, 910	0 380, 984	0 4, 495, 894	1, 232, 677 -1, 443	1, 232, 677 4, 494, 451	
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 458, 654	1, 438, 496			7, 660, 465	
56.00	05600 RADI OI SOTOPE	172, 048	541, 104			712, 139	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 617, 088 1, 293, 776	5, 115, 437 617, 340			7, 727, 471 1, 889, 394	
66.00	06600 PHYSI CAL THERAPY	2, 578, 938	173, 417			2, 655, 132	
69.00	06900 ELECTROCARDI OLOGY	2, 693, 030	2, 513, 336			5, 133, 319	69.00
69. 01 69. 02	06901 PULMONARY 06902 CARDI OPULMONARY	0 98, 746	0 61, 235	0 159, 981	0	0 159, 981	
69. 02	06903 SLEEP LAB	268, 135	25, 029		0	293, 164	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	-	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0 5, 492, 184	0 5, 492, 184		1, 280, 938 5, 492, 184	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0,472,104	0,472,104		18, 834, 489	
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
88.00	OUTPATIENT SERVICE COST CENTERS	380, 806	99, 005	479, 811	0	479, 811	88 00
88.01	08801 RURAL HEALTH CLINIC II	472, 041	55, 946			527, 987	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	-	0	89.00
90. 00 90. 01	09000 CLINIC 09001 IMED	451, 973 0	839, 894 0	1, 291, 867 0		1, 016, 133 0	90.00 90.01
90.02	09002 ONCOLOGY	2, 311, 492	897, 522	3, 209, 014	-78, 882	3, 130, 132	
90.03	09003 OUTPATIENT CENTER	0	0	0	0	0	90.03
90. 04 90. 05	09004 HBURG URGENT CARE CLINIC 09005 DIABETES MGMT CLINIC	1, 357, 137 64, 622	156, 766 2, 061	1, 513, 903 66, 683		1, 492, 564 66, 650	
91.00	09100 EMERGENCY	8, 466, 662	1, 225, 488			9, 475, 719	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	2, 033, 203	151, 720	2, 184, 923	-19, 137	2, 165, 786	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100 HOME HEALTH AGENCY	1, 983, 501	354, 722	2, 338, 223	-57, 247	2, 280, 976	101.00
116.00	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	116.00
118.00		65, 869, 478	69, 835, 058	135, 704, 536	0	135, 704, 536	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		-		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	27, 846, 342 995, 770	5, 092, 458 39, 845			32, 938, 800 1, 035, 615	
	07950 LODGE	4, 565	39, 845 10, 757	15, 322	0	15, 322	
194.01	07951 OTHER NRCC	0	0	0	0	0	194.01
	07952 MEMORIAL HOSPITAL FOUNDATION 07953 MKT/PHY SERVICES	94, 264 203, 733	5, 150 57, 041	99, 414 260, 774	0	99, 414 260, 774	
	07953 MKT/PHY SERVICES 07954 COMMUNITY EDUCATION	203, 733 334, 392	129, 485			463, 877	
194.05	07955 VOLUNTEER	228, 371	18, 927	247, 298	0	247, 298	194.05
	07956 MAB 07957 OFFSITE COVID SCREENING	0 96, 518	0 15, 259	0 111, 777	0		194.06 194.07
174.07	UNITE COND SCREENING	70, 318	10, 209	L III, 777	U	111,777	1174.07

Health Financial Systems ME	EMORIAL HOSP & H	EALTH CARE CTR	2	In Lie	eu of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider CO		Peri od:	Worksheet A	
				rom 07/01/2020		
				o 06/30/2021		pared:
		0.11			11/30/2021 2:	40 pm
Cost Center Description	Sal ari es	Other	•	Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.0807958 PUBLIC RELATIONS	0	0	0	0 0	0	194.08
194.0907959 UNUSED SPACE	0	0	0	0 0	0	194.09
194. 10 07960 EMERGENCY PREPAREDNESS	308, 922	1, 187, 604	1, 496, 526	0	1, 496, 526	194.10
194.11 07961 HOME OFFICE	0	0	0	0 0	0	194.11
200.00 TOTAL (SUM OF LINES 118 through 199)	95, 982, 355	76, 391, 584	172, 373, 939	0	172, 373, 939	200.00

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-011	From 07/01/2020	orksheet A
					ate/Time Prepare 1/30/2021 2:40 p
	Cost Center Description		Net Expenses For Allocation		
		6.00	7.00		
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	4,634,044	11, 465, 641		1.
. 00	00200 CAP REL COSTS MUBLE EQUIP	2, 759	5, 532, 618		2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	22, 991, 782	22, 991, 782		4.
. 00	00500 ADMI NI STRATI VE & GENERAL	18, 303, 657	24, 134, 725		5.
. 00	00600 MAINTENANCE & REPAIRS	4, 845, 718	8, 580, 591		6.
. 00	00800 LAUNDRY & LINEN SERVICE	0	365, 727		8.
00 0.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 697, 053 -18, 632	1, 697, 053 344, 736		9. 10.
	01100 CAFETERI A	-551, 202	684, 518		11.
3.00	01300 NURSI NG ADMI NI STRATI ON	-8, 319	914, 762		13.
4.00	01400 CENTRAL SERVICES & SUPPLY	-2, 580	413, 248		14.
	01500 PHARMACY	-303, 188	1, 852, 802		15.
	01600 MEDI CAL RECORDS & LI BRARY	1, 738, 031	1, 738, 031		16.
	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0 E7 412	832, 537		21.
2.00	INPATIENT ROUTINE SERVICE COST CENTERS	-57, 413	929, 165		22.
D. 00		-213, 529	5, 723, 914		30.
	03100 I NTENSI VE CARE UNI T	0	2, 852, 660		31.
0. 00	04000 SUBPROVI DER – I PF	-325, 016	1, 374, 121		40
	04100 SUBPROVIDER - IRF	-57, 358	736, 089		41
3.00	04300 NURSERY	0	616, 339		43
1.00	04400 SKI LLED NURSING FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	1, 331, 502		44
0. 00	05000 OPERATING ROOM	-1, 488, 258	13, 577, 962		50
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 232, 677		52
8.00	05300 ANESTHESI OLOGY	-3, 966, 657	527, 794		53
		-4, 243, 212	3, 417, 253		54
. 00	05600 RADI OI SOTOPE	0	712, 139		56
0.00		-190, 178	7, 537, 293		60
5.00 5.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-9, 938 -295, 469	1, 879, 456 2, 359, 663		65
9.00	06900 ELECTROCARDI OLOGY	-694, 923	4, 438, 396		69
9.01	06901 PULMONARY	0	0		69
9. 02	06902 CARDI OPULMONARY	0	159, 981		69.
9. 03	06903 SLEEP LAB	-3, 662	289, 502		69
	07000 ELECTROENCEPHALOGRAPHY	0	0		70
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	1, 280, 938		71
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	5, 492, 184 18, 834, 489		72
I. 00	07400 RENAL DI ALYSI S	0	0		74
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	-666	479, 145		88
	08801 RURAL HEALTH CLINIC II	-838	527, 149		88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89
	09000 CLINIC	-372, 156	643, 977		90
	09001   MED 09002   ONCOLOGY	0	3, 130, 132		90
	09002 ONCOLOGI 09003 OUTPATI ENT CENTER	0	0		90
	09004 HBURG URGENT CARE CLINIC	-318, 264	1, 174, 300		90
). 05	09005 DIABETES MGMT CLINIC	0	66, 650		90
	09100 EMERGENCY	-5, 210, 478	4, 265, 241		91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92
. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	205 000	1, 779, 984		95
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	-385, 802	1, 779, 984		95
	10100 HOME HEALTH AGENCY	0	2, 280, 976		101
	SPECIAL PURPOSE COST CENTERS				
	11600 HOSPI CE	0	0		116
8.00		35, 495, 306	171, 199, 842		118
0 00	NONREI MBURSABLE COST CENTERS				100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 32, 938, 800		190 192
	19200 PHYSICIANS PRIVATE OFFICES 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 035, 615		192
	07950 LODGE	0	15, 322		192
	07951 OTHER NRCC	0	0		194
4. 02	07952 MEMORIAL HOSPITAL FOUNDATION	0	99, 414		194
	07953 MKT/PHY SERVICES	3, 815, 782	4, 076, 556		194
	07954 COMMUNITY EDUCATION	0	463, 877		194
	07955 VOLUNTEER	0	247, 298		194
	07956 MAB 07957 OFFSITE COVID SCREENING	0	0 111, 777		194 194
	07957 OFFSITE COVID SCREENING	0	0		194
	07959 UNUSED SPACE	0	o		194

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR		In Lieu	u of Form CMS-2552-	-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0115	Period:	Worksheet A	
				From 07/01/2020 To 06/30/2021	Date/Time Prepared 11/30/2021 2:40 pm	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation				
	6.00	7.00				
194.1007960 EMERGENCY PREPAREDNESS	0	1, 496, 526			194. 1	10
194.11 07961 HOME OFFICE	0	0			194. 1	11
200.00 TOTAL (SUM OF LINES 118 through 199)	39, 311, 088	211, 685, 027			200. 0	00

	Financial Systems SIFICATIONS	MEN	IORIAL HOSP & H	EALTH CARE CTR Provider CCN: 1		Form CMS-2552-10 ksheet A-6
					From 07/01/2020 To 06/30/2021 Dat	e/Time Prepared:
		Increases				<u>30/2021 2:40 pm</u>
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
	A - LABOR AND DELIVERY		5 40 001			
1.00 2.00	NURSERY DELIVERY ROOM & LABOR ROOM	43.00 52.00	548, 801 1, 097, 601	67, 538 135, 076		1.00
	0		1, 646, 402	202, 614		
1.00	B – CAFETERI A CAFETERI A	11.00	814, 279	421, 441		1.00
	0		814, 279	421, 441		
1.00	C - BILLABLE SUPPLES MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 280, 938		1.00
2.00	PATI ENTS	0.00		0		2.00
2.00 3.00		0.00 0.00	0	0		2.00 3.00
4.00		0.00	0	0		4.00
5.00 6.00		0.00 0.00	0	0		5.00 6.00
7.00		0.00	0	0		7.00
8.00 9.00		0.00 0.00	0	0		8.00 9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0.00 0.00	0	0		11.00 12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0.00 0.00	0	0		14.00 15.00
16.00		0.00	0	0		16.00
17. 00 18. 00		0.00 0.00	0	0		17.00 18.00
19.00		0.00	0	0		19.00
20. 00 21. 00		0.00 0.00	0	0		20.00 21.00
21.00		0.00	0	0		21.00
23. 00 24. 00		0.00 0.00	0	0		23.00 24.00
24.00	<u> </u>	0.00	o	1, 280, 938		24.00
1.00	D - DRUGS RECLASS DRUGS CHARGED TO PATIENTS	73.00	0	18, 834, 489		1.00
2.00		0.00	0	0		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
5.00		0.00	Ö	0		5.00
6.00 7.00		0.00 0.00	0	0		6.00 7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0.00 0.00	0	0		9.00 10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0.00 0.00	0	0		12.00 13.00
14.00		0.00	0	0		14.00
15. 00 16. 00		0.00 0.00	0	0		15.00 16.00
17.00		0.00	0	0		17.00
18. 00 19. 00		0.00 0.00	0	0		18.00 19.00
20.00	L	0.00	0	0		20.00
	O E - INTERN AND RESIDENT RECLA		0	18, 834, 489		
1.00	I&R SERVICES-SALARY &	21.00	0	832, 537		1.00
	FRINGES_APPRVD			832, 537		
	F - DI SABI LI TY LEAVE RECLASS		1			
1.00 2.00	ADMINISTRATIVE & GENERAL LAUNDRY & LINEN SERVICE	5.00 8.00	0	12, 978 2, 706		1.00
3.00	DI ETARY	10.00	0	24, 726		3.00
4.00 5.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	13, 697 7, 417		4.00 5.00
6.00	PHARMACY	15.00	0	45, 478		6.00
7.00	I &R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	1, 020		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	102, 655		8.00
9. 00 10. 00	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31.00 40.00	0	20, 423 21, 807		9.00 10.00
11.00	SUBPROVI DER – I RF	41.00	0	11, 225		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	5, 682		12.00

# Health Financial Systems RECLASSIFICATIONS

# MEMORI AL HOSP & HEALTH CARE CTR Provi der CCN: 15-0115 Peri od: Erom 07

In Lieu of Form CMS-2552-10 Worksheet A-6

JON. 13-0113	FELLUU.	WULKSHEEL A-U
	From 07/01/2020	
		Date/Time Prepared:
		11/30/2021 2:40 pm

					From 07/01/2020 To 06/30/2021	Date/Time Prepared: 11/30/2021 2:40 pm
		Increases				
	Cost Center	Line #	Sal ary	Other		
	2. 00	3.00	4.00	5.00		
13.00	OPERATING ROOM	50.00	0	71, 154		13.00
14.00	ANESTHESI OLOGY	53.00	0	60, 505		14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	54, 595		15.00
16.00	LABORATORY	60.00	0	27, 038		16.00
17.00	RESPI RATORY THERAPY	65.00	0	20, 726		17.00
18.00	PHYSI CAL THERAPY	66.00	0	72, 586		18.00
19.00	ELECTROCARDI OLOGY	69.00	0	38, 096		19.00
20.00	SLEEP LAB	69.03	0	991		20.00
21.00	RURAL HEALTH CLINIC	88.00	0	10, 700		21.00
22.00	RURAL HEALTH CLINIC II	88.01	0	26, 405		22.00
23.00	CLINIC	90.00	0	8, 313		23.00
24.00	ONCOLOGY	90.02	0	39, 655		24.00
25.00	HBURG URGENT CARE CLINIC	90.04	0	19, 414		25.00
26.00	EMERGENCY	91.00	0	4, 424		26.00
27.00	AMBULANCE SERVICES	95.00	0	16, 866		27.00
28.00	HOME HEALTH AGENCY	101.00	0	35, 418		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	165, 806		29.00
30.00	PSYCHI ATRI C/PSYCHOLOGI CAL	192.01	0	3, 465		30.00
	SERVI CES					
31.00	COMMUNITY EDUCATION	194.04	0	1, 782		31.00
32.00	VOLUNTEER	194.05	0	12, 434		32.00
33.00	EMERGENCY PREPAREDNESS	194.10	0	660		33.00
	TOTALS		0	960, 847		
500.00	Grand Total: Increases		2, 460, 681	22, 532, 866		500.00

	Financial Systems SIFICATIONS	MEMO	DRIAL HOSP & HI	EALTH CARE CTR Provider CCN: 15		In Lieu of Form Workshee	
					From 07/0 To 06/3	30/2021 Date/Tir	ne Prepared:
		Decreases	0.1			11730720	021 2:40 pm
	Cost Center 6.00	Li ne # 7.00	Salary 8.00		A-7 Ref. 0.00		
	A - LABOR AND DELIVERY	7.00	0.00	7.00	0.00		
1.00	ADULTS & PEDIATRICS	30.00	1, 646, 402	202, 614	0		1.00
2.00			0 1, 646, 402	0	0		2.00
	B – CAFETERIA		1, 040, 402	202, 614			
1.00	DI ETARY	10.00	814, 279	421, 441	0		1.00
	0		814, 279	421, 441			
1 00	C - BILLABLE SUPPLES	40.00		544	0		
1.00 2.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	516 12, 827	o		1.00
. 00	PHARMACY	15.00	0	2, 855	0		3.00
. 00	I&R SERVICES-OTHER PRGM.	22.00	О	4	0		4.00
00	COSTS APPRVD	20.00		177 050			F 00
. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	177, 959 99, 821	0		5. 00 6. 00
7.00	SUBPROVIDER - IPF	40.00	0	3, 748	0		7.00
8.00	SUBPROVI DER – I RF	41.00	0	4, 142	Ō		8.00
. 00	SKILLED NURSING FACILITY	44.00	0	30, 184	0		9.00
0.00	OPERATING ROOM	50.00	0	70, 114	0		10.00
1.00 2.00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0	1, 443 113, 985	0		11.00
2.00 3.00	RADI OLOGI - DI AGNOSTI C	56.00	0	610	0		13.00
4.00	LABORATORY	60.00	o	59	o		14.00
5.00	RESPI RATORY THERAPY	65.00	0	4, 432	0		15.00
6.00	PHYSI CAL THERAPY	66.00	0	93, 798	0		16.00
7.00	ELECTROCARDI OLOGY	69.00	0	50, 162	0		17.00
8.00 9.00	CLINIC ONCOLOGY	90.00 90.02	0	260, 221 78, 256	0		18.00 19.00
5.00 D.00	HBURG URGENT CARE CLINIC	90.02	0	6, 649	0		20.00
1.00	DIABETES MGMT CLINIC	90.05	0	33	Ō		21.00
2.00	EMERGENCY	91.00	0	203, 854	0		22.00
3.00	AMBULANCE SERVICES	95.00	0	9, 312	0		23.00
4.00	HOME_HEALTH_AGENCY	1 <u>01.00</u>	o	55,954 1,280,938	<u>0</u>		24.00
	D - DRUGS RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	258	0		1.00
. 00		10.00 14.00	0	5, 951 104	0		2.00 3.00
. 00	CENTRAL SERVICES & SUPPLY PHARMACY	15.00	0	18, 600, 480	0		4.00
. 00	ADULTS & PEDIATRICS	30.00	0	530	0		5. 00
. 00	INTENSIVE CARE UNIT	31.00	0	36	0		6.00
. 00	SUBPROVIDER - IPF	40.00	0	12	0		7.00
. 00	OPERATING ROOM	50.00	0	896	0		8.00
. 00 0. 00	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54.00 56.00	0	122, 700 403	o		9. 00 10. 00
1.00	LABORATORY	60.00	0	4, 995	0		11.00
2.00	RESPI RATORY THERAPY	65.00	0	17, 290	Ō		12.00
3.00	PHYSICAL THERAPY	66.00	0	3, 425	0		13.00
4.00	ELECTROCARDI OLOGY	69.00	0	22, 885	0		14.00
5.00 6.00	CLINIC ONCOLOGY	90.00 90.02	0	15, 513 626	0		15.00 16.00
7.00 7.00	HBURG URGENT CARE CLINIC	90.02 90.04	0	14, 690	0		17.00
8.00	EMERGENCY	91.00	0	12, 577	0		18.00
9.00	AMBULANCE SERVICES	95.00	0	9, 825	0		19.00
0. 00	HOME HEALTH AGENCY	<u> </u>	0	1, 293	<u>0</u>		20.00
	O E - INTERN AND RESIDENT RECLA	\$\$	0	18, 834, 489			
. 00	I &R SERVICES-OTHER PRGM.	22.00	0	832, 537	0		1.00
	COSTS APPRVD						
	0 F - DISABILITY LEAVE RECLASS	I	0	832, 537			
. 00	ADMI NI STRATI VE & GENERAL	5.00	12, 978	0	0		1.00
. 00	LAUNDRY & LINEN SERVICE	8.00	2, 706	0	ō		2.00
. 00	DI ETARY	10.00	24, 726	0	0		3.00
. 00	NURSING ADMINISTRATION	13.00	13, 697	0	0		4.00
. 00 . 00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	7, 417 45, 478	0	0		5.00
	I&R SERVICES-OTHER PRGM.	22.00	45, 478 1, 020	0	0		7.00
	COSTS APPRVD	22.00	1, 020	U U			/.00
. 00		20.00	102, 655	0	О		8.00
	ADULTS & PEDIATRICS	30.00	102,000				
. 00 . 00	INTENSIVE CARE UNIT	31.00	20, 423	O	0		
8.00 9.00 0.00	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31. 00 40. 00	20, 423 21, 807	0	0		9.00 10.00
7.00 3.00 9.00 10.00 11.00 12.00	INTENSIVE CARE UNIT	31.00	20, 423	0 0 0	0 0 0		

# Health Financial Systems RECLASSIFICATIONS

### MEMORIAL HOSP & HEALTH CARE CTR

In Lieu of Form CMS-2552-10

Health	Financial Systems	ME	MORIAL HOSP & H	HEALTH CARE CT	R	In Lieu	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (		Peri od:	Worksheet A-	-6
						From 07/01/2020		
						To 06/30/2021	Date/Time Pr	
		Deerseese					11/30/2021 2	2:40 pm
	Cost Conton	Decreases	Colorry	Others	What A 7 Def	1		
	Cost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	-		
13.00	OPERATING ROOM	50.00	71, 154	9.00				13.00
				0				
14.00		53.00	60, 505	0				14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	54, 595	0				15.00
16.00	LABORATORY	60.00	27, 038	0				16.00
17.00	RESPI RATORY THERAPY	65.00	20, 726	0				17.00
18.00	PHYSICAL THERAPY	66.00	72, 586	0	(	D		18.00
19.00	ELECTROCARDI OLOGY	69.00	38, 096	0	(	D		19.00
20.00	SLEEP LAB	69. 03	991	0	(	D		20.00
21.00	RURAL HEALTH CLINIC	88.00	10, 700	0	(	D		21.00
22.00	RURAL HEALTH CLINIC II	88. 01	26, 405	0	(	D		22.00
23.00	CLINIC	90.00	8, 313	0	(	D		23.00
24.00	ONCOLOGY	90.02	39, 655	0	(	C		24.00
25.00	HBURG URGENT CARE CLINIC	90.04	19, 414	0	(	C		25.00
26.00	EMERGENCY	91.00	4, 424	0	(	C		26.00
27.00	AMBULANCE SERVICES	95.00	16, 866	0	(	D		27.00
28.00	HOME HEALTH AGENCY	101.00	35, 418	0	(	b		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	165, 806	0	(	b		29.00
30.00	PSYCHI ATRI C/PSYCHOLOGI CAL	192.01	3, 465	0	(	b		30.00
	SERVI CES							
31.00	COMMUNITY EDUCATION	194.04	1, 782	0	(	b		31.00
32.00	VOLUNTEER	194.05	12, 434	0	(	b		32.00
33.00	EMERGENCY PREPAREDNESS	194.10	660	0	(	b		33.00
	TOTALS	†	960, 847	0		1		1
500.00	Grand Total: Decreases		3, 421, 528	21, 572, 019		1		500.00
	1 · · · · · · · · · · · · · · · · · · ·	1						

2.00       Land Improvements       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	Heal th	Financial Systems ME	MORIAL HOSP & H	IEALTH CARE CTF	2		In Lie	u of Form CMS-2	2552-10
Beginning Balances         Purchases         Donation         Total Netirements         Disposal s and Retirements           1.00         2.00         3.00         4.00         5.00           Land         11.046,937         107,626         0         107,626         0         1.00           2.00         Land Improvements         0         0         0         0         0         0         2.00           3.00         Buil ding Improvements         11,046,937         107,626         0         107,626         0         1.00           3.00         Buil dings and Fixtures         121,307,544         298,147         0         296,37,067         0         20         5.00           6.00         Fixed Equipment         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	RECONC	LIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0115	From	07/01/2020	Part I Date/Time Pre	pared:
Bai ances         Retirements           1.00         2.00         3.00         4.00         5.00           1.00         Land         1.00         2.00         3.00         4.00         5.00           1.00         Land         11,046,937         107,626         0         107,626         0         1.00           2.00         Land Improvements         11,046,937         107,626         0         107,626         0         1.00           3.00         Buil dings and Fixtures         121,307,544         298,147         0         298,147         0         3.00           4.00         Buil ding Improvements         1,172,693         29,637,067         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0					Acqui si ti on	S			
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           Land         11,004,937         107,626         0         107,626         0         100           2:00         Land improvements         11,046,937         107,626         0         100         2.00           3:00         Buildings and Fixtures         11,046,937         107,626         0         107,626         0         100         2.00           3:00         Buildings and Fixtures         121,307,544         298,147         0         298,147         0         3.00         4.00         5.00         2.00         3.00         4.00         0         2.00         3.00         4.00         2.00         3.00         0         0         0         2.00         3.00         0         0         2.00         3.00         0         0         2.00         3.00         0         2.00         3.00         0         0         2.00         3.00         0         2.00         3.00         0         0         3.00         0         3.00         0         3.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td></td> <td>Begi nni ng</td> <td>Purchases</td> <td>Donati on</td> <td></td> <td>Total</td> <td>Disposals and</td> <td></td>			Begi nni ng	Purchases	Donati on		Total	Disposals and	
PART I         - ANALYSI'S OF CHANGES IN CAPITAL ASSET BALANCES         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0									
1.00       Land       11,046,937       107,626       0       107,626       0       1.00         2.00       Land Improvements       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			1.00	2.00	3.00		4.00	5.00	
2.00         Land Improvements         0         0         0         0         0         2.00           3.00         Buildings and Fixtures         121, 307, 544         298, 147         0         298, 147         0         3.00           4.00         Building Improvements         1, 172, 693         29, 637, 067         0         4.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
3.00       Buildings and Fixtures       121, 307, 544       298, 147       0       298, 147       0       3.00         4.00       Building Improvements       1, 172, 693       29, 637, 067       0       29, 637, 067       0       4.00         5.00       Fixed Equipment       103, 337, 152       11, 441, 558       0       11, 441, 558       0       6.00         7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       236, 864, 326       41, 484, 398       0       41, 484, 398       0       8.00       9.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	1.00	Land	11, 046, 937	107, 626		0	107, 626	0	1.00
4.00       Building Improvements       1,172,693       29,637,067       0       29,637,067       0       4.00         5.00       Fixed Equipment       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	2.00	Land Improvements	0	0		0	0	0	2.00
5.00       Fixed Equipment       0       0       0       0       0       0       5.00         6.00       Movable Equipment       103, 337, 152       11, 441, 558       0       11, 441, 558       0       6.00         7.00       HIT designated Assets       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	3.00	Buildings and Fixtures	121, 307, 544	298, 147		0	298, 147	0	3.00
6.00       Movable Equipment       103, 337, 152       11, 441, 558       0       11, 441, 558       0       6.00         7.00       HIT designated Assets       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	4.00	Building Improvements	1, 172, 693	29, 637, 067		0	29, 637, 067	0	4.00
7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       236,864,326       41,484,398       0       41,484,398       0       8.00         9.00       Reconciling items       0       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       236,864,326       41,484,398       0       41,484,398       0       10.00         Full y line 8 minus line 9)       236,864,326       41,484,398       0       41,484,398       0       10.00         Full y line 8 minus line 9)       236,864,326       Full y line 6       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td>5.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>5.00</td>	5.00		0	0		0	0	0	5.00
7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       236,864,326       41,484,398       0       41,484,398       0       8.00       9.00         9.00       Reconciling items       0       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       236,864,326       41,484,398       0       41,484,398       0       10.00         Fully       Depreciated         Assets       6.00       7.00       7.00       1.00       10.00       10.00       10.00       10.00         PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00       Land       11,154,563       0       1.00       2.00         2.00       Land Improvements       121,605,691       0       3.00       3.00       3.00       3.00       3.00       5.00       5.00       Fixed Equipment       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<	6.00	Movable Equipment	103, 337, 152	11, 441, 558		0	11, 441, 558	0	6.00
9.00         Reconciling Items         0         0         0         0         0         9.00           10.00         Total (line 8 minus line 9)         236,864,326         41,484,398         0         41,484,398         0         41,484,398         0         10.00           Image: the start of the start	7.00		0	0		0	0	0	7.00
10.00         Total (line 8 minus line 9)         236,864,326         41,484,398         0         41,484,398         0         10.00           Ending Balance         Fully         Depreciated         Assets         6.00         7.00         7.00         7.00         7.00         7.00         7.00         1.00         2.00         Land         0         0         0         2.00         2.00         Land Improvements         0         0         0         2.00         3.00         Buildings and Fixtures         121,605,691         0         3.00         3.00         4.00         5.00         5.00         Fixed Equipment         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	8.00	Subtotal (sum of lines 1-7)	236, 864, 326	41, 484, 398		0	41, 484, 398	0	8.00
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET         BALANCES         0         7.00           1.00         Land         11,154,563         0         0         2.00         10,00         2.00         2.00         2.00         Land         11,154,563         0         2.00         2.00         3.00         Buildings and Fixtures         121,605,691         0         2.00         3.00         4.00         Suilding Improvements         30,809,760         0         4.00         5.00         Fixed Equipment         0         0         0         0         5.00         5.00         Fixed Equipment         114,778,710         0         4.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00	9.00	Reconciling Items	0	0		0	0	0	9.00
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         Fully Depreciated Assets         1.00         1.00         1.00         2.00         0         7.00         1.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         3.00         9.00         9.00         0         0         0         0         2.00         2.00         3.00         8.01 ding s and Fixtures         121,605,691         0         3.00         4.00         5.00         Fixed Equipment         0         0         0         3.00         4.00         5.00         5.00         Fixed Equipment         114,778,710         0         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         7.00         4.00         7.00         4.00         7.00         4.00         7.00         4.00         7.00         4.00         7.00         4.00         7.00         8.00         9.00         9.00         9.00	10.00	Total (line 8 minus line 9)	236, 864, 326	41, 484, 398		0	41, 484, 398	0	10.00
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET         BALANCES         1.00         7.00           1.00         Land         11,154,563         0         2.00         2.00         Land Improvements         0         0         0         2.00         3.00         Buildings and Fixtures         121,605,691         0         3.00         4.00         Silding Improvements         3.00,809,760         0         4.00         5.00         Fixed Equipment         114,778,710         0         5.00         6.00         7.00         4.00         5.00         5.00         5.00         5.00         Fixed Equipment         114,778,710         0         6.00         7.00         4.00         5.00         5.00         5.00         5.00         9.00         8.00         9.00         9.00         9.00         9.00			Endi ng Bal ance						
6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         11,154,563         0         1.00           2.00         Land         11,154,563         0         2.00           3.00         Buildings and Fixtures         121,605,691         0         3.00           4.00         Building Improvements         30,809,760         0         4.00           5.00         Fixed Equipment         0         0         5.00           6.00         Movable Equipment         114,778,710         0         5.00           8.00         Subtotal (sum of lines 1-7)         278,348,724         0         8.00           9.00         Reconciling Items         0         0         9.00			J						
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         11, 154, 563         0         1.00           2.00         Land Improvements         0         0         2.00           3.00         Buildings and Fixtures         121, 605, 691         0         3.00           4.00         Building Improvements         30, 809, 760         0         4.00           5.00         Fixed Equipment         0         0         5.00         5.00         Fixed Equipment         0         0         5.00         5.00         Fixed Equipment         0         0         5.00         5.00         6.00         7.00         8.00         9.00         7.00         8.00         9.00         9.00         9.00         9.00         9.00				Assets					
1.00       Land       11, 154, 563       0       1.00         2.00       Land Improvements       0       0       2.00         3.00       Buildings and Fixtures       121, 605, 691       0       3.00         4.00       Building Improvements       30, 809, 760       0       4.00         5.00       Fixed Equipment       0       0       5.00         6.00       Movable Equipment       114, 778, 710       0       5.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       278, 348, 724       0       8.00         9.00       Reconciling Items       0       0       9.00			6.00	7.00					
2.00       Land Improvements       0       0       2.00         3.00       Buildings and Fixtures       121,605,691       0       3.00         4.00       Building Improvements       30,809,760       0       4.00         5.00       Fixed Equipment       0       0       5.00         6.00       Movable Equipment       114,778,710       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       278,348,724       0       8.00         9.00       Reconciling Items       0       0       9.00		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
3.00       Buildings and Fixtures       121,605,691       0       3.00         4.00       Building Improvements       30,809,760       0       4.00         5.00       Fixed Equipment       0       0       5.00         6.00       Movable Equipment       114,778,710       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       278,348,724       0       8.00         9.00       Reconciling Items       0       0       9.00	1.00	Land	11, 154, 563	0					1.00
4.00       Building Improvements       30,809,760       0       4.00         5.00       Fixed Equipment       0       0       5.00         6.00       Movable Equipment       114,778,710       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       278,348,724       0       8.00         9.00       Reconciling Items       0       0       9.00	2.00	Land Improvements	0	0					2.00
5.00       Fixed Equipment       0       0       5.00         6.00       Movable Equipment       114,778,710       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       278,348,724       0       8.00         9.00       Reconciling Items       0       0       9.00	3.00	Buildings and Fixtures	121, 605, 691	0					3.00
6.00       Movable Equipment       114,778,710       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       278,348,724       0       8.00         9.00       Reconciling Items       0       0       9.00	4.00	Building Improvements	30, 809, 760	0					4.00
7.00         HIT designated Assets         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         278,348,724         0         8.00         8.00           9.00         Reconciling Items         0         0         0         9.00	5.00	Fixed Equipment	0	0					5.00
7.00         HIT designated Assets         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         278,348,724         0         8.00         8.00           9.00         Reconciling Items         0         0         0         9.00	6.00	Movable Equipment	114, 778, 710	0					6.00
8.00         Subtotal (sum of lines 1-7)         278, 348, 724         0         8.00           9.00         Reconciling Items         0         0         9.00	7.00		0	0					7.00
9.00 Reconciling Items 0 0 9.00	8.00		278, 348, 724	0					8.00
			0	0					9.00
10.00   10tar (The & minus The 9)   278,348,724  0    10.00	10.00	Total (line 8 minus line 9)	278, 348, 724	0					10.00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu o						u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CO		Period:	Worksheet A-7	
					From 07/01/2020		
					Fo 06/30/2021	Date/Time Pre 11/30/2021 2:4	
	SUMMARY OF CAPITAL					117 307 2021 2.	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3, 551, 746		2, 309, 93	7 145, 638	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5, 529, 859	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	9, 081, 605		2, 309, 93	7 145, 638	0	3.00
		SUMMARY OF CAPITAL					
				-			
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions) 14.00	15.00	-			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1 00	1.00 CAP REL COSTS-BLDG & FIXT 0 6, 831, 597						1.00
2.00	CAP REL COSTS-BLDG & FIXT	0					2.00
2.00	Total (sum of lines 1-2)	0	5, 529, 859 12, 361, 456				2.00
5.00	Total (sum of filles 1-2)	U U	12, 301, 430	1			3.00

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTF	2	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part III Date/Time Prep 11/30/2021 2:4	pared: 40 pm
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	163, 570, 014 114, 778, 710 278, 348, 724	0	114, 778, 71 278, 348, 72	0 0. 412356		1.00 2.00 3.00
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				0 40 405 707	004.07/	1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			0 10, 495, 727 0 5, 532, 618 0 16, 028, 345	824, 276 0 824, 276	1.00 2.00 3.00
		SL	JMMARY OF CAPI		021/270	0100
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		145 (20	[		11 4/5 / 41	1 00
2.00 CAP REL COSTS-BLUG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 0 0	0		0 0 0 0 0 0	11, 465, 641 5, 532, 618 16, 998, 259	1.00 2.00 3.00

## MEMORIAL HOSP & HEALTH CARE CTR

Heal th Financial	Systems	MEN	MORIAL HOSP & I	HEALTH CARE CTR	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EX				Provider CCN: 15-0115	Peri od:	Worksheet A-8	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
				Expense Classification o	n Worksheet A	11/30/2021 2:	40 pm
				To/From Which the Amount is			
					, <b>,</b>		
Cost	Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	income - CAP REL	В	-2, 309, 937	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
	& FIXT (chapter 2) income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	E EQUIP (chapter 2)		0	CAP REL CUSTS-MUBLE EQUIP	2.00	0	2.00
	income - other		0		0.00	0	3.00
(chapter 2			_				
	antity, and time (chapter 8)		0		0.00	0	4.00
	nd rebates of		0		0.00	0	5.00
	(chapter 8)		-			-	
	provider space by		0		0.00	0	6.00
	(chapter 8)	А	0		F 00	0	7 00
	services (pay excluded) (chapter	A	0	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
21)							
	n and radio service		0		0.00	0	8.00
(chapter 2							0.00
	ot (chapter 21) based physician	A-8-2	-12, 955, 296		0.00	0	9.00 10.00
adj ustment	1 5	R-0-2	-12, 755, 270			0	10.00
	crap, waste, etc.	В	-6, 936	ADMI NI STRATI VE & GENERAL	5.00	0	11.00
(chapter 2						_	
	ganization ons (chapter 10)	A-8-1	62, 177, 396			0	12.00
	nd linen service		0		0.00	0	13.00
	employees and guests	В	-551, 202	CAFETERI A	11.00		14.00
	quarters to employee		0		0.00	0	15.00
and others					0.00		1/ 00
	edical and surgical to other than		0		0.00	0	16.00
patients							
	rugs to other than	В	-303, 188	PHARMACY	15.00	0	17.00
patients			45 007		1/ 00		40.00
18.00 Sale of me abstracts	edical records and	В	-15, 207	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	nd allied health		0		0.00	0	19.00
	(tuition, fees,						
books, etc		_	_				
20.00 Vending ma 21.00 Income fro	achines om imposition of	В	0	ADMINISTRATIVE & GENERAL	5.00 0.00		20.00 21.00
	finance or penalty		0		0.00	0	21.00
	chapter 21)						
	expense on Medicare		0		0.00	0	22.00
	its and borrowings to						
	care overpayments for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
therapy co	sts in excess of		0		00.00		
	n (chapter 14)						o · · · ·
	for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	osts in excess of n (chapter 14)						
	on review -		0	*** Cost Center Deleted ***	114.00		25.00
	s' compensation						
(chapter 2			0		1.00		24 00
26.00 Depreciati COSTS-BLDG	on - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	on - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
COSTS-MVBL							
	ian Anesthetist		0	*** Cost Center Deleted ***			28.00
2	s' assistant for occupational	A-8-3	0	*** Cost Center Deleted ***	0.00		29.00 30.00
,	sts in excess of		0		07.00		00.00
limitation	n (chapter 14)						
	non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
instructio	-	100	0	*** Cost Center Deleted ***	40.00		21 00
	for speech costs in excess of	A-8-3	0		68.00		31.00
	(chapter 14)						
32.00 CAH HIT Ac	justment for		0		0.00	0	32.00
	on and Interest	٨	2 / 1 /		12.00		22.00
33. UU   ADVERTISIN	NG - NURSING ADMIN	A	-2,614	NURSING ADMINISTRATION	13.00	0	33.00

	Financial Systems	MEN	IORIAL HOSP & H	HEALTH CARE CTR		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0115	Peri od:	Worksheet A-8	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	narod
					10 00/ 30/ 2021	11/30/2021 2:	
				Expense Classification	on Worksheet A		
				To/From Which the Amount i			
					-		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	ADVERTISING - SKILLED NURSING	A		ADULTS & PEDIATRICS	30.00		
33.02	ADVERTISING - CARING HANDS	A		SUBPROVI DER – I PF	40.00		00.02
33.03	ADVERTISING - PT	A		PHYSICAL THERAPY	66.00	0	
33.04	ADVERTISING - SLEEP CENTER	A		SLEEP LAB	69.03	0	00.01
33.05	ADVERTISING - FRENCH LICK	A		RURAL HEALTH CLINIC	88.00	0	
33.06	ADVERTISING - LOOGOOTEE	A		RURAL HEALTH CLINIC II	88.01	0	
33.07	ADVERTISING - WOUND CARE	A		CLINIC	90.00	0	33.07
33.08	ADVERTISING - HUNTINGBURG	A	-236	HBURG URGENT CARE CLINIC	90.04	0	33.08
33.09	ADVERTISING - AMBULANCE	A	-4, 557	AMBULANCE SERVICES	95.00	0	33.09
33.10	PHYSICIAN RECRUITMENT	A		I&R SERVICES-OTHER PRGM.	22.00	0	33.10
				COSTS APPRVD			
33. 11	MI SCELLANEOUS REVENUE - ADMIN	В		ADMINISTRATIVE & GENERAL	5.00	0	33.11
33. 12	MI SCELLANEOUS - ENGINEERING	В		MAINTENANCE & REPAIRS	6.00	0	33.12
33.13	MI SCELLANEOUS - DI ETARY	В		DI ETARY	10.00	0	001.10
33. 15	MI SCELLANEOUS - CLINICAL	В	-5, 705	NURSING ADMINISTRATION	13.00	0	33.15
33. 16	MI SCELLANEOUS - STERI LE PROC	В		CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33. 17	MI SCELLANEOUS - PERI NATAL SVCS		-213, 479	ADULTS & PEDIATRICS	30.00	0	33.17
33. 18	MI SCELLANEOUS - REHAB	В	-24, 062	SUBPROVI DER – I RF	41.00	0	33.18
33. 19	MI SCELLANEOUS - RADI OLOGY	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.20	MI SCELLANEOUS - LABS	В	-40, 178	LABORATORY	60.00	0	33.20
33. 21	MI SCELLANEOUS - THERAPY	В	-295, 233	PHYSICAL THERAPY	66.00	0	33. 21
33. 22	MI SCELLANEOUS - SLEEP LAB	В	-2,950	SLEEP LAB	69.03	0	33.22
33. 23	MISCELLANEOUS - FRENCH LICK	В	-266	RURAL HEALTH CLINIC	88.00	0	33.23
33.25	MI SCELLANEOUS - HBURG URGENT	В	-15, 914	HBURG URGENT CARE CLINIC	90.04	0	33.25
	CARE CL						
33.26	MI SCELLANEOUS - AMBULANCE	В		AMBULANCE SERVICES	95.00		00.20
33. 27	CRNA EXPENSE	A	-917, 175	OPERATING ROOM	50.00	0	33.27
33. 28	CRNA EXPENSE	A	-2, 672, 639	ANESTHESI OLOGY	53.00	0	33.28
33. 29	I/R START UP COSTS	A	2, 759	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 29
	AMORTI ZATI ON						
33. 30	I/R START UP COSTS AMORTIZATION	A	11, 370	MAINTENANCE & REPAIRS	6.00	0	33.30
33. 31	I/R START UP COSTS	A	219, 884	I&R SERVICES-OTHER PRGM.	22.00	0	33.31
	AMORTI ZATI ON			COSTS APPRVD			
33. 32	GAINSHARE	A	-1, 930, 000	ADMI NI STRATI VE & GENERAL	5.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49)		39, 311, 088				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	MEMORIAL HOSP &	HEALTH CARE CTR	In Lie	eu of Form CMS-:	2552-10		
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0115	Peri od:	Worksheet A-8	-1		
OFFICE	COSTS			From 07/01/2020 To 06/30/2021		parad		
				10 00/30/2021	Date/Time Pre 11/30/2021 2:			
	Line No.	Cost Center	Expense Items	Amount of	Amount			
				Allowable Cost	Included in			
					Wks. A, column			
					5			
	1.00	2.00	3. 00	4.00	5.00			
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:							
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3, 956, 099	4, 483, 848	1.00		
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	6, 943, 981	0	2.00		
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFI TS 22, 991, 782		0	3.00		
4.00	5.00	ADMINISTRATIVE & GENERAL	A&G 20, 650		0	4.00		
4.01	6.00	MAINTENANCE & REPAIRS	PLANT ENGINEERING	4, 853, 306	0	4.01		
4.02	9.00	HOUSEKEEPING	ENVI RONMENTAL SERVI CES	1, 697, 053	0	4.02		
4.03	16.00	MEDICAL RECORDS & LIBRARY	MEDI CAL RECORDS	1, 753, 238	0	4.03		
4.04	194.03	MKT/PHY SERVICES	PHYSICIAN SERVICES	3, 815, 782	0	4.04		
4.05	0.00			0	0	4.05		
5.00	TOTALS (sum of lines 1-4).			66, 661, 244	4, 483, 848	5.00		
	Transfer column 6, line 5 to							
	Worksheet A-8, column 2,							
	line 12.							

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
 B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	С	МННСС	0. 00 MEM	HOS OP SURG	40.00	6.00
7.00	В		0. 00 MEMO	ORIAL HOME O	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

(1) Use the following symbols to indicate 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.

Health Financial Syst	ems	MEN	MORIAL HOS	P & HEAI	_TH CARE (	CTR		In Lieu	u of Form CMS-	2552-10
STATEMENT OF COSTS OF	SERVICES FROM	RELATED ORGANIZA	ATIONS AND	HOME	Provi der	CCN: 1	15-0115	Peri od:	Worksheet A-8	-1
OFFICE COSTS								From 07/01/2020		
								To 06/30/2021	Date/Time Pre	pared:
									11/30/2021 2:	40 pm
Net	Wkst. A-7 Ref.									
Adjustments										
(col. 4 minus										
col. 5)*										
6.00	7.00									
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								CLAI MED		

	HOME OFFICE COSTS	i:	
1.00	-527, 749	0	1.00
2.00	6, 943, 981	9	2.00
3.00	22, 991, 782	0	3.00
4.00	20, 650, 003	0	4.00
4.01	4, 853, 306	0	4.01
4.02	1, 697, 053	0	4.02
4.03	1, 753, 238	0	4.03
4.04	3, 815, 782	0	4.04
4.05	0	0	4.05
5.00	62, 177, 396		5.00

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	ed Organization(s) d/or Home Office		
T	ype of Business		
	6.00		
B. INTER	RELATIONSHIP TO RELA	TED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming

	sement under title XVIII.		
	SURGERY CENTER		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00		1	10.00
100.00		10	00.00

(1) Use the following symbols to indicate 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.

PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT	Provider CCN: 15-0115 Period:			Worksheet A-8	3-2	
						From 07/01/2020 To 06/30/2021	)	
						To 06/30/2021	Date/Time Pre	epared:
							11/30/2021 2:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		I &R SERVICES-OTHER PRGM.	947, 068	0	947, 068	197, 500	7, 061	1.00
		COSTS APPRVD						
2.00		SUBPROVIDER - IPF	324, 916					
3.00		SUBPROVIDER - IRF	33, 296					3.00
4.00		OPERATING ROOM	43, 334					4.00
5.00		ANESTHESI OLOGY	1, 294, 018					5.00
6.00		RADI OLOGY-DI AGNOSTI C	4, 242, 885	4, 242, 885	C			6.00
7.00		LABORATORY	150, 000	150, 000	C	271, 900	0	7.00
8.00	65.00	RESPI RATORY THERAPY	9, 938	9, 938	C	211, 500	0	8.00
9.00	69.00	ELECTROCARDI OLOGY	694, 923	694, 923	C	211, 500	0	9.00
10.00		CLINIC	371, 576	371, 576	C	211, 500	0	10.00
11.00	90.04	HBURG URGENT CARE CLINIC	302, 114	302, 114	C	211, 500	0	11.00
12.00		EMERGENCY	5, 210, 478	5, 210, 478	C	211, 500	0	12.00
13.00		AMBULANCE SERVICES	1, 206					
200.00			13, 625, 752		-	,		200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		ruonti i ruo		Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12	i nour unee	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		I &R SERVICES-OTHER PRGM.	670, 456					1.00
1.00		COSTS APPRVD	070, 100	00,020		j ő	Ŭ	1.00
2.00		SUBPROVIDER - IPF	0	0	c	0	0	2.00
3.00		SUBPROVIDER – IRF	0		-		0	3.00
4.00		OPERATI NG ROOM	0	0	0		0	4.00
5.00		ANESTHESI OLOGY		0		-	0	
6.00		RADI OLOGY-DI AGNOSTI C					0	6.00
7.00		LABORATORY	0	0		-	0	
8.00		RESPI RATORY THERAPY	0				0	8.00
9.00		ELECTROCARDI OLOGY	0			-	0	9.00
		CLINIC	0			-	0	
10.00			0				0	10.00
11.00		HBURG URGENT CARE CLINIC	0	0		0	0	11.00
12.00		EMERGENCY	0	0	C	-	0	12.00
13.00	95.00	AMBULANCE SERVICES	0	0	C	-	0	13.00
200.00			670, 456			-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	44.00	47.00	10.00		
1.00	1.00	2.00	15.00	16.00	17.00	18.00		4 00
1.00	22.00	I &R SERVICES-OTHER PRGM.	0	670, 456	276, 612	276, 612		1.00
2 00		COSTS APPRVD	_	_	_			0.00
2.00		SUBPROVIDER - IPF	0	0				2.00
3.00		SUBPROVIDER - IRF	0	0				3.00
4.00		OPERATING ROOM	0					4.00
5.00		ANESTHESI OLOGY	0					5.00
6.00		RADI OLOGY-DI AGNOSTI C	0					6.00
7.00		LABORATORY	0	0	C			7.00
8.00		RESPI RATORY THERAPY	0	0	C	9, 938		8.00
9.00	69.00	ELECTROCARDI OLOGY	0	0	C	694, 923		9.00
10.00		CLINIC	0	0	C	371, 576		10.00
11.00		HBURG URGENT CARE CLINIC	0	0	C	302, 114		11.00
12.00		EMERGENCY	0		C			12.00
13.00		AMBULANCE SERVICES	0		C			13.00
200.00			0		276, 612			200.00

COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/30/2021 2:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	11, 465, 641	11, 465, 641				1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT	5, 532, 618	11, 403, 041	5, 532, 61	8		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	22, 991, 782	0		0 22, 991, 782		4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	24, 134, 725 8, 580, 591	316, 529 15, 942			25, 500, 580 8, 732, 448	5.00 6.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	365, 727	36, 334				1
9.00	00900 HOUSEKEEPI NG	1, 697, 053	0		0 0	1, 697, 053	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	344, 736 684, 518	33, 915 113, 464				1
13.00	01300 NURSI NG ADMI NI STRATI ON	914, 762	25, 267	12, 19	2 204, 416	1, 156, 637	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	413, 248	21, 068				1
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 852, 802 1, 738, 031	66, 251 0		9 457, 773 0 0		15.00 16.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	832, 537	0		0 0	832, 537	21.00
22.00	02200 I & R SERVICES-OTHER PRGM. COSTS APPRVD I NPATI ENT ROUTI NE SERVICE COST CENTERS	929, 165	93, 411	45,07	4 230, 065	1, 297, 715	22.00
30.00	03000 ADULTS & PEDIATRICS	5, 723, 914	567, 658	273, 91	7 1, 340, 850	7, 906, 339	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 852, 660	260, 630	125, 76	4 659, 987	3, 899, 041	31.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 374, 121	205, 897				1
41.00	04300 NURSERY	736, 089 616, 339	107, 423 67, 404				1
44.00	04400 SKILLED NURSING FACILITY	1, 331, 502	116, 823				1
E0 00	ANCI LLARY SERVI CE COST CENTERS	12 577 042	773, 919	272 44	4 1 1 4 0 E 4 E	15 072 002	50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	13, 577, 962 1, 232, 677	134, 808				1
53.00	05300 ANESTHESI OLOGY	527, 794	0		0 981, 020		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 417, 253	260, 267				54.00
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	712, 139 7, 537, 293	17, 684 125, 609				
65.00	06500 RESPIRATORY THERAPY	1, 879, 456	46, 097				1
66.00	06600 PHYSI CAL THERAPY	2, 359, 663	107, 674				66.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 PULMONARY	4, 438, 396	245, 239 0		7 642, 398 0 0	5, 444, 370 0	69.00 69.01
69.02	06902 CARDI OPULMONARY	159, 981	30, 481				
69.03	06903 SLEEP LAB	289, 502	35, 018				1
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 1, 280, 938	0		0 0 0 0	0 1, 280, 938	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 492, 184	0		0 0	5, 492, 184	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18, 834, 489	0		0 0	18, 834, 489	
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0	1	0 0	0	74.00
88.00	08800 RURAL HEALTH CLINIC	479, 145	36, 008				1
88. 01 89. 00	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	527, 149	83, 071 0		5 107, 828 0 0		88. 01 89. 00
90.00	09000 CLINIC	643, 977	106, 683				
90. 01	09001 I MED	0	0		0 0	0	90. 01
90. 02 90. 03	09002 ONCOLOGY 09003 OUTPATI ENT CENTER	3, 130, 132	211, 662	102, 13	5 549, 703	3, 993, 632 0	90. 02 90. 03
90.04	09004 HBURG URGENT CARE CLINIC	1, 174, 300	100, 066	48, 28	6 323, 681	1, 646, 333	
90.05	09005 DI ABETES MGMT CLINIC	66, 650	10, 327				
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 265, 241	201, 460	97, 21	2 2, 047, 557	6, 611, 470 0	
72.00	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 779, 984	40, 558			2, 327, 994	
96.00 101.00	09600 DURABLE MEDICAL EQUIP-RENTED	0 2, 280, 976	0 47, 100		0 0 8 471, 366	-	96.00
101.00	SPECIAL PURPOSE COST CENTERS	2,200,770	47,100		0 471,300	2,022,170	101.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 171, 199, 842	0 4, 661, 747		0 0 4 15, 750, 109		116. 00 118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 662			,	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	32, 938, 800	1, 915, 377				
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07950 LODGE	1, 035, 615 15, 322	46, 148 541, 376				
	07951 OTHER NRCC	0	041, 570		0 0		194.00
	07952 MEMORIAL HOSPITAL FOUNDATION	99, 414	18, 875				•
	07953 MKT/PHY SERVICES	4, 076, 556 463, 877	1, 504 92, 609				
0-		100,077	,2,007	1,00		001,000	

Health Financial Systems	MEMORIAL HOSP & H	HEALTH CARE CTR	R	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 07/01/2020 To 06/30/2021 		
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
194. 05 07955 VOLUNTEER	247, 298	0		0 52, 249	299, 547	194.05
194.0607956 MAB	0	0		0 0	0	194.06
194. 07 07957 OFFSI TE COVI D SCREENI NG	111, 777	0		0 23, 354	135, 131	194.07
194.0807958 PUBLIC RELATIONS	0	0		0 0	0	194. 08
194.0907959 UNUSED SPACE	0	0		0 0	0	194.09
194.1007960 EMERGENCY PREPAREDNESS	1, 496, 526	0		0 74, 588	1, 571, 114	194.10
194. 11 07961 HOME OFFICE	0	4, 169, 343	2, 011, 87	1 0	6, 181, 214	194. 11
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	211, 685, 027	11, 465, 641	5, 532, 61	8 22, 991, 782	211, 685, 027	202.00

	LLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 07/01/2020 o 06/30/2021	Worksheet B Part I Date/Time Pre 11/30/2021 2:	epared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	REPAI RS 6.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	25, 500, 580				1	5.00
6.00	00600 MAI NTENANCE & REPAI RS	1, 196, 031	9, 928, 479			1	6.00
8.00	00800 LAUNDRY & LINEN SERVICE	67, 216	32, 402	590, 374	1 000 100	1	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	232, 435 61, 349	0 30, 245	0 4, 427	1, 929, 488 5, 897	549, 836	9.00
	01100 CAFETERIA	143, 779	101, 186	0	19, 729	0,030	
13.00	01300 NURSI NG ADMI NI STRATI ON	158, 418	22, 533	0	4, 393	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	69, 754	18, 789	21, 677	3, 663	0	
		329, 918	59, 082 0	0	11, 520	0	
	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD	238, 048 114, 028	0	0	0	0	
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	177, 740	83, 303	0	16, 242	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1					
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1,082,884	506, 234	116, 461	98, 703 45, 318	217, 994	
	04000 SUBPROVI DER – I PF	534, 028 284, 080	232, 428 183, 618	45, 336 15, 499	45, 318 35, 801	103, 164 57, 100	
	04100 SUBPROVI DER – I RF	143, 397	95, 799	11, 865	18, 678	27, 643	
	04300 NURSERY	116, 290	60, 110	353	11, 720	34, 724	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	248, 294	104, 182	26, 714	20, 313	109, 211	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	2, 174, 152	690, 175	86, 172	134, 567	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	232, 581	120, 221	34, 941	23, 440	0	
53.00	05300 ANESTHESI OLOGY	206, 653	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	733, 122	232, 104	73, 693	45, 254	0	
	05600 RADI OI SOTOPE 06000 LABORATORY	106,830	15, 771	0	3,075	0	
	06500 RESPIRATORY THERAPY	1, 143, 678 308, 967	112, 017 41, 109	3, 150 0	21, 841 8, 015	0	
	06600 PHYSI CAL THERAPY	428, 114	96, 023	14, 157	18, 722	0	
	06900 ELECTROCARDI OLOGY	745, 683	218, 702	36, 792	42, 642	0	69.00
	06901 PULMONARY	0	0	0	0	0	0
	06902 CARDI OPULMONARY 06903 SLEEP LAB	31, 373 55, 615	27, 183 31, 229	174 3, 511	5, 300 6, 089	0	
	07000 ELECTROENCEPHALOGRAPHY	55, 015	31, 229	3, 511	0,089	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	175, 442	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	752, 231	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	2, 579, 647	0	0	0	0	
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	74.00
	08800 RURAL HEALTH CLINIC	85, 203	32, 112	0	6, 261	0	88. 00
	08801 RURAL HEALTH CLINIC II	103, 837	74, 082	0	14, 444	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	104 547	0	0	10 550	0	
	09001 I MED	124, 567	95, 140 0	1, 229	18, 550 0	0	
	09002 ONCOLOGY	546, 984	188, 759	12, 268	36, 803		1
	09003 OUTPATI ENT CENTER	0	0	0	0	0	
	09004 HBURG URGENT CARE CLINIC	225, 488	89, 238	1, 205	17, 399		
	09005 DIABETES MGMT CLINIC 09100 EMERGENCY	13, 367 905, 533	9, 210 179, 661	0 77, 150	1, 796 35, 029		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	705, 555	179,001	77,150	55, 027	0	92.00
	OTHER REIMBURSABLE COST CENTERS	· · ·					
	09500 AMBULANCE SERVICES	318, 851	36, 169	0	7, 052		95.00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	0 386, 536	0 42, 004	0	0 8, 190		96.00
101.00	SPECIAL PURPOSE COST CENTERS	300, 530	42, 004	0	0, 190	0	
116.00	11600 HOSPI CE	0	0	0	0	0	116.00
	NONREI MBURSABLE COST CENTERS	17, 582, 143	3, 860, 820	586, 774			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	3, 789 5, 817, 712	16, 643 1, 708, 119	0 3, 600	3, 245 333, 041		190.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	184, 098	41, 154		8, 024		192.00
194.00	07950 LODGE	112, 179	482, 795	0	94, 133	0	194.00
	07951 OTHER NRCC	0	0	0	0		194.01
	07952 MEMORIAL HOSPITAL FOUNDATION	20, 573	16, 833	0	3, 282		194.02
	07953 MKT/PHY SERVICES 07954 COMMUNITY EDUCATION	565, 399 93, 362	1, 341 82, 588		262 16, 103		194.03
	07955 VOLUNTEER	41, 027	02, 000 N	0	10, 103		194.04
	07956 MAB	0	0	0	0	0	194.06
194.06		1	0	0	0		194.07
194.07	07957 OFFSITE COVID SCREENING 07958 PUBLIC RELATIONS	18, 508 0	0	0	0		194.07

Health Financial Systems M	EMORIAL HOSP & I	HEALTH CARE CTF	2	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2020	Worksheet B Part I	
				o 06/30/2021		
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	REPAI RS	LINEN SERVICE			
	5.00	6.00	8.00	9.00	10.00	
194. 10 07960 EMERGENCY PREPAREDNESS	215, 186	0	(	0 0	0	194.10
194.11 07961 HOME OFFICE	846, 604	3, 718, 186	(	724, 952	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	25, 500, 580	9, 928, 479	590, 374	1, 929, 488	549, 836	202.00

	Financial Systems MEI ALLOCATION - GENERAL SERVICE COSTS	MORIAL HOSP & H	HEALTH CARE CTR Provider CC	N: 15-0115 Pe	eriod: com 07/01/2020	i of Form CMS-2 Worksheet B Part I	
				To	06/30/2021	Date/Time Pre 11/30/2021 2:	pared: 40 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
10.00	01100 CAFETERIA	1, 314, 453					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	14, 832	1, 356, 813				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 800	0	631, 969			14.00
15.00	01500 PHARMACY	31, 862	0	3, 201	2, 844, 378	4 07 ( 070	15.00
16.00 21.00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1, 976, 079 0	16.00 21.00
21.00	02200 I &R SERVICES-SALART & TRINGES APPRVD	6, 804	0	170	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		- 1		-1		
30.00	03000 ADULTS & PEDIATRICS	102, 501	373, 110	15, 891	0	39, 352	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	54,608	198, 776	4, 608	0	26, 237	
40.00	04000 SUBPROVIDER - TPF 04100 SUBPROVIDER - TRF	30, 467 10, 878	110, 901 39, 598	928 341	0	11, 176 4, 529	
43.00	04300 NURSERY	10, 508	38, 250	0	0	4,657	
44.00	04400 SKILLED NURSING FACILITY	27, 593	100, 441	1, 771	0	4, 291	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	05 474	212.045	400 (70		040.445	50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	85, 176 21, 017	310, 045 0	188, 679 0	0	248, 115 5, 977	50.00 52.00
53.00	05300 ANESTHESI OLOGY	21,017	0	16, 330	0	9,033	
54.00	05400 RADI OLOGY-DI AGNOSTI C	59, 404	0	14, 556	Ō	256, 161	
56.00	05600 RADI OI SOTOPE	2, 643	0	169	0	35, 971	56.00
60.00	06000 LABORATORY	62,754	0	127, 907	0	196, 128	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	29, 513 50, 253	0	23, 502 2, 003	0	20, 953 38, 783	
69.00	06900 ELECTROCARDI OLOGY	37, 929	0	103, 392	0	136, 318	
69.01	06901 PULMONARY	0,,,,2,	0	00,072	0	0	69.01
69. 02	06902 CARDI OPULMONARY	2, 259	0	223	О	3, 338	69. 02
69.03	06903 SLEEP LAB	6, 416	0	548	0	5, 447	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0 63, 467	0	0 26, 120	70.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	03, 407	0	53, 154	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 844, 378	384, 494	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
00 00	OUTPATIENT SERVICE COST CENTERS	6, 456	0	365	0	2, 977	88.00
	08801 RURAL HEALTH CLINIC	9, 128	0	541	0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLI NI C	10, 334	0	4, 115	0	14, 947	
90.01	09001   I MED	0	0	0	0	0	90.01
90. 02 90. 03	09002 ONCOLOGY 09003 OUTPATI ENT CENTER	51, 014	185, 692	7, 419	0	59, 521 0	90. 02 90. 03
	09004 HBURG URGENT CARE CLINIC	23, 357	0	1, 872	0	11, 675	
90.05	09005 DIABETES MGMT CLINIC	1, 359	0	83	О	396	90. 05
	09100 EMERGENCY	80, 213	0	7, 763	0	165, 935	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	54, 562	0	2, 243	0	19, 460	95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	
101.00	10100 HOME HEALTH AGENCY	43, 295	0	1, 480	0	9, 387	101.00
11/ 00	SPECIAL PURPOSE COST CENTERS		0				11/ 00
116.00 118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0 958, 142	0 1, 356, 813	0 593, 567	0 2, 844, 378	0 1, 797, 653	116.00
110.00	NONREI MBURSABLE COST CENTERS	730, 142	1, 330, 013	373, 307	2, 044, 370	1, 777, 000	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	305, 876	0	21, 849	0	171, 244	
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	16, 895 142	0	175	0		192. 01 194. 00
	07950 LODGE 07951 OTHER NRCC	142	0	68 0	0		194.00 194.01
	07952 MEMORIAL HOSPITAL FOUNDATION	2, 609	0	84	o		194.01
194.03	07953 MKT/PHY SERVICES	2, 494	0	8	0	1, 193	194.03
	07954 COMMUNITY EDUCATION	12,009	0	1, 081	0		194.04
	07955 VOLUNTEER	4,174	0	114	0		194.05
	07956 MAB 07957 OFFSITE COVID SCREENING	3, 318 0	0	0 120	0		194. 06 194. 07
	07958 PUBLIC RELATIONS	0	0	0	0		194.07
	1 1	-	-	-	-	-	

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTR	2	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				rom 07/01/2020		
				o 06/30/2021		
					11/30/2021 2:	<u>40 pm</u>
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194.0907959 UNUSED SPACE	0	0	0	0 0	0	194.09
194. 10 07960 EMERGENCY PREPAREDNESS	8, 794	0	14, 903	3 0	0	194.10
194.11 07961 HOME OFFICE	0	0	C	0 0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 314, 453	1, 356, 813	631, 969	2, 844, 378	1, 976, 079	202.00

		u of Form CMS-2552-10
)115	Period: Erom 07/01/2020	Worksheet B Part I Date/Time Prepared:
	To 06/30/2021	Date/Time Prepared:

					rom 07/01/2020 o 06/30/2021	Part I Date/Time Pre	
		INTERNS &	RESI DENTS			11/30/2021 2:	40 pm
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	Intern &	Total	
	·	Y & FRINGES	PRGM. COSTS		Residents Cost & Post		
					Stepdown		
		21.00	22.00	24.00	Adjustments 25.00	26.00	
	NERAL SERVICE COST CENTERS						
	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	500 ADMI NI STRATI VE & GENERAL 600 MAI NTENANCE & REPAI RS						5.00 6.00
	800 LAUNDRY & LINEN SERVICE						8.00
	900 HOUSEKEEPI NG 000 DI ETARY						9.00 10.00
							11.00
	300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
	500 PHARMACY 600 MEDICAL RECORDS & LIBRARY						15.00
	100 I &R SERVICES-SALARY & FRINGES APPRVD	946, 565					16.00 21.00
	200 I &R SERVICES-OTHER PRGM. COSTS APPRVD PATIENT ROUTINE SERVICE COST CENTERS		1, 581, 974				22.00
30.00 03	000 ADULTS & PEDIATRICS	309, 749	517, 681	11, 286, 899	-827, 430	10, 459, 469	30.00
	100 I NTENSI VE CARE UNI T 000 SUBPROVI DER – I PF	0 52, 908	0 88, 423	5, 143, 544 2, 945, 024		5, 143, 544 2, 803, 693	
41.00 04	100 SUBPROVI DER – I RF	0	00, 423	1, 399, 696	0	1, 399, 696	41.00
	300 NURSERY 400 SKI LLED NURSI NG FACI LI TY	0	0	1, 125, 670 2, 455, 650		1, 125, 670 2, 455, 650	
AN	CILLARY SERVICE COST CENTERS	-					
	000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	116, 397 0	194, 531 0	20, 101, 901 2, 136, 292		19, 790, 973 2, 136, 292	
53.00 05	300 ANESTHESI OLOGY	18, 277	30, 546	1, 811, 860	-48, 823	1, 763, 037	53.00
	400 RADI OLOGY-DI AGNOSTI C 600 RADI OI SOTOPE	30, 783 0	51, 446 0	6, 849, 184 944, 444		6, 766, 955 944, 444	
60.00 06	000 LABORATORY	4, 810	8, 038	10, 030, 535	-12, 848	10, 017, 687	60.00
	500 RESPI RATORY THERAPY 600 PHYSI CAL THERAPY	0	0	2, 687, 888 3, 773, 796		2, 687, 888 3, 773, 796	
69.00 06	900 ELECTROCARDI OLOGY	24,049	40, 192	6, 830, 069	-64, 241	6, 765, 828	69.00
	901 PULMONARY 902 CARDI OPULMONARY	21, 163 24, 049	35, 369 40, 192	56, 532 363, 154		0 298, 913	69. 01 69. 02
	903 SLEEP LAB 000 ELECTROENCEPHALOGRAPHY	0	0	514, 912		514, 912	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 0	C 1, 545, 967	-	0 1, 545, 967	70.00 71.00
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	0	6, 297, 569		6, 297, 569	
74.00 07	400 RENAL DIALYSIS	0	0	24, 643, 008 C		24, 643, 008 0	
	TPATIENT SERVICE COST CENTERS 800 RURAL HEALTH CLINIC	0	0	755, 454	0	755, 454	88.00
88.01 08	801 RURAL HEALTH CLINIC II	0	0	963, 286		963, 286	88. 01
	900 FEDERALLY QUALI FIED HEALTH CENTER 000 CLINIC	0	0	C 1, 178, 371	-	0 1, 178, 371	89.00 90.00
90.01 09	001 I MED	0	0	C	0 0	0	90. 01
	002 ONCOLOGY 003 OUTPATI ENT CENTER	0	0	5, 082, 092 0		5, 082, 092 0	90. 02 90. 03
90.04 09	004 HBURG URGENT CARE CLINIC	23, 087	38, 585	2, 078, 239	-61, 672	2, 016, 567	90.04
	005 DIABETES MGMT CLINIC 100 EMERGENCY	0 41, 364	0 69, 131	123, 807 8, 173, 249		123, 807 8, 062, 754	
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	HER REIMBURSABLE COST CENTERS 500 AMBULANCE SERVICES	0	0	2, 766, 331	0	2, 766, 331	95.00
	600 DURABLE MEDI CAL EQUI P-RENTED	0	0	C	0 0	0	96.00
	100 HOME HEALTH AGENCY ECIAL PURPOSE COST CENTERS	0	0	3, 313, 062	2 0	3, 313, 062	101.00
	600 HOSPICE	((( ()))	1 114 124	127 277 405	-		116.00
118.00 NO	SUBTOTALS         (SUM OF LINES 1 through 117)           NREIMBURSABLE         COST CENTERS	666, 636	1, 114, 134	137, 377, 485	-1, 780, 770	135, 596, 715	118.UU
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0 254, 918	0 426, 040	51, 344		51, 344	
192.01 19	201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	234, 918	4∠0, 040 0	51, 518, 511 1, 600, 468		50, 837, 553 1, 600, 468	192.01
	950 LODGE 951 OTHER NRCC	0	0	1, 508, 355 C		1, 508, 355 0	194. 00 194. 01
194.0207	952 MEMORIAL HOSPITAL FOUNDATION	0	0	193, 586	0	193, 586	194. 02
	953 MKT/PHY SERVICES 954 COMMUNITY EDUCATION	0	0	4, 698, 779 886, 796		4, 698, 779 886, 796	
174.0407		ן ע ע	ų	000, 790	'I U	000, 790	1 74.04

Health Financial Systems	MEMORIAL HOSP & H				u of Form CMS-2	2552-T
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2020	Worksheet B Part I	
				To 06/30/2021	Date/Time Pre 11/30/2021 2:	
	INTERNS &	RESIDENTS				
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	Intern &	Total	
	Y & FRINGES	PRGM. COSTS		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	21.00	22.00	24.00	25.00	26.00	
194. 05 07955 VOLUNTEER	0	0	344, 86	2 0	344, 862	
194. 06 07956 MAB	0	0	3, 31	8 0	3, 318	194.00
194. 07 07957 OFFSI TE COVI D SCREENING	0	0	153, 75	9 0	153, 759	194. 0
194. 08 07958 PUBLIC RELATIONS	0	0		0 0	0	194.0
194.0907959UNUSED SPACE	0	0		0 0	0	194. 0
194. 10 07960 EMERGENCY PREPAREDNESS	0	0	1, 809, 99	7 0	1, 809, 997	194.1
194. 11 07961 HOME OFFICE	25, 011	41, 800	11, 537, 76	7 -66, 811	11, 470, 956	194.1
200.00 Cross Foot Adjustments	0	0		0 0	0	200. 0
201.00 Negative Cost Centers	0	0		0 0	0	201.0
202.00 TOTAL (sum lines 118 through 201)	946, 565	1, 581, 974	211, 685, 02	7 -2, 528, 539	209, 156, 488	202.00

LOCATION OF CAPITAL RELATED COSTS		IEALTH CARE CTF Provider C	CN: 15-0115	Period: From 07/01/2020 To 06/30/2021	u of Form CMS- Worksheet B Part II Date/Time Pre 11/30/2021 2:	pare
		CAPI TAL REI	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		1.00	2.00	2A	4.00	-
GENERAL SERVICE COST CENTERS	1					
00 00100 CAP REL COSTS-BLDG & FIXT						1.
00 00200 CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	2.
00 00500 ADMI NI STRATI VE & GENERAL	0	316, 529	152, 73	-	0	
00 00600 MAI NTENANCE & REPAI RS	0	15, 942	7, 69:		0	
00 00800 LAUNDRY & LINEN SERVICE	0	36, 334	17, 533		0	
00 00900 HOUSEKEEPI NG	0	0		0 0	0	
. 00  01000  DI ETARY . 00  01100  CAFETERI A	0	33, 915	16, 36		0	
. 00  01100  CAFETERIA . 00  01300  NURSING ADMINISTRATION	0	113, 464 25, 267	54, 75 ⁻ 12, 19:		0	
. 00 01400 CENTRAL SERVICES & SUPPLY	0	21, 068	10, 16		0	
. 00 01500 PHARMACY	0	66, 251	31, 969		0	
. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	(	0 0	0	16.
. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	(	0	0	
. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	93, 411	45, 074	4 138, 485	0	22.
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	567, 658	273, 91	7 841, 575	0	30.
. 00 03100 I NTENSI VE CARE UNI T	0	260, 630	125, 764		0	
. 00 04000 SUBPROVIDER - IPF	0	205, 897	99, 353		0	40
. 00 04100 SUBPROVIDER - IRF	0	107, 423	51, 830		0	
. 00 04300 NURSERY	0	67, 404	32, 52		0	
. 00 04400 SKI LLED NURSI NG FACI LI TY	0	116, 823	56, 372	2 173, 195	0	44
ANCI LLARY SERVICE COST CENTERS	0	773, 919	373, 440	6 1, 147, 365	0	50
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	134, 808	65, 050		0	
00 05300 ANESTHESI OLOGY	0	0		0 0	0	
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	260, 267	125, 589	9 385, 856	0	54
. 00 05600 RADI OI SOTOPE	0	17, 684	8, 53		0	
	0	125, 609	60, 61		0	
. 00 06500 RESPI RATORY THERAPY . 00 06600 PHYSI CAL THERAPY	0	46, 097 107, 674	22, 24 51, 95		0	65 66
. 00 06900 ELECTROCARDI OLOGY	0	245, 239	118, 33		0	
. 01 06901 PULMONARY	0	0		0 0	0	
. 02 06902 CARDI OPULMONARY	0	30, 481	14, 708	8 45, 189	0	69
. 03 06903 SLEEP LAB	0	35, 018	16, 898		0	
00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS . 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
. 00 07400 RENAL DIALYSIS	0	0	(	0 0	0	
OUTPATIENT SERVICE COST CENTERS						
. 00 08800 RURAL HEALTH CLINIC	0	36, 008	17, 37		0	
. 01  08801 RURAL HEALTH CLINIC II . 00  08900 FEDERALLY QUALIFIED HEALTH CENTER	0	83, 071	40, 08	5 123, 156 0 0	0	
. 00 09000 CLINIC	0	106, 683	51, 479		0	
. 01 09001 I MED	0	000,000	(	0 0	0	
. 02 09002 ONCOLOGY	0	211, 662	102, 13	5 313, 797	0	90
. 03 09003 OUTPATI ENT CENTER	0	0	(	0 0	0	
. 04 09004 HBURG URGENT CARE CLINIC	0	100, 066	48, 280		0	
. 05 09005 DIABETES MGMT CLINIC . 00 09100 EMERGENCY	0	10, 327	4, 98		0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	201, 460	97, 212	2 298,072	0	91
OTHER REIMBURSABLE COST CENTERS	I			0		1 12
. 00 09500 AMBULANCE SERVICES	0	40, 558	19, 57	1 60, 129	0	
. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	0 0	0	
1.00 10100 HOME HEALTH AGENCY	0	47, 100	22, 728	8 69, 828	0	101
SPECIAL PURPOSE COST CENTERS 6. 00 11600 HOSPICE	0	0		0 0	0	116
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 661, 747	2, 249, 474			118
NONREI MBURSABLE COST CENTERS	. 0	1,001,747	2,277,47		0	1.10
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 662	9, 00	5 27, 667	0	190
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 915, 377	924, 24			192
2. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	46, 148				192
4. 00 07950  LODGE	0	541, 376	261, 23	5 802, 611		194
4. 01 07951 OTHER NRCC 4. 02 07952 MEMORIAL HOSPITAL FOUNDATION	0	0 18, 875	9, 108	0 8 27,983		194 194
4.02 07952 MEMORIAL HOSPITAL FOUNDATION 4.03 07953 MKT/PHY SERVICES	0	18, 875	9,108			194
4. 04 07954 COMMUNITY EDUCATION	0	92, 609	44, 68		0	194
4. 05 07955 VOLUNTEER	0	0		0 0		194

Health Financial Systems M	EMORIAL HOSP & I	HEALTH CARE CTR	R	In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0115	Peri od:	Worksheet B	
				From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	pared:
	_				11/30/2021 2:	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
Cost center bescription	Assigned New	DEDG & TIXI	WVDLL LQUIF	Subtotal	BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4.00	
194. 06 07956 MAB	0	0		0 0	0	194.06
194.0707957 OFFSI TE COVI D SCREENI NG	0	0		0 0	0	194.07
194. 08 07958 PUBLIC RELATIONS	0	0		0 0	0	194.08
194.0907959UNUSED SPACE	0	0		0 0	0	194.09
194.1007960 EMERGENCY PREPAREDNESS	0	0		0 0	0	194.10
194.11 07961 HOME OFFICE	0	4, 169, 343	2, 011, 87	6, 181, 214	0	194.11
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	11, 465, 641	5, 532, 61	8 16, 998, 259	0	202.00

Heal th	Fina	nci a	I S	yste	ms		
	TLON			TAI	DEL	ATED	

## MEMORIAL HOSP & HEALTH CARE CTR

1.00 2.00 4.00 5.00 6.00 9.00 10.00 11.00 13.00 14.00 15.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	Cost Center Description Cost Center Description GENERAL SERVICE COST CENTERS D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0600 MAINTENANCE & REPAIRS D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1000 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D1600 MEDICAL RECORDS & LIBRARY D1600 MEDICAL RECORDS & LIBRARY D1600 I&R SERVICES-OTHER PRGM. COSTS APPRVD D1700 I&R SERVICES-OTHER PRGM. COST SAPPRVD D1700 I&R SERVICES-OTHER PRGM. SAPPRVD D1	ADMI NI STRATI VE & GENERAL 5.00 469, 266 22, 006 1, 237 4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826 5, 227	Provi der CC MAI NTENANCE & REPAI RS 6.00 45, 641 149 0 139 465 104 86 272 0 0 383 2, 327	CN: 15-0115 Pr Fi Tr LAUNDRY & LI NEN SERVI CE 8.00 55, 253 0 414 0 0 2, 029 0 0 0 0 0 0 0 0 0	eri od: om 07/01/2020 o 06/30/2021 HOUSEKEEPI NG 9.00 4,277 13 44 10 8 26 0	Worksheet B Part II Date/Time Pre 11/30/2021 2:- DI ETARY 10.00 51,975 0 0 0	40 pm 1.00 2.00 4.00 5.00 6.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 22.\ 00\\ 30.\ 00\\ 41.\ 00\\ 43.\ 00\\ 44.\ 00\\ 50.\ 00\\ 52.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0600 MAINTENANCE & REPAIRS D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D2100 I&R SERVICES-SALARY & FRINGES APPRVD D2000 ADULTS & PEDIATRICS D3100 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D3100 SUBPROVIDER - IRF D4300 NURSERY	& GENERAL 5.00 469,266 22,006 1,237 4,277 1,129 2,645 2,915 1,283 6,070 4,380 2,098 3,270 19,924 9,826	REPAI RS 6.00 45,641 149 0 139 465 104 86 272 0 0 383	LINEN SERVICE 8.00 55,253 0 414 0 2,029 0 0 0 0 0	9.00 4,277 13 44 10 8 26	DI ETARY 10. 00 51, 975 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00
$\begin{array}{c} 1. \ 00 \\ 2. \ 00 \\ 4. \ 00 \\ 5. \ 00 \\ 6. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 15. \ 00 \\ 15. \ 00 \\ 22. \ 00 \\ 30. \ 00 \\ 41. \ 00 \\ 43. \ 00 \\ 44. \ 00 \\ 50. \ 00 \\ 52. \ 00 \end{array}$	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO600 MAINTENANCE & REPAIRS D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1500 PHARMACY D1500 I&R SERVICES-SALARY & FRINGES APPRVD D2200 I&R SERVICES-SALARY & FRINGES APPRVD D2200 I&R SERVICES-OTHER PRGM. COSTS APPRVD D1400 CUNTRAL SERVICE COST CENTERS D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D4000 SUBPROVIDER - IRF D4300 NURSERY	5.00 469,266 22,006 1,237 4,277 1,129 2,645 2,915 1,283 6,070 4,380 2,098 3,270 19,924 9,826	6.00 45,641 149 0 139 465 104 86 272 0 0 383	8.00 55,253 0 414 0 2,029 0 0 0 0	4, 277 13 44 10 8 26	51, 975 0 0	2.00 4.00 5.00 6.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 22.\ 00\\ 30.\ 00\\ 41.\ 00\\ 43.\ 00\\ 44.\ 00\\ 50.\ 00\\ 52.\ 00\\ \end{array}$	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO600 MAINTENANCE & REPAIRS D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1500 PHARMACY D1500 I&R SERVICES-SALARY & FRINGES APPRVD D2200 I&R SERVICES-SALARY & FRINGES APPRVD D2200 I&R SERVICES-OTHER PRGM. COSTS APPRVD D1400 CUNTRAL SERVICE COST CENTERS D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D4000 SUBPROVIDER - IRF D4300 NURSERY	469, 266 22, 006 1, 237 4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270	45, 641 149 0 139 465 104 86 272 0 0 383	55, 253 0 414 0 2, 029 0 0 0	4, 277 13 44 10 8 26	51, 975 0 0	2.00 4.00 5.00 6.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ 22.\ 00\\ 30.\ 00\\ 41.\ 00\\ 43.\ 00\\ 44.\ 00\\ 50.\ 00\\ 52.\ 00\\ \end{array}$	D0200       CAP REL COSTS-MVBLE EQUIP         D0400       EMPLOYEE BENEFITS DEPARTMENT         D0500       ADMINISTRATIVE & GENERAL         D0500       MAINTENANCE & REPAIRS         D0800       LAUNDRY & LINEN SERVICE         D0900       HOUSEKEEPING         D11000       DIETARY         D1100       CAFETERIA         D1300       NURSING ADMINISTRATION         D1400       CENTRAL SERVICES & SUPPLY         D1500       PHARMACY         D1600       I&R SERVICES-SALARY & FRINGES APPRVD         D1200       I & SERVICES-OTHER PRGM. COSTS APPRVD         D2200       I & SERVICE COST CENTERS         D3000       ADULTS & PEDIATRICS         D3100       SUBPROVIDER - I PF         D4000       SUBPROVIDER - I RF         D4100       SUBPROVIDER - I RF	22, 006 1, 237 4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	149 0 139 465 104 86 272 0 0 0 383	0 414 0 2, 029 0 0 0	13 44 10 8 26	0 0	2.00 4.00 5.00 6.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ 22.\ 00\\ 30.\ 00\\ 31.\ 00\\ 40.\ 00\\ 41.\ 00\\ 43.\ 00\\ 44.\ 00\\ 50.\ 00\\ 52.\ 00\\ \end{array}$	D0400       EMPLOYEE BENEFITS DEPARTMENT         D0500       ADMI NI STRATI VE & GENERAL         D0500       MAI NTEMANCE & REPAIRS         D0800       LAUNDRY & LINEN SERVICE         D0900       HOUSEKEEPING         D1100       DI ETARY         D1400       CENTRAL SERVICES & SUPPLY         D1500       PHARMACY         D1600       I&R SERVICES & SUPPLY         D1500       PHARMACY         D16100       I&R SERVICES-SALARY & FRINGES APPRVD         D2200       I&R SERVICES-OTHER PRGM. COSTS APPRVD         D2200       I&R SERVICE CASE UNIT         D3100       JULTS & PEDIATRICS         D3100       SUBPROVIDER - IPF         D4400       SUBPROVIDER - IRF	22, 006 1, 237 4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	149 0 139 465 104 86 272 0 0 0 383	0 414 0 2, 029 0 0 0	13 44 10 8 26	0 0	4.00 5.00 6.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ 22.\ 00\\ 30.\ 00\\ 31.\ 00\\ 40.\ 00\\ 41.\ 00\\ 43.\ 00\\ 44.\ 00\\ 50.\ 00\\ 52.\ 00\\ \end{array}$	D0500       ADMI NI STRATI VE & GENERAL         D0600       MAI NTENANCE & REPAI RS         D0800       LAUNDRY & LINEN SERVICE         D0900       HOUSEKEEPI NG         D1000       DI ETARY         D1100       CAFETERI A         D1300       NURSI NG ADMI NI STRATI ON         D1400       CENTRAL SERVI CES & SUPPLY         D1500       PHARMACY         D1600       MEDI CAL RECORDS & LI BRARY         D21001       & SERVI CES-SALARY & FRI NGES APPRVD         D22001       & R SERVI CES-OTHER PRGM. COSTS APPRVD         D2000       ADULTS & PEDI ATRI CS         D3100       INTENSI VE CARE UNI T         D4000       SUBPROVI DER - I PF         D4100       SUBPROVI DER - I RF         D4100       SUBPROVI DER - I RF         D4100       NURSERY	22, 006 1, 237 4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	149 0 139 465 104 86 272 0 0 0 383	0 414 0 2, 029 0 0 0	13 44 10 8 26	0 0	5.00 6.00 8.00 9.00 10.00 11.00
6.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	D0600 MAINTENANCE & REPAIRS D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D1600 MEDICAL RECORDS & LIBRARY D1700 JUBROVICES-OTHER PRGM. COSTS APPRVD D1700 ADULTS & PEDIATRICS D1700 ADULTS & PEDIATRICS D1700 SUBPROVIDER - IPF D1700 SUBPROVIDER - IRF D1700 NURSERY	22, 006 1, 237 4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	149 0 139 465 104 86 272 0 0 0 383	0 414 0 2, 029 0 0 0	13 44 10 8 26	0 0	6.00 8.00 9.00 10.00 11.00
8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 55.00	D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D2100 I&R SERVICES-SALARY & FRINGES APPRVD D2200 I&R SERVICES-OTHER PRGM. COSTS APPRVD D1000 ADULTS & PEDIATRICS D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D4000 SUBPROVIDER - IRF D4300 NURSERY	1, 237 4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270	149 0 139 465 104 86 272 0 0 0 383	0 414 0 2, 029 0 0 0	13 44 10 8 26	0 0	8.00 9.00 10.00 11.00
9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 03000 ADULTS & PEDIATRICS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY	4, 277 1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	0 139 465 104 86 272 0 0 383	0 414 0 2, 029 0 0 0	13 44 10 8 26	0 0	9.00 10.00 11.00
10.00 11.00 13.00 14.00 15.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	D1000 DI ETARY D1100 CAFETERI A D1300 NURSI NG ADMI NI STRATI ON D1400 CENTRAL SERVI CES & SUPPLY D1500 PHARMACY D1600 MEDI CAL RECORDS & LI BRARY D2100 I &R SERVI CES-SALARY & FRI NGES APPRVD D2200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD D2200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD D1 NPATI ENT ROUTI NE SERVI CE COST CENTERS D3000 ADULTS & PEDI ATRI CS D3100 I NTENSI VE CARE UNI T D4000 SUBPROVI DER - I RF D4300 NURSERY	1, 129 2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270	139 465 104 86 272 0 0 383	414 0 2, 029 0 0 0	13 44 10 8 26	0 0	10.00 11.00
11. 00 13. 00 14. 00 15. 00 16. 00 21. 00 22. 00 30. 00 31. 00 40. 00 41. 00 43. 00 44. 00 50. 00 52. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 1 NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I RF 04300 NURSERY	2, 645 2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	465 104 86 272 0 0 383	0 0 2, 029 0 0 0	44 10 8 26	0 0	11.00
13.00 14.00 15.00 16.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 1 & R SERVI CES-OTHER PRGM. COSTS APPRVD 1 NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	2, 915 1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	104 86 272 0 0 383	0 2, 029 0 0 0	10 8 26	0	•
14.00 15.00 16.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 50.00 52.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02200 I & SERVICES-SALARY & FRINGES APPRVD 1000 I & SERVICES-OTHER PRGM. COSTS APPRVD 1010 I & SERVICES 1010 I &	1, 283 6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	86 272 0 0 383	2, 029 0 0 0	8 26	-	13.00
15.00 16.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 50.00 52.00	D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D2100 I&R SERVICES-SALARY & FRINGES APPRVD D2200 I&R SERVICES-OTHER PRGM. COSTS APPRVD INPATI ENT ROUTINE SERVICE COST CENTERS D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D4000 SUBPROVIDER - IPF D4100 SUBPROVIDER - IRF D4300 NURSERY	6, 070 4, 380 2, 098 3, 270 19, 924 9, 826	272 0 0 383	0	26	0	14.00
16.00 21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	01600 MEDI CAL RECORDS & LI BRARY 02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	4, 380 2, 098 3, 270 19, 924 9, 826	0 0 383	0		0	15.00
21.00 22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD INPATIENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDIATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	2, 098 3, 270 19, 924 9, 826	0 383	-		0	16.00
22.00 30.00 31.00 40.00 41.00 43.00 44.00 50.00 52.00	D2200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS D3000 ADULTS & PEDI ATRI CS I NTENSI VE CARE UNI T D4000 SUBPROVI DER - I PF D4100 SUBPROVI DER - I RF D4300 NURSERY	3, 270 19, 924 9, 826		0	o	0	21.00
30. 00 31. 00 40. 00 41. 00 43. 00 44. 00 50. 00 52. 00	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D4000 SUBPROVIDER - IPF D4100 SUBPROVIDER - IRF D4300 NURSERY	9, 826	2 327	0	36	0	22.00
31.00 40.00 41.00 43.00 44.00 50.00 52.00	D3100 I NTENSI VE CARE UNI T D4000 SUBPROVI DER – I PF D4100 SUBPROVI DER – I RF D4300 NURSERY	9, 826	2 227				
40.00 41.00 43.00 44.00 50.00 52.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04300 NURSERY		2, 321	10, 900	219	20, 606	30.00
41.00 43.00 44.00 50.00 52.00	04100 SUBPROVI DER – I RF 04300 NURSERY	5 227	1, 068	4, 243	100	9, 752	31.00
43.00 44.00 50.00 52.00	D4300 NURSERY	5,227	844	1, 451	79	5, 398	40.00
44.00 50.00 52.00		2, 638	440	1, 110	41	2, 613	41.00
50. 00 52. 00	NAAOO SKILLED NURSING EACLILTY	2, 140	276	33	26	3, 282	
50.00 52.00		4, 568	479	2, 500	45	10, 324	44.00
52.00	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	40, 002	3, 173	8, 065	298	0	50.00
<b>FO OO</b>	D5200 DELIVERY ROOM & LABOR ROOM	4, 279	553	3, 270	52	0	52.00
	05300 ANESTHESI OLOGY	3,802	0	0	0	0	53.00
	D5400 RADI OLOGY-DI AGNOSTI C	13, 489	1,067	6, 897	100	0	54.00
	05600 RADI OI SOTOPE	1,966	72 515	0 295	7	0	56.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	21, 043 5, 685	189	295	48 18	0	60.00 65.00
	D6600 PHYSI CAL THERAPY	7,877	441	1, 325	42	0	66.00
	06900 ELECTROCARDI OLOGY	13, 720	1, 005	3, 443	95	0	69.00
	D6901 PULMONARY	13, 720	1,005	0, 445	23 0	0	69.01
	06902 CARDI OPULMONARY	577	125	16	12	0	69.02
	D6903 SLEEP LAB	1, 023	144	329	13	0	69.03
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 228	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 840	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	47, 463	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
	DUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	1, 568	148	0	14	0	
	D8801 RURAL HEALTH CLINIC II	1, 910	341	0	32	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	-	0	0	
	09000 CLINIC	2, 292	437	115	41	0	
	09001 I MED	0	0	0	0	0	90.01
	09002 ONCOLOGY	10, 064	868	1, 148	82	0	90.02
	09003 OUTPATIENT CENTER	0	0	0	0	0	90.03
	D9004 HBURG URGENT CARE CLINIC D9005 DIABETES MGMT CLINIC	4, 149	410	113 0	39	0	90.04
	DIABETES MOMT CLINIC	246 16, 661	42 826	-	4 78	0	90.05
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 001	020	7, 220	/0	0	91.00
	OTHER REIMBURSABLE COST CENTERS				I		72.00
	09500 AMBULANCE SERVICES	5,867	166	0	16	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0,007	0	0	0	0	1
	10100 HOME HEALTH AGENCY	7, 112	193	0	18	-	101.00
	SPECIAL PURPOSE COST CENTERS	,,					1.0.1.00
	11600 H0SPI CE	0	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	323, 496	17, 747	54, 916	1, 656	51, 975	
	VONREI MBURSABLE COST CENTERS				· · · · ·		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	70	77	0	7	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	107, 117	7, 852	337	738		192.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 387	189	0	18		192.01
	D7950 LODGE	2,064	2, 219	0	209		194.00
194.00	D7951 OTHER NRCC	0	0	0	0	0	194.01
	07952 MEMORIAL HOSPITAL FOUNDATION	379	77	0	7	0	194. 0
194.01	ST SZIMEMORTAL HOST TAL TOURDATION	10, 403	6	0	1	0	194.0
194. 01 194. 02 194. 03	07953 MKT/PHY SERVICES		200	0	36	0	1174.0
194. 01 194. 02 194. 03		1, 718	380			0	
194.01 194.02 194.03 194.04	07953 MKT/PHY SERVICES	1, 718 755	380	0	0		194. 04
194. 01 194. 02 194. 03 194. 04 194. 05	07953 MKT/PHY SERVICES 07954 COMMUNITY EDUCATION			0	0 0	0	194. 04 194. 05
194.01 194.02 194.03 194.04 194.05 194.05	07953 MKT/PHY SERVICES 07954 COMMUNITY EDUCATION 07955 VOLUNTEER	755		0 0 0	0 0 0	0 0 0	194. 04 194. 05 194. 06 194. 07
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08	07953 MKT/PHY SERVICES 07954 COMMUNITY EDUCATION 07955 VOLUNTEER 07956 MAB	755 0		0 0 0 0	0 0 0 0	0 0 0 0	194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTR	2	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Peri od:	Worksheet B	
				From 07/01/2020		
				To 06/30/2021	Date/Time Pre	pared:
					11/30/2021 2:	<u>40 pm</u>
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	REPAI RS	LINEN SERVICE			
	5.00	6.00	8.00	9.00	10.00	
194.1007960 EMERGENCY PREPAREDNESS	3, 959	0	(	0 0	0	194. 10
194. 11 07961 HOME OFFICE	15, 577	17, 094	(	0 1,605	0	194.11
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	(	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	469, 266	45, 641	55, 25	3 4, 277	51, 975	202.00

	Financial Systems MER TION OF CAPITAL RELATED COSTS	MORIAL HOSP & H	HEALTH CARE CTR Provider CC	N: 15-0115 P	<u>In Lie</u> eriod: rom 07/01/2020	u of Form CMS-: Worksheet B Part II	2552-10
				T		Date/Time Pre 11/30/2021 2:	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	171, 369					11.00
13.00	01300 NURSING ADMINISTRATION	1, 934	42, 422				13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	1, 147	0	35, 787			14.00
15.00	01500 PHARMACY	4, 154	0	181	108, 923		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	4, 380	•
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I & SERVICES-OTHER PRGM. COSTS APPRVD	887	0	10	0	0	22.00
30.00	03000 ADULTS & PEDI ATRI CS	13, 363	11, 666	900	0	83	30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 119	6, 215	261	0	56	•
40.00	04000 SUBPROVI DER – I PF	3, 972	3, 467	53	0	24	40.00
41.00	04100 SUBPROVI DER – I RF	1, 418	1, 238	19	0	10	41.00
43.00	04300 NURSERY	1, 370	1, 196	0	0	10	•
44.00	04400 SKI LLED NURSI NG FACI LI TY	3, 597	3, 140	100	0	9	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS	11, 105	9, 694	10, 682	0	526	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 740	9,094	10, 082	0	13	
53.00	05300 ANESTHESI OLOGY	2,895	0	925	0	19	
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 745	0	824	0	543	
56.00	05600 RADI OI SOTOPE	345	0	10	0	76	56.00
60.00	06000 LABORATORY	8, 181	0	7, 244	0	416	•
65.00	06500 RESPI RATORY THERAPY	3, 848	0	1, 331	0	44	65.00
66.00	06600 PHYSI CAL THERAPY	6, 552	0	113	0	82	66.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 PULMONARY	4, 945 0	0	5, 855 0	0	289 0	69.00 69.01
69.02	06902 CARDI OPULMONARY	295	0	13	0	7	69.02
69.03	06903 SLEEP LAB	837	0	31	0	12	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3, 594	0	55	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	113	1
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	108, 923 0	1, 004 0	•
74.00	OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	0	0	0	74.00
88.00	08800 RURAL HEALTH CLINIC	842	0	21	0	6	88.00
	08801 RURAL HEALTH CLINIC II	1, 190	0	31	0	7	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	•
90.00	09000 CLINIC	1, 347	0	233		32	•
90.01	09001   I MED	0	0	0		0	•
90. 02 90. 03	09002 ONCOLOGY 09003 OUTPATI ENT CENTER	6, 651	5, 806	420	0	126 0	
	09004 HBURG URGENT CARE CLINIC	3, 045	0	106	0	25	•
90.04 90.05	09005 DI ABETES MGMT CLINIC	177	0	5	0	1	90.04
	09100 EMERGENCY	10, 458	o o	440	Ő	352	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
_	OTHER REIMBURSABLE COST CENTERS						l
	09500 AMBULANCE SERVICES	7, 113	0	127	0	41	•
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0 84		0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	5, 644	UU	04	U	20	101.00
116 00	11600 HOSPI CE	0	0	0	0	0	116.00
118.00		124, 916	42, 422	33, 613			118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	39, 878	0	1, 237	0		192.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 203	0	10	0		192.01 194.00
	07950 LODGE 07951 OTHER NRCC	18 0		4 0	0		194.00
	07952 MEMORIAL HOSPITAL FOUNDATION	340	0	5	0		194.02
	07953 MKT/PHY SERVICES	325	o o	0	Ő		194.03
194.04	07954 COMMUNI TY EDUCATI ON	1, 566	0	61	0		194.04
	07955 VOLUNTEER	544	0	6	0		194.05
		433	0	0	0		194.06
	07957 OFFSITE COVID SCREENING	0	0	7	0		194.07
174.08	07958 PUBLIC RELATIONS	0	l U	0	l U	0	194.08

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTR	2	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				rom 07/01/2020		
			1	o 06/30/2021	Date/Time Pre	
					11/30/2021 2:	<u>40 pm</u>
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194.0907959 UNUSED SPACE	0	0	0	0 0	0	194.09
194.1007960 EMERGENCY PREPAREDNESS	1, 146	0	844	1 0	0	194.10
194. 11 07961 HOME OFFICE	0	0	C	0 0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	171, 369	42, 422	35, 787	108, 923	4, 380	202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO		Period: From 07/01/2020	Worksheet B Part II	
					To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		INTERNS &	RESI DENTS			11/00/2021 2:	
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVI CES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
		01.00		04.00	Adjustments	0( 00	
	GENERAL SERVICE COST CENTERS	21.00	22.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00							15.00
16.00 21.00	01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRVD	2, 098					16.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	2,0,0	143, 071				22.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS			921, 56		921, 563	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF			425, 03 325, 76		425, 034 325, 765	
41.00	04100 SUBPROVI DER – I RF			168, 78		168, 786	
43.00	04300 NURSERY			108, 26		108, 262	
44.00	04400 SKI LLED NURSI NG FACI LI TY			197, 95	7 0	197, 957	44.00
50.00	ANCI LLARY SERVICE COST CENTERS			1, 230, 91	0 0	1, 230, 910	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM			210, 76		210, 765	
53.00	05300 ANESTHESI OLOGY			7,64	1 0	7, 641	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C			416, 52		416, 521	
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY			28, 69 223, 96		28, 693 223, 962	
65.00	06500 RESPI RATORY THERAPY			79, 45		79, 456	
66. 00	06600 PHYSI CAL THERAPY			176, 06		176, 063	
69.00	06900 ELECTROCARDI OLOGY			392, 92	8 0	392, 928	
69. 01 69. 02	06901 PULMONARY 06902 CARDI OPULMONARY			46, 23	4 0	0 46, 234	
69.03	06903 SLEEP LAB			54, 30		54, 305	
70.00	07000 ELECTROENCEPHALOGRAPHY				0 0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			6, 87 13, 95		6, 877	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			13, 95	-	13, 953	72.00
	07400 RENAL DIALYSIS				0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II			55, 98 126, 66		55, 982 126, 667	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			120, 00	0 0	120, 007	
90.00	09000 CLI NI C			162, 65	9 0	162, 659	
90.01	09001   MED				0 0	0	
90.02	09002 ONCOLOGY 09003 OUTPATI ENT CENTER			338, 96	2 0	338, 962 0	
90.03				156, 23	9 0	156, 239	
90. 05	09005 DIABETES MGMT CLINIC			15, 78		15, 785	
91.00				334, 70	7 0	334, 707	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
95.00	09500 AMBULANCE SERVICES			73, 45	9 0	73, 459	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED				0 0	0	
101.00	10100 HOME HEALTH AGENCY			82, 89	9 0	82, 899	101.00
116 00	SPECIAL PURPOSE COST CENTERS				0 0	0	116.00
118.00		0	0			6, 540, 424	
2.00	NONREI MBURSABLE COST CENTERS					-, - , 0, 121	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			27, 82			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 PSYCHLATRI C/PSYCHOLOGI CAL SERVI CES			2, 997, 14		2, 997, 143	192.00 192.01
	07950 LODGE			74, 23 807, 12		74, 236 807, 125	
	07951 OTHER NRCC				0 0		194.01
	07952 MEMORIAL HOSPITAL FOUNDATION			28, 79			194.02
104 03	07953 MKT/PHY SERVICES			12, 96			194.03
	07954 COMMUNITY EDUCATION			141, 05		1/1 // // //	194.04

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR	R	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/30/2021 2:	
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVI CES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post	Total	
				Stepdown Adjustments		
	21.00	22.00	24.00	25.00	26.00	
194. 05 07955 VOLUNTEER			1, 305			194.05
194. 06 07956 MAB			433			194.06
194. 07 07957 OFFSITE COVID SCREENING			348	3 0		194.07
194. 08 07958 PUBLIC RELATIONS			(	0 0		194.08
194. 09 07959 UNUSED SPACE			(	0 0		194.09
194. 10 07960 EMERGENCY PREPAREDNESS			5, 949			194.10
194. 11 07961 HOME OFFICE			6, 215, 490		6, 215, 490	
200.00 Cross Foot Adjustments	2, 098	143, 071	145, 169	0	145, 169	
201.00 Negative Cost Centers	0	0	(	0		201.00
202.00  TOTAL (sum lines 118 through 201)	2,098	143, 071	16, 998, 259	0	16, 998, 259	202.00

## MEMORIAL HOSP & HEALTH CARE CTR

Heal th	Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTR	2	In Lie	u of Form CMS-	2552-10
	ALLOCATION - STATISTICAL BASIS		Provider CC	F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet B-1 Date/Time Pre	
			LATED COSTS			11/30/2021 2:	40 pm
		CAFTIAL KL	LATED COSTS				
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	0.00	SALARI ES)		5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5A	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	914, 814					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	,,	914, 814				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	95, 021, 508	6		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	25, 255		3, 705, 465			5.00
6.00	00600 MAINTENANCE & REPAIRS	1, 272		529, 923		8, 732, 448	•
8.00	00800 LAUNDRY & LINEN SERVICE	2,899		294, 101		490, 756	•
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	2,706	, i i i i i i i i i i i i i i i i i i i	C 218, 637	-	1, 697, 053 447, 918	1
11.00	01100 CAFETERI A	9,053		814, 279		1, 049, 759	1
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 016		844, 819		1, 156, 637	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 681	1, 681	267, 825	0	509, 286	14.00
15.00	01500 PHARMACY	5, 286	5, 286	1, 891, 904		2, 408, 795	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	C	0	1, 738, 031	
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0 7,453	0 7, 453	0 950, 822	-	832, 537 1, 297, 715	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	7,455	7,455	930, 822	. 0	1,277,713	22.00
30.00	03000 ADULTS & PEDIATRICS	45, 292	45, 292	5, 541, 526	0	7, 906, 339	30.00
31.00	03100 I NTENSI VE CARE UNI T	20, 795	20, 795	2, 727, 623	0	3, 899, 041	31.00
40.00	04000 SUBPROVI DER – I PF	16, 428		1, 631, 449		2, 074, 123	
41.00	04100 SUBPROVIDER - IRF	8, 571		626, 622		1, 046, 968	
43.00		5, 378		548, 801		849,058	•
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	9, 321	9, 321	1, 273, 509	0	1, 812, 840	44.00
50.00	05000 OPERATING ROOM	61, 749	61, 749	4, 746, 842	0	15, 873, 892	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 756		1, 097, 601			
53.00	05300 ANESTHESI OLOGY	0	0	4, 054, 405	0	1, 508, 814	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 766		6, 404, 059		5, 352, 661	54.00
56.00	05600 RADI OI SOTOPE	1, 411		172, 048		779, 985	
60.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	10,022		2, 590, 050		8, 350, 212	
65.00 66.00	06600 PHYSI CAL THERAPY	3, 678 8, 591		1, 273, 050 2, 506, 352		2, 255, 829 3, 125, 741	
69.00	06900 ELECTROCARDI OLOGY	19, 567		2, 654, 934		5, 444, 370	
69.01	06901 PULMONARY	0		C		0	69.01
69. 02	06902 CARDI OPULMONARY	2, 432		98, 746		229, 063	
69.03	06903 SLEEP LAB	2, 794	2, 794	267, 144		406, 057	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	1, 280, 938 5, 492, 184	
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	-		
	07400 RENAL DI ALYSI S	0	0	C	0		
	OUTPATIENT SERVICE COST CENTERS	1			1	1	
88.00	08800 RURAL HEALTH CLINIC	2,873		370, 106		622, 080	
88. 01 89. 00	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	6, 628		445, 636 C		758, 133 0	1
90.00	09000 CLINIC	8, 512	-	443, 660	-	909, 489	
90.01	09001   I MED	0,012	0,012	C	0	0	90.01
90.02	09002 ONCOLOGY	16, 888	16, 888	2, 271, 837	0	3, 993, 632	90.02
90.03	09003 OUTPATI ENT CENTER	0	0	C	0	0	90.03
90.04	09004 HBURG URGENT CARE CLINIC	7, 984		1, 337, 723		1, 646, 333	
90.05	09005 DIABETES MGMT CLINIC	824		64, 622		97, 596	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	16, 074	16, 074	8, 462, 238	0	6, 611, 470	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00		3, 236	3, 236	2, 016, 337	0	2, 327, 994	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0		96.00
101.00	10100 HOME HEALTH AGENCY	3, 758	3, 758	1, 948, 083	0	2, 822, 170	101.00
	SPECIAL PURPOSE COST CENTERS						1
116.00	11600 HOSPICE	271.040	271 040	45 002 779			116.00
110.00	SUBTOTALS         (SUM OF LINES 1 through 117)           NONREI MBURSABLE         COST         CENTERS	371, 949	371, 949	65, 092, 778	-25, 500, 580	128, 370, 551	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 489	1, 489	C	0	27,667	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	152, 823		27, 680, 536	0	42, 476, 112	
192.0	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 682	3, 682	992, 305	0	1, 344, 133	192.01
	07950 LODGE	43, 195		4, 565	0	819, 038	
	07951 OTHER NRCC	0	0		0		194.01
	207952 MEMORIAL HOSPITAL FOUNDATION 307953 MKT/PHY SERVICES	1, 506 120		94, 264 203, 733		150, 205 4, 128, 082	
	4 07954 COMMUNITY EDUCATION	7, 389					194.04
	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	332, 010	0		1 · · · · • • •

## MEMORIAL HOSP & HEALTH CARE CTR Provider CCN: 15-0115 Period:

In Lieu of Form CMS-2552-10 od: worksheet B-1

OUDI MELOUN			in ovrider of		rom 07/01/2020	Nor Koneet B 1	
				Ť		Date/Time Pre 11/30/2021 2:	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		& GENERAL (ACCUM. COST)	
				(GROSS		(ACCOM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
194.050795		0	0	215, 937	0	299, 547	
194.0607950		0	0	0	0		194.06
	OFFSITE COVID SCREENING	0	0	96, 518	0	135, 131	
	PUBLIC RELATIONS	0	0	0	0		194.08
	UNUSED SPACE	0	0	0	0		194. 09
	EMERGENCY PREPAREDNESS	0	0	308, 262	0	1, 571, 114	
	HOME OFFICE	332, 661	332, 661	0	0	6, 181, 214	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		F 500 (40	00 001 700			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	11, 465, 641	5, 532, 618	22, 991, 782		25, 500, 580	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12. 533303	6. 047806	0. 241964		0. 136964	203.00
204.00	Cost to be allocated (per Wkst. B,			0		469, 266	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 000000		0. 002520	205.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

	Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTF	CN: 15-0115 F	Period:	u of Form CMS- Worksheet B-1	
					rom 07/01/2020 o 06/30/2021	Date/Time Pre	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	11/30/2021 2: CAFETERI A (HOURS)	40 pm
		6.00	LAUNDRY) 8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00 4.00 5.00 6.00 8.00 9.00 10.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	888, 287 2, 899 0 2, 706	0	885, 388			1.00 2.00 4.00 5.00 6.00 8.00 9.00 10.00
11. 00 13. 00 14. 00 15. 00 16. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	9, 053 2, 016 1, 681 5, 286 0	0 0 31, 332 0 0	9, 053 2, 016 1, 681 5, 286	3 0 0 0 0 0 0 0	2, 024, 180 22, 841 13, 552 49, 065 0	11.00 13.00 14.00 15.00 16.00
21. 00 22. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 7, 453	0		-	0 10, 477	21.00 22.00
30.00 31.00 40.00 41.00 43.00 44.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY	45, 292 20, 795 16, 428 8, 571 5, 378 9, 321	65, 528 22, 402 17, 149	20, 795 16, 428 8, 571 5, 378	4, 094 2, 266 1, 097 3 1, 378	157, 846 84, 093 46, 917 16, 752 16, 182 42, 492	31.00 40.00 41.00 43.00
	ANCI LLARY SERVI CE COST CENTERS	-					
50.00 52.00 53.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	61, 749 10, 756 0		10, 756	0	131, 166 32, 365 34, 197	52.00
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	20, 766 1, 411	106, 514 0	20, 766 1, 411		91, 479 4, 070	•
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	10, 022 3, 678	4, 553 0			96, 637 45, 448	60.00 65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	8, 591 19, 567	20, 462 53, 178			77, 386 58, 408	
69. 01 69. 02	06901 PULMONARY 06902 CARDI OPULMONARY	0 2, 432	0 251	2, 432	-	0 3, 479	
69. 03 70. 00	06903 SLEEP LAB 07000 ELECTROENCEPHALOGRAPHY	2, 794 0	0	, c	0 0	9, 881 0	70.00
71.00 72.00 73.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0 0 0		0	0 0 0	71.00 72.00 73.00
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0			0	
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	2, 873 6, 628		6, 628	3 0	9, 942 14, 056	88.01
89.00 90.00 90.01	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 8, 512	0 1, 776	8, 512	-	0 15, 914	90.00
90.01 90.02 90.03	09001 I MED 09002 ONCOLOGY 09003 OUTPATI ENT CENTER	16, 888	17, 732	16, 888		0 78, 558 0	90.01 90.02 90.03
90.03 90.04 90.05	09004 HBURG URGENT CARE CLINIC 09005 DI ABETES MGMT CLINIC	7, 984	1, 741	7, 984 824		35, 968 2, 093	90.04
90.05 91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	16, 074				2, 093 123, 523	•
95.00	OTHER REIMBURSABLE COST CENTERS	3, 236	0	3, 236	0	84, 022	
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	0 3, 758	0		-	0 66, 671	96.00 101.00
116.00 118.00	SPECIAL PURPOSE COST CENTERS 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 345, 422	-		-		116.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 489		1, 489		1, 475, 480	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	152, 823	5, 203		3 0	471, 034	
194.00	07950 LODGE 07951 OTHER NRCC	43, 195		43, 195	5 0	218	194.00 194.01
194.02	07952 MEMORIAL HOSPITAL FOUNDATION 07953 MKT/PHY SERVICES	1, 506 120		1, 506 120	0	4, 017	194.01 194.02 194.03
194.04	07953 WETPHT SERVICES 07954 COMMUNITY EDUCATION 07955 VOLUNTEER	7, 389	0	7, 389	0	18, 493	194.03 194.04 194.05
194.06	07956 MAB 07956 TOPSI OFFSI TE COVI D SCREENI NG	0			0 0	5, 110	194.05 194.06 194.07
174.07	UN AN UN STIL COVID SCREENING	0	I 0	1 (	'I U	0	1174.07

Heal th Finar	ncial Systems ME	MORIAL HOSP & H	HEALTH CARE CT	2	In Lie	u of Form CMS-	2552-10
COST ALLOCA	FION – STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
					rom 07/01/2020 o 06/30/2021	Date/Time Pre 11/30/2021 2:	pared: 40 pm
	Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		REPAI RS	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(HOURS)	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)				
		6.00	8.00	9,00	10.00	11.00	
194 08 07958	PUBLIC RELATIONS	0.00	0.00	,	0		194.08
	UNUSED SPACE	0	0		0		194.09
	EMERGENCY PREPAREDNESS	0	0		0		194.10
	HOME OFFICE	332, 661	0	332, 661	0		194, 11
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9, 928, 479	590, 374	1, 929, 488	549, 836	1, 314, 453	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11. 177107	0. 691864	2. 179257	25. 198717	0. 649376	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	45, 641	55, 253	4, 277	51, 975	171, 369	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 051381	0. 064751	0. 004831	2. 381989	0. 084661	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems Mi LLOCATION - STATISTICAL BASIS	EMORIAL HOSP & H	Provider CO	CN: 15-0115	Period:	u of Form CMS-2 Worksheet B-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	
						11/30/2021 2: INTERNS &	40 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	RESI DENTS SERVI CES-SALAR	
	· ·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	Y & FRINGES	
		(DI RECT NURS.	SUPPLY (COSTED	REQUI S. )	LI BRARY (REVENUE)	(ASSIGNED TIME)	
		HRS.) 13.00	REQUIS.) 14.00	15.00	16.00	21.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	21.00	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						5.00 6.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
10. 00 11. 00	01100 CAFETERIA						10.00
	01300 NURSI NG ADMI NI STRATI ON	574,006	40 755 054			-	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	12, 755, 054 64, 611	10	0		14.00 15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 598, 115, 385		16.00
	02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD	0	0 3, 427		0 0 0 0	984	21.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	157, 846 84, 093	320, 732 93, 001		0 11, 910, 283 0 7, 941, 129	322	1
40.00	04000 SUBPROVI DER – I PF	46, 917	18, 722		0 3, 382, 465	55	40.00
	04100 SUBPROVI DER – I RF 04300 NURSERY	16, 752 16, 182	6, 890 0		0 1, 370, 806 0 1, 409, 500	0	
	04400 SKI LLED NURSI NG FACI LI TY	42, 492	35, 752		0 1, 298, 700	0	1
E0.00	ANCI LLARY SERVI CE COST CENTERS	121 144	3, 808, 181		0 75, 095, 454	121	50.00
	05200 DELIVERY ROOM & LABOR ROOM	131, 166 0	3, 808, 181		0 75, 095, 454 0 1, 808, 890	0	1
	05300 ANESTHESI OLOGY	0	329, 592		0 2, 733, 851	19	
	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	293, 786 3, 420		0 77, 530, 583 0 10, 887, 205	32	1
60.00	06000 LABORATORY	0	2, 581, 530		0 59, 360, 841	5	60.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	474, 345 40, 419		0 6, 341, 706 0 11, 738, 185	0	
69.00	06900 ELECTROCARDI OLOGY	0	2, 086, 741		0 41, 258, 413	25	69.00
69. 01 69. 02	06901 PULMONARY 06902 CARDI OPULMONARY	0	0 4, 492		0 0 0 1, 010, 274	22	
	06903 SLEEP LAB	0	11, 053		0 1, 648, 499	0	1
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 280, 938 0		0 7, 905, 672 0 16, 087, 897	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	10		0	
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	74.00
	08800 RURAL HEALTH CLINIC	0	7, 372		0 901, 163	0	
	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	10, 926 0		0 944, 524 0 0	0	
90.00	09000 CLINIC	0	83, 057		0 4, 523, 761	0	90.00
	09001   MED 09002 ONCOLOGY	0 78, 558	0 149, 730		0 0 0 18, 014, 816	0	1
	09003 OUTPATI ENT CENTER	0	149,730		0 18, 014, 818	0	
	09004 HBURG URGENT CARE CLINIC	0	37, 783		0 3, 533, 679	24	
	09005 DIABETES MGMT CLINIC 09100 EMERGENCY	0	1, 674 156, 671		0 119, 763 0 50, 222, 599	0 43	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	45, 268		0 5, 889, 690	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	29, 872		0 2, 841, 026	0	101.00
116.00	11600 HOSPI CE	0	0		0 0		116.00
118.00		574,006	11, 979, 985	10	0 544, 112, 411	693	118.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	440, 981		0 51, 829, 292	265	192.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07950 LODGE	0	3, 535 1, 366		0 1, 812, 666 0 0		192.01 194.00
194.01	07951 OTHER NRCC	0	0		0 0	0	194. 01
	07952 MEMORIAL HOSPITAL FOUNDATION	0	1, 705		0 0	0	194.02
	07953 MKT/PHY SERVICES	0	164		0 361,016		194.03

Health Financial Systems ME	MORIAL HOSP & H	EALTH CARE CTR	2	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 07/01/2020	Worksheet B-1	
				To 06/30/2021	Date/Time Pre 11/30/2021 2:	
					INTERNS &	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	RESI DENTS SERVI CES-SALAR	
cost center beschiption	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	Y & FRINGES	
		SUPPLY	REQUIS.)	LIBRARY	(ASSI GNED	
	(DI RECT NURS.	(COSTED		(REVENUE)	TIME)	
	HRS. )	REQUIS.)		(		
	13.00	14.00	15.00	16.00	21.00	
194. 05 07955 VOLUNTEER	0	2, 291		0 0	0	194.05
194. 06 07956 MAB	0	0		0 0	0	194.06
194.0707957OFFSITE COVID SCREENING	0	2, 430		0 0	0	194.07
194. 08 07958 PUBLIC RELATIONS	0	0		0 0		194.08
194.0907959UNUSED SPACE	0	0		0 0		194.09
194. 10 07960 EMERGENCY PREPAREDNESS	0	300, 780		0 0	0	194.10
194.1107961HOME OFFICE	0	0		0 0	26	194. 11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 356, 813	631, 969	2, 844, 37	8 1, 976, 079	946, 565	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 363761	0. 049547	28, 443. 78000	0 0. 003304	961.956301	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	42, 422	35, 787	108, 92	3 4, 380	2, 098	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 073905	0. 002806	1, 089. 23000	0 0. 000007	2. 132114	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

			From 07/01/2020 To 06/30/2021	Date/Time Prepar 11/30/2021 2:40
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM. COSTS (ASSI GNED TI ME) 22.00		
	L SERVICE COST CENTERS	1		
	CAP REL COSTS-BLDG & FIXT			1
	CAP REL COSTS-MVBLE EQUIP			2
	EMPLOYEE BENEFITS DEPARTMENT			4
00 00500	ADMINISTRATIVE & GENERAL			5
00 00600	MAINTENANCE & REPAIRS			6
00800 00	LAUNDRY & LINEN SERVICE			8
00900	HOUSEKEEPING			9
00 01000	DI ETARY			10
1 1	CAFETERIA			11
	NURSING ADMINISTRATION			13
1 1	CENTRAL SERVICES & SUPPLY			14
00 01500				15
1 1	MEDICAL RECORDS & LIBRARY			16
1 1	I &R SERVICES-SALARY & FRINGES APPRVD			21
	I &R SERVICES-OTHER PRGM. COSTS APPRVD	984		22
	ENT ROUTINE SERVICE COST CENTERS	000		
	ADULTS & PEDIATRICS	322		30
1 1		0 55		31 40
	SUBPROVIDER – IPF SUBPROVIDER – IRF	55		40
	NURSERY	0		43
	SKILLED NURSING FACILITY	0		43
	ARY SERVICE COST CENTERS	0		
	OPERATI NG ROOM	121		50
	DELIVERY ROOM & LABOR ROOM	0		52
	ANESTHESI OLOGY	19		53
	RADI OLOGY-DI AGNOSTI C	32		54
	RADI OI SOTOPE	0		56
	LABORATORY	5		60
00 06500	RESPI RATORY THERAPY	0		65
00 06600	PHYSI CAL THERAPY	0		66
00 06900	ELECTROCARDI OLOGY	25		69
01 06901	PULMONARY	22		69
02 06902	CARDI OPULMONARY	25		69
	SLEEP LAB	0		69
	ELECTROENCEPHALOGRAPHY	0		70
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71
	IMPL. DEV. CHARGED TO PATIENTS	0		72
	DRUGS CHARGED TO PATIENTS	0		73
	RENAL DIALYSIS	0		74
	I ENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0		88
	RURAL HEALTH CLINIC II	0		88
	FEDERALLY QUALIFIED HEALTH CENTER	0		89
00 09000		0		90
01 09001		0		90
	ONCOLOGY	0		90
	OUTPATI ENT CENTER	0		90
04 09004	HBURG URGENT CARE CLINIC	24		90
	DIABETES MGMT CLINIC	0		90
00 09100		43		91
	OBSERVATION BEDS (NON-DISTINCT PART)			92
	REIMBURSABLE COST CENTERS	-		
	AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	0		95
	HOME HEALTH AGENCY	0		96 101
	L PURPOSE COST CENTERS	0		101
00 11600				116
. 00	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	693		118
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190
	PHYSI CI ANS' PRI VATE OFFI CES	265		192
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		192
. 00 07950		0		194
	OTHER NRCC	0		194
	MEMORIAL HOSPITAL FOUNDATION	0		194
	MKT/PHY SERVICES	0		194
4. 04 07954	COMMUNITY EDUCATION	0		194
	VOLUNTEER	0		194

Health Financial	Systems ME	MORIAL HOSP & HE	EALTH CARE CTR	In Lie	u of Form CMS-2552-10
COST ALLOCATION -	STATI STI CAL BASI S		Provider CCN: 15-0115	Peri od:	Worksheet B-1
				From 07/01/2020	Data (Tima Drana and
				To 06/30/2021	Date/Time Prepared: 11/30/2021 2:40 pm
		INTERNS &			117 307 2021 2. 40 pm
		RESI DENTS			
Cost	Center Description	SERVI CES-OTHER			
	·	PRGM. COSTS			
		(ASSI GNED			
		TIME)			
		22.00			
194.0607956 MAB		0			194.06
194.07079570FFSI	TE COVID SCREENING	0			194. 07
194.0807958 PUBLI	C RELATIONS	0			194. 08
194.0907959 UNUSE	ED SPACE	0			194. 09
194.1007960 EMERG	GENCY PREPAREDNESS	0			194. 10
194.1107961 HOME	OFFICE	26			194. 11
200.00 Cross	s Foot Adjustments				200. 00
201.00 Negat	tive Cost Centers				201.00
202.00 Cost	to be allocated (per Wkst. B,	1, 581, 974			202.00
Part					
	cost multiplier (Wkst. B, Part I)	1, 607. 697154			203.00
	to be allocated (per Wkst. B,	143, 071			204.00
Part					
	cost multiplier (Wkst. B, Part	145. 397358			205.00
)					
	adjustment amount to be allocated				206.00
	Wkst. B-2)				
	unit cost multiplier (Wkst. D,				207.00
Parts	s III and IV)				I

Hear tr	Financial Systems Mi	EMURIAL HUSP & I	HEALTH CARE CTH	`	III LIE	u of Form CMS-2	2552-10
COMPU	ATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
			T: +1 -		11	11/30/2021 2: PPS	40 pm
			ii tie	XVIII	<u>Hospital</u> Costs	PP5	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	COST CENTER DESCRIPTION	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.	nag .		Di Sui i owanee		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	10, 459, 469		10, 459, 46	09 0	10, 459, 469	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 143, 544		5, 143, 54	4 0	5, 143, 544	31.00
10.00	04000 SUBPROVI DER – I PF	2, 803, 693		2, 803, 69	03 0	2, 803, 693	40.00
41.00	04100 SUBPROVI DER – I RF	1, 399, 696		1, 399, 69		1, 399, 696	
13.00	04300 NURSERY	1, 125, 670		1, 125, 67		1, 125, 670	
44.00	04400 SKILLED NURSING FACILITY	2, 455, 650		2, 455, 65	0 0	2, 455, 650	44.00
	ANCI LLARY SERVI CE COST CENTERS			L			
50.00	05000 OPERATING ROOM	19, 790, 973		19, 790, 97			
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 136, 292		2, 136, 29		2, 136, 292	
53.00	05300 ANESTHESI OLOGY	1, 763, 037		1, 763, 03		1, 763, 037	
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 766, 955		6, 766, 95		6, 766, 955	
56.00	05600 RADI OI SOTOPE	944, 444		944, 44		944, 444	
0.00	06000 LABORATORY	10, 017, 687		10, 017, 68		10, 017, 687	
5.00	06500 RESPI RATORY THERAPY	2, 687, 888	0	2, 687, 88		2, 687, 888	
6.00	06600 PHYSI CAL THERAPY	3, 773, 796	0	3, 773, 79		3, 773, 796	
9.00	06900 ELECTROCARDI OLOGY	6, 765, 828		6, 765, 82		6, 765, 828	
59.01 59.02	06901 PULMONARY 06902 CARDI OPULMONARY	0 298, 913		298, 91	0 0 3 0	0 298, 913	
59.02 59.03	06902 CARDI OPOLIMONARY 06903 SLEEP LAB					298, 913 514, 912	
70.00	07000 ELECTROENCEPHALOGRAPHY	514, 912		514, 91	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 545, 967		1, 545, 96		1, 545, 967	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 297, 569		6, 297, 56		6, 297, 569	
73.00	07300 DRUGS CHARGED TO PATIENTS	24, 643, 008		24, 643, 00		24, 643, 008	
74.00	07400 RENAL DIALYSIS	24, 043, 008		24, 043, 00	0 0	24, 043, 008	
4.00	OUTPATIENT SERVICE COST CENTERS	0			0 0	0	/4.0
88. 00	08800 RURAL HEALTH CLINIC	755, 454		755, 45	64 0	755, 454	88. 00
38.01	08801 RURAL HEALTH CLINIC II	963, 286		963, 28		963, 286	
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		,00,20	0 0	0	
90.00	09000 CLINIC	1, 178, 371		1, 178, 37		1, 178, 371	
0. 01	09001   I MED	0			0 0	0	1
90. 02	09002 ONCOLOGY	5, 082, 092		5, 082, 09	02 0	5, 082, 092	90.02
0. 03	09003 OUTPATI ENT CENTER	0			0 0	0	
0. 04	09004 HBURG URGENT CARE CLINIC	2, 016, 567		2, 016, 56	07 0	2, 016, 567	90.04
0. 05	09005 DIABETES MGMT CLINIC	123, 807		123, 80	07 0	123, 807	90.0
91.00	09100 EMERGENCY	8, 062, 754		8, 062, 75	64 0	8, 062, 754	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 449, 826		2, 449, 82	26	2, 449, 826	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	2, 766, 331		2, 766, 33		2, 766, 331	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	
01.00	10100 HOME HEALTH AGENCY	3, 313, 062		3, 313, 06	2	3, 313, 062	101.00
	SPECIAL PURPOSE COST CENTERS	-					
	11600 HOSPI CE	0			0		116. 0
	Subtotal (see instructions)	138, 046, 541	0				
200.00 201.00 202.00		2, 449, 826 135, 596, 715	0	2, 449, 82 135, 596, 71		2, 449, 826 135, 596, 715	

	ATION OF RATIO OF COSTS TO CHARGES	MURIAL HUSP & H	Provi der C	CN: 15-0115 F	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/30/2021 2:	epared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	+ col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			1		
	03000 ADULTS & PEDI ATRI CS	11, 910, 283		11, 910, 283			30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 941, 129		7, 941, 129			31.00
40.00	04000 SUBPROVI DER – I PF	3, 382, 465		3, 382, 465			40.00
	04100 SUBPROVIDER - IRF	1, 370, 806		1, 370, 806			41.00
43.00	04300 NURSERY	1, 409, 500		1, 409, 500			43.00
44.00	04400 SKILLED NURSING FACILITY	1, 298, 700		1, 298, 700	)		44.00
	ANCI LLARY SERVI CE COST CENTERS	I			1		
50.00	05000 OPERATING ROOM	9, 612, 599	65, 482, 855				
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 804, 829	4, 061				
	05300 ANESTHESI OLOGY	745, 635	1, 988, 216			0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 247, 234	68, 283, 349			0.00000	
56.00	05600 RADI OI SOTOPE	314, 264	10, 572, 941			0. 000000	
60.00	06000 LABORATORY	10, 383, 123	48, 977, 718				
65.00	06500 RESPI RATORY THERAPY	1, 499, 693	4, 842, 013			0. 000000	
66.00	06600 PHYSI CAL THERAPY	5, 754, 158	5, 984, 027			0.00000	
69.00	06900 ELECTROCARDI OLOGY	12, 251, 873	29, 006, 540			0.00000	
69.01	06901 PULMONARY	0	0				
69.02	06902 CARDI OPULMONARY	652	1,009,622			0.00000	
	06903 SLEEP LAB	0	1, 648, 499			0.00000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0.000000		
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 299, 598	5, 606, 074				
	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 429, 577	9, 658, 320				
	07300 DRUGS CHARGED TO PATIENTS	29, 087, 426	87, 313, 611				
74.00	07400 RENAL DI ALYSI S	0	0	(	0.000000	0. 000000	74.00
00.00	OUTPATIENT SERVICE COST CENTERS		001 1(2	001 1/2			00.00
		0	901, 163				88.00
88.01	08801 RURAL HEALTH CLINIC II	0	944, 524				88.01
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0			0 000000	89.00
90.00 90.01	09000 CLINIC 09001 I MED	93, 777	4, 429, 984	4, 523, 761			
90. 01 90. 02	09002 ONCOLOGY	172 475	U 17 042 241		0.00000		
	09003 OUTPATI ENT CENTER	172, 475	17, 842, 341	18, 014, 816	0. 282106 0. 000000	0. 000000	
90. 03 90. 04	09004 HBURG URGENT CARE CLINIC	5, 092	3, 528, 587	3, 533, 679		0. 000000	
90.04 90.05	09005 DIABETES MGMT CLINIC	5, 092	3, 528, 587			0. 000000	
	09100 EMERGENCY	8, 700, 478	41, 522, 121				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	395, 231	5, 345, 521	5, 740, 752		0. 000000	
92.00	OTHER REIMBURSABLE COST CENTERS	395, 231	0, 340, 021	5,740,752	0. 420743	0.00000	92.00
95.00	09500 AMBULANCE SERVICES	1, 342, 119	4, 547, 571	5, 889, 690	0. 469690	0. 000000	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	1, 342, 119	4, 547, 571	5, 669, 690			
	10100 HOME HEALTH AGENCY	0	2, 841, 026	-		0.00000	101.00
101.00	SPECIAL PURPOSE COST CENTERS	U U	2,041,020	2,041,020	<u>и</u>		
116 00	11600 HOSPI CE	0	0				116.00
200.00		127, 452, 716	422, 400, 447				200.00
200.00		127,452,710	422,400,447	347,033,103			200.00
201.00		127, 452, 716	422, 400, 447	549, 853, 163	3		201.00
202.00		1 121, 432, 110	722, 400, 447	577,055,100	1	I	1202.00

OMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepar 11/30/2021 2:40	ared D pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
0.00	03000 ADULTS & PEDIATRICS				3	30.0
1.00	03100 I NTENSI VE CARE UNI T				3	31.0
0.00	04000 SUBPROVI DER – I PF				4	40. 0
1.00	04100 SUBPROVI DER – I RF				4	41.0
3.00	04300 NURSERY				4	43.0
4.00	04400 SKILLED NURSING FACILITY				4	44. (
	ANCILLARY SERVICE COST CENTERS					
0.00	05000 OPERATING ROOM	0. 263544			5	50. (
2.00	05200 DELIVERY ROOM & LABOR ROOM	1. 180996			5	52. (
3.00	05300 ANESTHESI OLOGY	0. 644891			5	53. (
4.00	05400 RADI OLOGY-DI AGNOSTI C	0. 087281			5	54.
5.00	05600 RADI OI SOTOPE	0. 086748				56.
0. 00	06000 LABORATORY	0. 168759				60.
5.00	06500 RESPI RATORY THERAPY	0. 423843				65.
5.00	06600 PHYSI CAL THERAPY	0. 321497				66.
9.00	06900 ELECTROCARDI OLOGY	0. 163987				69.
9. 01	06901 PULMONARY	0. 000000				69.
. 02	06902 CARDI OPULMONARY	0. 295873				69.
7.03	06903 SLEEP LAB	0. 312352				69.
D. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 195552				71.
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 391448				72.
3.00	07300 DRUGS CHARGED TO PATIENTS	0. 211708				73.
4.00	07400 RENAL DIALYSIS	0. 000000				74.
	OUTPATIENT SERVICE COST CENTERS					
3.00	08800 RURAL HEALTH CLINIC				8	88.
3. 01	08801 RURAL HEALTH CLINIC II					88.
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89.
), 00	09000 CLI NI C	0. 260485				90.
. 01	09001   MED	0.000000			9	90.
). 02	09002 ONCOLOGY	0. 282106				90.
). 03	09003 OUTPATIENT CENTER	0.000000				90.
. 04	09004 HBURG URGENT CARE CLINIC	0. 570671			9	90.
). 05	09005 DIABETES MGMT CLINIC	1.033767				90.
1.00	09100 EMERGENCY	0. 160540			9	91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 426743				92.
	OTHER REIMBURSABLE COST CENTERS					
5.00	09500 AMBULANCE SERVICES	0. 469690			9	95.
	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000				96.
	10100 HOME HEALTH AGENCY					01.0
	SPECIAL PURPOSE COST CENTERS					
16.00	11600 H0SPI CE				11	16. (
00.00						00.
01.00						01. (
02.00						02. (

Health Financial Systems Mi	EMORIAL HUSP & I	HEALTH CARE CT	<i></i>	In Lie	OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/30/2021 2:	pared:
		Ti +1	e XIX	Hospi tal	Cost	40 pili
					COST	
Cost Costos Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
Cost Center Description	(from Wkst. B,			Disallowance		
	Part I, col.	Adj .		DISal Lowance		
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	10, 459, 469		10, 459, 4	69 0	10, 459, 469	30.00
	5, 143, 544		5, 143, 5			
40. 00 04000 SUBPROVIDER - IPF	2, 803, 693		2, 803, 6		2, 803, 693	
41.00 04100 SUBPROVI DER – I RF	1, 399, 696		1, 399, 6			
43. 00 04300 NURSERY	1, 125, 670		1, 125, 6			
44. 00 04400 SKILLED NURSING FACILITY	2, 455, 650		2, 455, 6	50 0	2, 455, 650	44.00
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	19, 790, 973		19, 790, 9	73 0	19, 790, 973	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 136, 292		2, 136, 2	92 0	2, 136, 292	52.00
53. 00 05300 ANESTHESI OLOGY	1, 763, 037		1, 763, 0	37 0	1, 763, 037	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	6, 766, 955		6, 766, 9	55 0	6, 766, 955	54.00
56. 00 05600 RADI OI SOTOPE	944, 444		944, 4	44 0	944, 444	56.00
60. 00 06000 LABORATORY	10, 017, 687		10, 017, 6			
65. 00 06500 RESPIRATORY THERAPY	2, 687, 888					
66. 00 06600 PHYSI CAL THERAPY	3, 773, 796					
69. 00 06900 ELECTROCARDI OLOGY	6, 765, 828		6, 765, 8			
69. 01 06901 PULMONARY	0, 705, 828		0, 705, 8	0 0		
69. 02 06902 CARDI OPULMONARY	-		200.0			
	298, 913		298, 9		,	
69. 03 06903 SLEEP LAB	514, 912		514, 9			
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 545, 967		1, 545, 9		1, 545, 967	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 297, 569		6, 297, 5			
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 643, 008		24, 643, 0	0 80	24, 643, 008	73.00
74.00 07400 RENAL DIALYSIS	0			0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS		i	1		i	
88.00 08800 RURAL HEALTH CLINIC	755, 454		755, 4			
88.01 08801 RURAL HEALTH CLINIC II	963, 286		963, 2	86 0	963, 286	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	1, 178, 371		1, 178, 3	71 0	1, 178, 371	90.00
90. 01 09001 I MED	0			0 0	0	90.01
90. 02 09002 ONCOLOGY	5, 082, 092		5, 082, 0	92 0	5, 082, 092	90.02
90. 03 09003 OUTPATIENT CENTER	0			0 0	0	90.03
90. 04 09004 HBURG URGENT CARE CLINIC	2, 016, 567		2, 016, 5	67 0	2, 016, 567	
90. 05 09005 DIABETES MGMT CLINIC	123, 807		123, 8			
91. 00 09100 EMERGENCY	8, 062, 754		8, 062, 7		8, 062, 754	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 449, 826		2, 449, 8		2, 449, 826	
OTHER REIMBURSABLE COST CENTERS	2,447,020		2,447,0	20	2,447,020	72.00
95. 00 09500 AMBULANCE SERVICES	2, 766, 331		2, 766, 3	31 0	2, 766, 331	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2,700,331		2,700,3			
	-		2 212 0	-	-	
101.00 10100 HOME HEALTH AGENCY	3, 313, 062	I	3, 313, 0	02	3, 313, 062	101.00
SPECIAL PURPOSE COST CENTERS			1	0		111/ 00
116. 00 11600 HOSPI CE	0			0		116.00
200.00 Subtotal (see instructions)	138, 046, 541					
201.00 Less Observation Beds	2, 449, 826		2, 449, 8		2, 449, 826	
202.00 Total (see instructions)	135, 596, 715	0	135, 596, 7	15 0	135, 596, 715	202.00

131.00       D3100   INTENSI VE CARE UNIT       7, 941, 129       7, 941, 129       7, 941, 129       31, 120         0.00       D0000 SUBPROVI DER - IPF       3, 382, 465       3, 382, 465       40, 40         14.00       D4000 SUBPROVI DER - IPF       3, 382, 465       1, 370, 806       1, 370, 806       40, 40         14.00       D4000 SUBPROVI DER - IPF       1, 298, 700       1, 409, 500       1, 409, 500       41, 409, 500         3000 NURSERY       1, 298, 700       1, 298, 700       1, 298, 700       5, 442, 855       75, 095, 454       0, 263544       0, 0000000       53, 52, 00       5, 500       5, 460, 1, 808, 890       1, 1809, 690       0, 000000       53, 53, 00       5, 600       5, 600, 000, MESTHESI LOGY       745, 635       1, 948, 216       2, 73, 851       0, 64749       0, 000000       53, 54, 00       66, 00       66, 00       66, 00       66, 00       66, 00       68, 283, 349       77, 530, 583       0, 087281       0, 000000       56, 56, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66, 00       66	COMPUTATION OF RATIO OF COSTS TO CHARGES	WORTAL HUSF & H	Provi der C	CN: 15-0115 P	reni od: rom 07/01/2020 o 06/30/2021	Worksheet C Part I Date/Time Pre 11/30/2021 2:	epared:
Cost Center Description         Inpatient         Outpatient         Total (col. 5)         Cost or Other Ratio         TEFRA Inpatient Ratio           000         03000         10000         00000         000000         000000         0000000         0000000         00000000         000000000         0000000000         0000000000000000         000000000000000000000000000000000000			Ti tl	e XIX	Hospi tal	Cost	
IMPATI ENT ROUTINE SERVICE COST CENTERS         Impact Value         Valu	Cost Center Description	I npati ent				Inpati ent	
30:00       03000       ADULTS & PEDI ATRICS       11, 910, 283       11, 910, 283       30.         31:00       03:00       DINTENSI VE CARE LINIT       7, 941, 129       7, 941, 129       3, 332, 465       30.         40:00       OUDON SUBPROVIDER - IFF       1, 370, 806       1, 370, 806       41.       41.         41:00       DAIDON SKILLED NURSI RF ACLLITY       1, 298, 700       1, 298, 700       41.         44:00       DAIDON SKILLED NURSI RG FACLLITY       1, 204, 520       65, 482, 855       75, 095, 454       0. 263544       0. 0000000         50:00       DELIVEY ROMA & LABOR ROOM       1, 804, 823       44, 661       1, 808, 890       1. 1809960       0.0000000       55.         50:00       DELIVEY ROMA & LABOR ROOM       1, 804, 823       349       77, 503, 583       0. 047281       0. 0000000       54.         50:00       DESOD RADI DISOTOPE       314, 264       10, 572, 971       10, 887, 205       0. 086748       0. 0000000       56.         50:00       DESOD RADI DUSOTOPE       314, 264       10, 572, 971       10, 887, 205       0.086748       0.0000000       66.         66:00       OEOD RESTRATORY THERAPY       5, 754, 156       5, 944, 027       11, 738, 185       0.24947       0.0000000		6.00	7.00	8.00	9.00	10.00	
131.00        02100  INTENSIVE CARE_UNIT       7,941,129       7,941,129       31,100         040.00        0400  SUBPROVIDER - 1 PF       332,465       332,465       40,0         14.00        0400  SUBPROVIDER - 1 RF       1,370,806       41,0         13.00        0400  SKILLED NURSING FACILLTY       1,298,700       1,298,700       43,4         14.00        0400  SKILLED NURSING FACILLTY       1,298,700       1,298,700       43,4         11.00        0400  SKILLED NURSING FACILLTY       1,298,700       4,061       1,808,890       0,000000       52,5         50.00        05000  PELIVERN NOM & LABOR ROOM       1,844,827       4,061       1,808,890       0,000000       54,5         50.00        0500  RADIOLGOY-DI AKNOSTIC       9,247,234       68,283,349       77,503,583       0,06470       0,000000       54,5         50.00        0500  RADIOLGOY-DI AKNOSTIC       9,247,234       68,283,349       77,503,583       0,06470       0,000000       56,60       0,000000       60,00       0,000000       60,00       60,00       0,000000       60,00       0,000000       60,00       0,000000       60,00       0,000000       60,00       0,000000       60,00       0,000000       60,00       0,000000       60,00	INPATIENT ROUTINE SERVICE COST CENTERS					•	
40.00       040001       SUBPROVIDER - 1 PF       3, 382, 465       3, 382, 465       40.         41.00       041000       SUBPROVIDER - 1 RF       1, 370, 806       1, 370, 806       41.         43.00       044000       SKILLED NURSI NG FACILITY       1, 298, 700       1, 298, 700       43.         ANCILLARY SERVICE COST CENTERS	30. 00 03000 ADULTS & PEDI ATRI CS	11, 910, 283		11, 910, 283			30.00
40.00       040001       SUBPROVIDER - 1 PF       3, 382, 465       3, 382, 465       40.         41.00       041000       SUBPROVIDER - 1 RF       1, 370, 806       1, 370, 806       41.         43.00       044000       SKILLED NURSI NG FACILITY       1, 298, 700       1, 298, 700       43.         ANCILLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT	7, 941, 129		7, 941, 129			31.00
43:00       04300       NURSERY       1, 409, 500       1, 409, 500       43.         44:00       044000       SKILLED, NURSING FACILITY       1, 298, 700       43.         A4:00       05000       SERVICE COST CENTERS       1, 298, 700       43.         50:00       05000       DELIVERY ROM & LABOR ROM       9, 612, 599       65, 482, 855       75, 095, 454       0. 263544       0. 000000       53.         51:00       05300       DELIVERY ROM & LABOR ROM       1, 804, 829       4, 061       1, 808, 890       1. 1809960       0. 180976       0. 000000       53.         54:00       05400 RADI CLOPY ID AGNOSTIC       9, 247, 234       48, 977, 718       59, 360, 841       0. 163759       0.000000       56.         00       00000 LABORATORY       10, 383, 123       28, 977, 718       50, 314       50.       0. 423843       0.000000       65.         60:00       06600 PHYSICAL HERAPY       1, 499, 693       4, 844, 013       51, 318       0. 321497       0.000000       69.         61:01       06902 ELETROCARDI OLOGY       12, 251, 873       29, 066, 540       41, 258, 413       0. 600000       69.       0. 0.000000       0.000000       69.       0. 0.000000       69.       0. 0.000000       69. <td< td=""><td></td><td>3, 382, 465</td><td></td><td>3, 382, 465</td><td></td><td></td><td>40.00</td></td<>		3, 382, 465		3, 382, 465			40.00
44.00       0       0.4400       SKILLED NURSING FACILITY       1,298,700       1,298,700       44.         50.00       05000       OPERATING FOOM       9,612,599       65,482,855       75,095,454       0.263544       0.000000       50.         52.00       05200       DELIVERY ROM & LABOR ROM       1,804,829       4,061       1.808,890       1.180996       0.000000       52.         53.00       05300       AVESTNESI OLGOY       745,635       1,988,216       0.644891       0.000000       54.         56.00       06600 RADIO ISOTOPE       314,264       10,572,941       10,887,205       0.086748       0.000000       66.         66.00       06500 RESPI RATORY THERAPY       10,383,123       48,977,718       59,360,441       0.163759       0.000000       66.         66.00       06600 RESPI RATORY THERAPY       12,251,873       29,065,544       0.200000       66.       0.6000 RESPI RATORY THERAPY       12,251,873       29,066,544       0.1648,499       0.312352       0.000000       66.         69.01       0600 CLECTRCARDI DLOGY       12,251,873       29,066,544       7,905,672       0.100,0274       0.295873       0.000000       69.         69.01       0600       0       0       0       <	41.00 04100 SUBPROVIDER - IRF	1, 370, 806		1, 370, 806			41.00
ANCILLARY SERVICE COST CENTERS         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1 <th< td=""><td>43. 00 04300 NURSERY</td><td>1, 409, 500</td><td></td><td>1, 409, 500</td><td>)</td><td></td><td>43.00</td></th<>	43. 00 04300 NURSERY	1, 409, 500		1, 409, 500	)		43.00
50.00       05000       0PERATING ROOM       9, 612, 599       65, 842, 855       75, 095, 454       0. 263544       0. 000000       52.         52.00       05300       ALEOR ROOM       1.804, 829       4, 061       1.808, 890       1.180996       0.000000       52.         53.00       05300       ANESTHESI OLGGY       745, 635       1, 988, 216       2, 733, 851       0. 644891       0. 000000       53.         54.00       054000 RADI OLGY-DI AGNOSTI C       9, 247, 234       68, 283, 349       77, 730, 583       0.087281       0.000000       56.         60.00       06000 LABORATORY       10, 383, 123       48, 977, 718       59, 360, 841       0.168759       0.000000       65.         60.00       06000 RESPI RATORY THERAPY       1, 499, 693       4, 842, 013       6, 311, 766       0.423843       0.000000       66.         60.00       06000 RESPI RATORY THERAPY       12, 251, 873       29, 006, 540       41, 258, 413       0.163987       0.000000       69.         69.01       06903 PLUMONARY       652       1, 009, 622       1, 010, 274       0.295873       0.000000       69.         70.00       07000 ELECTROCARDIOLOGAPHY       0       1, 648, 499       1, 648, 499       0.312352       0.000000	44.00 04400 SKILLED NURSING FACILITY	1, 298, 700		1, 298, 700	)		44.00
52.00       05200       DELI VERY ROOM & LABOR ROOM       1.804, 829       4.061       1.808, 890       1.180996       0.000000       53.         53.00       05300       ANESTHESILOLOY       745, 635       1.988, 216       2.733, 851       0.644891       0.000000       53.         54.00       05400       RADI OLGY-DI AGNOSTI C       9.247, 234       68, 283, 349       77, 530, 583       0.087281       0.000000       54.         56.00       05600       LABORTORY       10.383, 123       48, 977, 718       59, 360, 841       0.168759       0.000000       66.         60.00       06000       LECTROCARDI OLGY       12, 251, 873       29, 006, 540       41, 258, 413       0.168759       0.000000       69.         69.01       06900       ELECTROCARDI OLGY       12, 251, 873       29, 006, 540       41, 258, 413       0.163987       0.000000       69.         69.01       06900       DECTROCARDI OLGARAPY       652       1.009, 622       1, 010, 274       0.295873       0.000000       69.         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       2, 299, 598       5, 666, 074       7, 905, 672       0.195552       0.000000       72.         72.00       07300       DRUGS CHARGED TO PATI E	ANCI LLARY SERVI CE COST CENTERS			•		•	
53:00       00       05:00       ANESTHESI OLCGY       745, 635       1, 968, 216       2, 733, 851       0. 644891       0. 000000       54.         54:00       05:000       RADI OLOGY-DI AGNOSTI C       9, 247, 234       66, 283, 349       77, 530, 583       0. 087281       0. 000000       54.         60:00       06:000       RADI OLOGY-DI AGNOSTI C       9, 247, 234       66, 283, 349       77, 530, 583       0. 087281       0. 000000       54.         60:00       06:000       RESPI RATORY       THERAPY       10, 383, 123       48, 977, 718       59, 360, 841       0. 168759       0. 000000       65.         60:00       06:000       RESPI RATORY       THERAPY       5, 754, 158       5, 984, 027       11, 738, 185       0. 21497       0. 000000       66.         69:00       06:000       LCETROCARDI OLGGY       12, 251, 873       29, 006, 504       41, 258, 413       0. 16397       0. 000000       69.         69:01       06:903       SLEEP LAB       0       1. 648, 499       1. 648, 499       0. 312352       0. 000000       71.         70:00       07000       MEDLCHARGED TO PATI ENTS       2.99, 598       5. 606, 074       7, 905, 672       0. 913148       0. 0000000       73. <td< td=""><td>50.00 05000 OPERATING ROOM</td><td>9, 612, 599</td><td>65, 482, 855</td><td>75, 095, 454</td><td>0. 263544</td><td>0.00000</td><td>50.00</td></td<>	50.00 05000 OPERATING ROOM	9, 612, 599	65, 482, 855	75, 095, 454	0. 263544	0.00000	50.00
54.00       05400       RADI 0LOGY - DI AGNOSTI C       9, 247, 234       66, 283, 349       77, 530, 583       0.087281       0.000000       54.         56.00       05600       RADI 0LOGY - DI AGNOSTI C       314, 264       10, 572, 941       10, 887, 205       0.086748       0.000000       56.         60.00       06000       LABORATORY       11, 499, 693       4, 842, 013       6, 341, 706       0.232843       0.000000       66.         60.00       06000       LECTROCARDI OLOGY       12, 251, 873       29, 006, 540       41, 258, 413       0.163787       0.000000       66.         69.00       06902       CARDI OPULMONARY       0       0       0       0.000000       69.         69.01       06903       SLEEP LAB       0       1, 648, 499       1, 648, 499       0.312352       0.000000       70.         70.00       07000       ELCTROCARDI CORAPHY       0       0       0       0.000000       70.         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       2, 299, 598       5, 666, 774       7, 905, 672       0.95552       0.000000       73.         72.00       07000       RECARA DI ALYSIS       0       0       0       0.000000       73.	52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 804, 829	4, 061	1, 808, 890	1. 180996	0. 000000	52.00
56.00       05600       RADI OI SOTOPE       314, 264       10, 572, 941       10, 887, 205       0.086748       0.000000       56.         60.00       06500       RESPI RATORY THERAPY       10, 383, 123       48, 977, 718       59, 360, 841       0.168759       0.000000       66.         60.00       06500       RESPI RATORY THERAPY       5, 754, 158       59, 984, 027       11, 738, 185       0.321497       0.000000       66.         69.00       06500       ELCETRCACRDI OLGGY       12, 251, 873       29, 006, 540       41, 258, 413       0.163987       0.000000       69.         69.01       06901       PLUMONARY       0       1, 009, 622       1, 010, 274       0.295873       0.000000       69.         69.03       06903       SLEET LAB       0       1, 648, 499       1, 648, 499       0.313352       0.000000       70.         71.00       07100       MPL       DEV, HARGED TO PATI ENTS       2, 299, 598       5, 666, 074       7, 905, 672       0.9391448       0.000000       72.         73.00       07300       RUSA HARGED TO PATI ENTS       29, 087, 426       67, 313, 611       116, 401, 037       0.211708       0.000000       72.         74.00       07400       RNAL DI ALYSI S	53. 00 05300 ANESTHESI OLOGY	745, 635	1, 988, 216	2, 733, 851	0. 644891	0. 000000	53.00
56.00       05600       RADI OI SOTOPE       314, 264       10, 572, 941       10, 887, 205       0.086748       0.000000       56.         60.00       06500       RESPI RATORY THERAPY       10, 383, 123       48, 977, 718       59, 360, 841       0.168759       0.000000       66.         60.00       06500       RESPI RATORY THERAPY       5, 754, 158       59, 84, 027       11, 738, 185       0.321497       0.000000       66.         69.00       06900       LECETRCARDI OLOGY       12, 251, 873       29, 006, 540       41, 258, 413       0.163987       0.000000       69.         69.01       06901       PLUMONARY       0       0       0       0.000000       69.         69.03       06903       SLEET LAB       0       1, 648, 499       1, 648, 499       0.313352       0.000000       70.         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0.000000       72.         73.00       07300       DRUS CHARGED TO PATI ENTS       2,999, 598       5, 666, 074       7, 905, 672       0.16387, 897       0.391448       0.000000       72.         74.00       07400       RENAT ENT SERVICE COST CENTERS       0       0       0       0.0000000	54.00 05400 RADI OLOGY-DI AGNOSTI C	9, 247, 234	68, 283, 349	77, 530, 583	0. 087281	0. 000000	54.00
65.00       06500       RESPI RATORY THERAPY       1, 499, 693       4, 842, 013       6, 341, 706       0. 423843       0. 000000       65.         66.00       06600       PHYSI CAL THERAPY       5, 754, 158       5, 984, 027       11, 738, 185       0. 321497       0. 000000       66.         69.00       06900       ELECTROCARDI OLOGY       12, 251, 873       29, 006, 540       11, 258, 413       0. 163987       0. 000000       69.         69.01       06902       CARDI OPLIMONARY       652       1, 009, 622       1, 010, 274       0. 295873       0. 000000       69.         69.02       06902       ELECTROENCEPHALOGRAPHY       0       1, 648, 499       0. 312352       0. 000000       70.         71.00       07100       INPL. DEV. CHARGED TO PATI ENTS       2, 299, 598       5, 606, 074       7, 905, 672       0. 391448       0. 000000       73.         73.00       07200       INPL. DEV. CHARGED TO PATI ENTS       29, 087, 426       87, 313, 611       116, 401, 037       0. 211708       0. 000000       73.         74.00       PAGO (RRAL, DIALYSIS       0       0       0       0       0. 000000       74.         75.000       07400       RRAL, DIALYSIS       0       0       0		314, 264	10, 572, 941	10, 887, 205	0. 086748	0. 000000	56.00
66.00       06000       PHYSI CAL THERAPY       5, 754, 158       5, 984, 027       11, 738, 185       0.321497       0.000000       69.         69.00       06900       ELECTROCARDIOLOGY       12, 251, 873       29, 006, 540       41, 258, 413       0.163987       0.000000       69.         69.01       06901       PULMONARY       652       1, 009, 622       1, 010, 274       0.295873       0.000000       69.         69.03       06902       CARDI OPULMONARY       652       1, 009, 622       1, 010, 274       0.295873       0.000000       69.         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0.000000       70.         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       2, 299, 598       5, 606, 074       7, 905, 672       0.195552       0.000000       73.         72.00       07300       DRUGS CHARGED TO PATIENTS       29, 087, 426       87, 313, 611       116, 401, 037       0.211708       0.000000       73.         74.00       07400       RENAL IFALTH CLINIC II       0       944, 524       944, 524       1.019864       0.000000       88.         88.01       08000       RURAL HEALTH CLINIC C       93, 777       4, 429, 984	60. 00 06000 LABORATORY	10, 383, 123	48, 977, 718	59, 360, 841	0. 168759	0. 000000	60.00
69.00       06900       ELECTROCARDIOLOGY       12, 251, 873       29, 006, 540       41, 258, 413       0.163987       0.000000       69.         69.01       06901       PULMONARY       0       0       0.000000       69.         69.02       06902       CARDIOPULMONARY       652       1, 009, 622       1, 010, 274       0.295873       0.000000       69.         69.03       06903       SLEEP LAB       0       1, 648, 499       1, 648, 499       0.312352       0.000000       69.         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       70.       0.000000       72.       79.5672       0.95852.       0.000000       72.         72.00       07300       DRUGS CHARGED T0 PATIENTS       29, 987, 426       87. 313, 611       116, 401, 037       0.211708       0.000000       73.         73.00       07300       DRUGS CHARGED T0 PATIENTS       29, 987, 426       87. 313, 611       116, 401, 037       0.211708       0.000000       74.         017400       RENAL HEALTH CLINIC       0       901, 163       901, 163       0.838310       0.000000       88.         88.00       08800       REDALIALYSIS       0       0       0       0.000	65. 00 06500 RESPI RATORY THERAPY	1, 499, 693	4, 842, 013	6, 341, 706	0. 423843	0. 000000	65.00
69. 01       06901       PULMONARY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	66. 00 06600 PHYSI CAL THERAPY	5, 754, 158	5, 984, 027	11, 738, 185	0. 321497	0. 000000	66.00
69. 02       06902       CARDI OPULMONARY       652       1, 009, 622       1, 010, 274       0. 295873       0. 000000       69.         69. 03       06903       SLEEP LAB       0       1, 648, 499       0. 312352       0. 000000       70.         70. 00       OTOOD       ELECTROENCEPHALOGRAPHY       0       0       0. 000000       70.       0. 000000       70.         71. 00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       2, 299, 598       5, 606, 074       7, 905, 672       0. 195552       0. 000000       71.         72. 00       07200 [ IMPL. DEV. CHARGED TO PATI ENTS       6, 429, 577       9, 658, 320       16, 087, 897       0. 291448       0. 000000       73.         74. 00       07400 [RENAL DI ALYSI S       0       0       0       0. 000000       74.         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0. 000000       88.       0. 8800       RIRAL HEALTH CLINI C II       0       944, 524       944, 524       1. 019864       0. 000000       88.         89. 00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       0       0       0       0. 0000000       90.       90.       0       0       0. 0000000       90.       90.01       9	69. 00 06900 ELECTROCARDI OLOGY	12, 251, 873	29, 006, 540	41, 258, 413	0. 163987	0. 000000	69.00
69.03       06903       SLEEP LAB       0       1, 648, 499       1, 648, 499       0. 312352       0. 000000       69.         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0.000000       0.000000       0.000000       71.         71.00       07000       IMPL. CLAL SUPPLIES CHARGED TO PATIENTS       2,299,598       5,606,074       7,905,672       0.195552       0.000000       72.         73.00       07300       DRUGS CHARGED TO PATIENTS       2,9087,426       87,313,611       116,087,897       0.391448       0.000000       72.         74.00       OT400       RENAL DI ALYSIS       0       0       0       0.000000       0.000000       74.         0       0400       RENAL DI ALYSIS       0       0       0       0.000000       88.         88.00       08801       RURAL HEALTH CLINIC       0       944,524       944,524       1.019864       0.000000       88.         88.01       08801       RURAL HEALTH CLINIC CHTER       93,777       4,429,984       4,523,761       0.260485       0.000000       90.       0       0       0       0.000000       0.000000       90.       90.02       00000       0.0000000       0	69.01 06901 PULMONARY	0	0	C	0. 000000	0. 000000	69.01
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0.000000         0.000000         70.           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         2, 299, 598         5, 606, 074         7, 905, 672         0.195552         0.000000         71.           72.00         07200 I MPL         DEV. CHARGED TO PATI ENTS         2, 299, 598         5, 606, 074         7, 905, 672         0.391448         0.000000         72.           73.00         07300         RUGS CHARGED TO PATI ENTS         29, 087, 426         87, 313, 611         116, 407, 937         0.211708         0.000000         73.           74.00         07400 [RNAL DIALYSIS         0         0         0         0.000000         74.         0.000000         0.000000         74.           74.00         07400 [RNAL HEALTH CLINIC         0         991, 163         901, 163         901, 163         0.000000         0.000000         88.           88.00         08800 RURAL HEALTH CLINIC CINIC         0         944, 524         944, 524         1.019864         0.000000         89.           90.00         09000 CLINIC         0         0         0         0.000000         0.0000000         0.0000000         90. </td <td>69. 02 06902 CARDI OPULMONARY</td> <td>652</td> <td>1, 009, 622</td> <td>1, 010, 274</td> <td>0. 295873</td> <td>0. 000000</td> <td>69.02</td>	69. 02 06902 CARDI OPULMONARY	652	1, 009, 622	1, 010, 274	0. 295873	0. 000000	69.02
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       2, 299, 598       5, 606, 074       7, 905, 672       0. 195552       0.000000       71.         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       6, 429, 577       9, 658, 320       16, 087, 897       0. 391448       0.000000       72.         73.00       07400       RENAL DI ALYSIS       0       0       0       0.000000       0.000000       73.         0UTPATI ENT SERVICE COST CENTERS       0       901, 163       901, 163       0.838310       0.000000       88.         88.00       08801       RURAL HEALTH CLINIC II       0       944, 524       944, 524       0.000000       89.         90.01       09000       CLINIC       93, 777       4, 429, 984       4, 523, 761       0.260485       0.000000       90.         90.02       09000       CLINIC       93, 777       4, 429, 984       4, 523, 761       0.260485       0.000000       90.       90.       0       0       0       0       0       0.000000       90.       90.00       90000       0.000000       0.000000       90.       0.000000       0.000000       90.       90.00       0.000000       0.000000       0.000000       0.000000       90	69. 03 06903 SLEEP LAB	0	1, 648, 499	1, 648, 499	0. 312352	0. 000000	69.03
72. 00       07200       IMPL.       DEV.       CHARGED TO PATIENTS       6, 429, 577       9, 658, 320       16, 087, 897       0. 391448       0. 000000       72.         73. 00       07300       DRUGS CHARGED TO PATIENTS       29, 087, 426       87, 313, 611       116, 401, 037       0. 211708       0. 000000       73.         74. 00       ORENAL DI ALYSIS       0       0       0       0. 000000       0. 000000       80.00         0       OUTPATIENT SERVICE COST CENTERS       0       901, 163       901, 163       0. 838310       0. 000000       88.         88. 00       08800       RURAL HEALTH CLINIC II       0       944, 524       944, 524       1.019864       0.000000       88.         89. 00       0       0       0       0       0       0       0.000000       0.000000       90.00         90. 00       OPOOD CLINIC       93, 777       4, 429, 984       4, 523, 761       0. 260485       0.000000       90.00       0.000000       0.000000       90.00         90. 01       09001       IMED       0       0       0       0       0.000000       0.000000       90.00         90. 04       09002       ONCLOGY       172, 475       17, 842, 341	70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0. 000000	0. 000000	70.00
73. 00       07300       DRUGS CHARGED TO PATIENTS       29, 087, 426       87, 313, 611       116, 401, 037       0. 211708       0. 000000       73.         74. 00       07400       RENAL DI ALYSI S       0       0       0       0       0.000000       0.000000       73.         0UTPATI ENT SERVICE COST CENTERS       0       011, 163       901, 163       0.838310       0.000000       88.         88. 01       08800       RURAL HEALTH CLINIC II       0       944, 524       944, 524       1.019864       0.000000       88.         89. 00       08900       FDERALLY QUALI FIED HEALTH CENTER       0       0       0       0.000000       89.         90. 00       09000       CLINIC       93, 777       4, 429, 984       4, 523, 761       0.260485       0.000000       90.         90. 01       MED       0       0       0       0       0.000000       0.000000       90.       90.000       0.000000       0.000000       90.       90.000       0.000000       0.000000       90.       90.00       0.000000       0.000000       90.       90.00       0.000000       0.000000       90.       90.00       0.000000       0.000000       90.       90.00       90.04       9004<	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 299, 598	5, 606, 074	7, 905, 672	0. 195552	0. 000000	71.00
74.00       OT400       RENAL DI ALYSI S       O       O       O.000000       0.000000       74.         0UTPATI ENT SERVICE COST CENTERS       0       901, 163       901, 163       0.838310       0.000000       88.         88.00       08800       RURAL HEALTH CLINIC II       0       944, 524       944, 524       1.019864       0.000000       88.         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0.000000       0.000000       89.         90.00       09000       CLINIC       93, 777       4, 429, 984       4, 523, 761       0.260485       0.000000       90.         90.01       09001       IMED       0       0       0       0.000000       0.000000       90.       90.       0.000000       90.       90.000       0.000000       90.       90.000       0.000000       90.       90.000       0.000000       90.       90.000000       90.000000       90.       90.000       0.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000       90.0000000       90.	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 429, 577	9, 658, 320	16, 087, 897	0. 391448	0. 000000	72.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0         901, 163         901, 163         0.838310         0.000000         88.           88.01         08801 RURAL HEALTH CLINIC II         0         944, 524         944, 524         1.019864         0.000000         88.           89.00         08900 FEDERALLY QUALI FIED HEALTH CENTER         0         944, 524         1.019864         0.000000         89.           90.00         09000 CLINIC         93, 777         4, 429, 984         4, 523, 761         0.260485         0.000000         90.           90.01         09001 IMED         0         0         0         0.000000         90.         90.00         0.000000         0.000000         90.           90.02         09002 [ONCOLOGY         172, 475         17, 842, 341         18, 014, 816         0.282106         0.000000         90.           90.03         09003 UTPATI ENT CENTER         0         0         0         0.000000         90.         90.003         0.000000         90.003         0.000000         90.003         90005 DI ABETES MGMT CLINIC         5,092         3,528,587         3,533,679         0.570671         0.000000         90.           90.05         09005 DI ABETE	73.00 07300 DRUGS CHARGED TO PATIENTS	29, 087, 426	87, 313, 611	116, 401, 037	0. 211708	0. 000000	73.00
88.00       08800       RURAL HEALTH CLINIC       0       901, 163       901, 163       0.838310       0.000000       88.         88.01       08801       RURAL HEALTH CLINIC II       0       944, 524       944, 524       1.019864       0.000000       88.         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0.000000       89.         90.00       09000       CLINIC       93, 777       4, 429, 984       4, 523, 761       0.260485       0.000000       90.         90.01       09001       IMED       0       0       0       0.000000       0.000000       90.         90.02       09002       ONCOLOGY       172, 475       17, 842, 341       18, 014, 816       0.282106       0.000000       90.         90.03       09003       OUTPATI ENT CENTER       0       0       0       0.000000       90.       90.       0.000000       90.       90.       0.000000       0.000000       90.       90.       0.000000       90.       90.       0.000000       90.       0.000000       90.       90.       90.       90.04       09004       HBURG URGENT CLARE CLINIC       5,092       3,528,587       3,533,679       0.570671	74.00 07400 RENAL DIALYSIS	0	0	C	0. 000000	0. 000000	74.00
88.01         08801         RURAL HEALTH CLINIC II         0         944, 524         944, 524         1.019864         0.000000         88.           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0.000000         0.000000         89.           90.00         09000         CLINIC         93,777         4,429,984         4,523,761         0.260485         0.000000         90.           90.01         09001         IMED         0         0         0         0.000000         90.         90.00         0.000000         0.000000         90.         90.00         0.000000         0.000000         90.         90.00         0.000000         90.00         0.000000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.00000         90.000000         90.00000         90.00000         90.00000         90.00000         90.000000         90.00000         90.00000         90.000000         90.000000         90.000000         90.0000000         90.0000000 <td>OUTPATIENT SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>	OUTPATIENT SERVICE COST CENTERS						1
89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0.000000       0.000000       89.         90.00       09000       CLINIC       93,777       4,429,984       4,523,761       0.260485       0.000000       90.         90.01       09001       IMED       0       0       0       0.000000       90.         90.02       09002       ONCOLOGY       172,475       17,842,341       18,014,816       0.282106       0.000000       90.         90.03       09003       OUTPATIENT CENTER       0       0       0       0.000000       90.       90.00000       90.000000       90.       90.000000       90.000000       90.       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.00000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       90.000000       91.000       90.000000       90.0000000<	88.00 08800 RURAL HEALTH CLINIC	0	901, 163	901, 163	0. 838310	0.00000	88.00
90. 00         09000         CLINIC         93,777         4,429,984         4,523,761         0.260485         0.00000         90.           90. 01         09001         IMED         0         0         0         0.000000         0.000000         90.           90. 02         09002         ONCOLOGY         172,475         17,842,341         18,014,816         0.282106         0.000000         90.           90. 03         09003         OUTPATIENT CENTER         0         0         0         0.000000         90.           90. 04         09004         HBURG URGENT CARE CLINIC         5,092         3,528,587         3,533,679         0.507671         0.000000         90.           90. 05         09005         DI ABETES MGMT CLINIC         0         119,763         119,763         1.033767         0.000000         90.           91. 00         09100         EMERGENCY         8,700,478         41,522,121         50,222,599         0.160540         0.000000         92.           07HER         REI MBURSABLE COST CENTERS         1,342,119         4,547,571         5,889,690         0.469690         0.000000         95.           95.00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0	88.01 08801 RURAL HEALTH CLINIC II	0	944, 524	944, 524	1. 019864	0. 000000	88.01
90. 01         09001         I MED         0         0         0         0         0.000000         0.000000         90.         90.         90. 02         09002         0NCOLOGY         172, 475         17, 842, 341         18, 014, 816         0.282106         0.000000         90.         90.         90. 03         09003         0UTPATI ENT CENTER         0         0         0         0         0.000000         90.         90.         90. 03         09003         0UTPATI ENT CENTER         0         0         0         0         0.000000         90.         90.         90. 05         09005         DI ABETES MGMT CLI NI C         5, 092         3, 528, 587         3, 533, 679         0.570671         0.000000         90.         90.         90. 05         09005         DI ABETES MGMT CLI NI C         0         119, 763         119, 763         1.03767         0.000000         91.         00         09100         DESERVATI ON BEDS (NON-DI STINCT PART)         395, 231         5, 345, 521         5, 740, 752         0.426743         0.000000         92.           0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00000	0. 000000	89.00
90. 02       09002       0NCOLOGY       172, 475       17, 842, 341       18, 014, 816       0. 282106       0. 000000       90.         90. 03       09003       0UTPATI ENT CENTER       0       0       0       0       0.000000       90.       90.       90.03       09003       0UTPATI ENT CENTER       0       0       0       0.000000       90.       90.       90.03       09003       0UTPATI ENT CENTER       0       0       0       0.000000       90.       90.03       0.000000       90.       0.000000       90.       90.03       0.000000       90.       0.000000       90.       0.000000       90.       90.05       09005       DI ABETES MGMT CLI NI C       0       119, 763       11.9, 763       1.033767       0.000000       91.       0.000000       91.       0.000000       91.       0.000000       91.       0.000000       91.       0.000000       91.       0.000000       91.       0.000000       91.       0.000000       92.       0.426743       0.000000       92.       0.000000       92.       0.426743       0.000000       92.       0.000000       92.       0.000000       94.       96.       0.000000       96.       0.000000       0.0000000       96.       96. <td>90. 00 09000 CLINIC</td> <td>93, 777</td> <td>4, 429, 984</td> <td>4, 523, 761</td> <td>0. 260485</td> <td>0. 000000</td> <td>90.00</td>	90. 00 09000 CLINIC	93, 777	4, 429, 984	4, 523, 761	0. 260485	0. 000000	90.00
90. 03       09003       0UTPATI ENT CENTER       0       0       0       0.00000       0.000000       90.         90. 04       09004       HBURG URGENT CARE CLINIC       5,092       3,528,587       3,533,679       0.570671       0.000000       90.       90.         90. 05       09005       DI ABETES MGMT CLINIC       0       119,763       119,763       1.033767       0.000000       90.       90.       90.       91.00       09100       EMERGENCY       8,700,478       41,522,121       50,222,599       0.160540       0.000000       91.       92.         92. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       395,231       5,345,521       5,740,752       0.426743       0.000000       92.         95. 00       09500       AMBULANCE SERVICES       1,342,119       4,547,571       5,889,690       0.469690       0.000000       95.         96. 00       09600       DURABLE MEDI CAL EQUI P-RENTED       0       0       0       0       0       0       0.000000       96.       0.000000       96.       0.000000       96.       0.000000       96.       0.000000       96.       0.000000       96.       0.000000       96.       0.0000000       0.000000       96.	90. 01 09001 I MED	0	0	C	0. 000000	0. 000000	90.01
90. 04         09004         HBURG URGENT CARE CLINIC         5, 092         3, 528, 587         3, 533, 679         0. 570671         0. 000000         90.           90. 05         09005         DI ABETES MGMT CLINIC         0         119, 763         119, 763         1.033767         0. 000000         90.           91. 00         09100         EMERGENCY         8, 700, 478         41, 522, 121         50, 222, 599         0. 160540         0. 000000         91.           92. 00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         395, 231         5, 345, 521         5, 740, 752         0. 426743         0. 000000         92.           0THER         REI MBURSABLE COST CENTERS         1, 342, 119         4, 547, 571         5, 889, 690         0. 469690         0. 000000         95.           96. 00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0. 000000         96.         101.0         0.000000         96.         101.0         10100         HOME HEALTH AGENCY         0         2, 841, 026         101.         101.           SPECIAL PURPOSE COST CENTERS         0         0         0         0         0         101.         101.           SPECIAL PURPOSE COST CENTERS	90. 02 09002 ONCOLOGY	172, 475	17, 842, 341	18, 014, 816	0. 282106	0. 000000	90.02
90. 05         09005         DI ABETES MGMT CLINIC         0         119,763         119,763         1.033767         0.000000         90.           91. 00         09100         EMERGENCY         8,700,478         41,522,121         50,222,599         0.160540         0.000000         91.           92. 00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         395,231         5,345,521         5,740,752         0.426743         0.000000         92.           0THER         REIMBURSABLE COST CENTERS         1,342,119         4,547,571         5,889,690         0.469690         0.000000         95.           96. 00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0.000000         96.           101.00         10100         HOME HEALTH AGENCY         0         2,841,026         2,841,026         101.           SPECIAL PURPOSE COST CENTERS           116. 00         11600         HOSPICE         0         0         0         116.	90. 03 09003 OUTPATI ENT CENTER	0	0	C	0. 000000	0. 000000	90.03
91. 00         09100         EMERGENCY         8, 700, 478         41, 522, 121         50, 222, 599         0. 160540         0. 000000         91.           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         395, 231         5, 345, 521         5, 740, 752         0. 426743         0. 000000         92.           OTHER         REI MBURSABLE COST CENTERS         1, 342, 119         4, 547, 571         5, 889, 690         0. 469690         0. 000000         95.           96. 00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0.000000         96.           101.00         10100         HOME         HEALTH AGENCY         0         2, 841, 026         2, 841, 026         101.           SPECIAL         PURPOSE COST CENTERS         1         0         0         0         101.	90. 04 09004 HBURG URGENT CARE CLINIC	5, 092	3, 528, 587	3, 533, 679	0. 570671	0. 000000	90.04
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         395, 231         5, 345, 521         5, 740, 752         0. 426743         0. 000000         92.           OTHER REIMBURSABLE COST CENTERS         09500         AMBULANCE SERVICES         1, 342, 119         4, 547, 571         5, 889, 690         0. 469690         0. 000000         95.         96. 00         09600         DURABLE MEDI CAL EQUIP-RENTED         0         0         0         0. 000000         96.         101.00         10100         HOME HEALTH AGENCY         0         2, 841, 026         2, 841, 026         101.         101.           SPECIAL PURPOSE COST CENTERS         1         0         0         0         0         116.00         10600         HOSPICE         116.	90.05 09005 DIABETES MGMT CLINIC	0	119, 763	119, 763	1. 033767	0. 000000	90.05
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         395, 231         5, 345, 521         5, 740, 752         0. 426743         0. 000000         92.           OTHER REIMBURSABLE COST CENTERS         09500         AMBULANCE SERVICES         1, 342, 119         4, 547, 571         5, 889, 690         0. 469690         0. 000000         95.         96. 00         09600         DURABLE MEDI CAL EQUIP-RENTED         0         0         0         0. 000000         96.         101.00         10100         HOME HEALTH AGENCY         0         2, 841, 026         2, 841, 026         101.         101.           SPECIAL PURPOSE COST CENTERS         1         0         0         0         0         116.00         10600         HOSPICE         116.	91.00 09100 EMERGENCY	8, 700, 478	41, 522, 121	50, 222, 599	0. 160540	0. 000000	91.00
95. 00         09500         AMBULANCE SERVI CES         1, 342, 119         4, 547, 571         5, 889, 690         0. 469690         0. 000000         95.           96. 00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         0. 000000         96.         0. 000000         96.         0. 000000         0. 000000         96.         10.00000         0.000000         96.         10.00000         0.000000         96.         10.00000         10.00000         10.000000         96.         10.000000         10.000000         96.         10.000000         10.000000         96.         10.000000         96.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.         101.		395, 231	5, 345, 521	5, 740, 752	0. 426743	0. 000000	92.00
96. 00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0.000000         0.000000         96.           101. 00         10100         HOME HEALTH AGENCY         0         2,841,026         2,841,026         101.         101.           SPECI AL PURPOSE COST CENTERS         0         0         0         0         116.	OTHER REIMBURSABLE COST CENTERS						1
96. 00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0.000000         0.000000         96.           101. 00         10100         HOME HEALTH AGENCY         0         2,841,026         2,841,026         101.         101.           SPECI AL PURPOSE COST CENTERS         0         0         0         0         116.	95. 00 09500 AMBULANCE SERVICES	1, 342, 119	4, 547, 571	5, 889, 690	0. 469690	0.00000	95.00
SPECIAL PURPOSE COST CENTERS           116.00         11600         HOSPI CE         0         0         116.	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C		0.00000	96.00
116. 00 11600 HOSPICE 0 0 0 116.		0	2, 841, 026	2, 841, 026			101.00
							114 00
200. 00 [Sub to tail (See First ructions) [127, 452, 716] 422, 400, 447[549, 853, 163] [200.		-	422 400 447				116.00
201.00 Less Observation Beds 201.		127,452,716	422, 400, 447	049, 803, 163			
		127, 452, 716	422, 400, 447	549, 853, 163			201. 00 202. 00

Heal th	Financial Systems N	IEMORIAL HOSP & HE	ALTH CARE CTR	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0115	Peri od:	Worksheet C	
				From 07/01/2020	Part I	
				To 06/30/2021	Date/Time Pre 11/30/2021 2:	
			Title XIX	Hospi tal	Cost	40 pili
	Cost Center Description	PPS Inpatient		10301 tui	0031	
	Cost center bescription	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11100				
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
40.00	04000 SUBPROVIDER - IPF					40.00
41.00	04100 SUBPROVIDER - IRF					41.00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44.00
44.00	ANCI LLARY SERVICE COST CENTERS					
50, 00	05000 OPERATING ROOM	0. 000000				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
52.00	05300 ANESTHESI OLOGY	0. 000000				53.00
53.00 54.00						
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56.00	05600 RADI OI SOTOPE	0.00000				56.00
60.00	06000 LABORATORY	0.000000				60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
69.01	06901 PULMONARY	0. 000000				69.01
69.02	06902 CARDI OPULMONARY	0. 000000				69.02
69.03	06903 SLEEP LAB	0. 000000				69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0. 000000				88.00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000				88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90.00	09000 CLINIC	0. 000000				90.00
90.01	09001 I MED	0. 000000				90.01
90.02	09002 ONCOLOGY	0. 000000				90.02
90.03	09003 OUTPATI ENT CENTER	0. 000000				90.03
90.04	09004 HBURG URGENT CARE CLINIC	0. 000000				90.04
90.05	09005 DIABETES MGMT CLINIC	0. 000000				90.05
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000				96.00
	10100 HOME HEALTH AGENCY					101.00
200	SPECIAL PURPOSE COST CENTERS					1
116.00	11600 HOSPI CE					116.00
200.00						200.00
201.00						201.00
202.00						202.00

Health Financial Systems M	EMORIAL HOSP & I	HEALTH CARE CT	२	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Pre 11/30/2021 2:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	- 1	-	-	1		
30. 00 ADULTS & PEDIATRICS	921, 563		921, 56			
31.00 INTENSIVE CARE UNIT	425, 034		425, 03			
40. 00 SUBPROVIDER - IPF	325, 765		325, 76			
41.00 SUBPROVIDER - IRF	168, 786	0	168, 78	6 1, 097	153.86	41.00
43.00 NURSERY	108, 262		108, 26	2 1, 378	78.56	43.00
44.00 SKILLED NURSING FACILITY	197, 957		197, 95	7 4, 334	45.68	44.00
200.00 Total (lines 30 through 199)	2, 147, 367		2, 147, 36	7 24, 466		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 ADULTS & PEDIATRICS	3, 624					30.00
31.00 INTENSIVE CARE UNIT	1, 924	199, 750				31.00
40. 00 SUBPROVIDER - IPF	884					40.00
41. 00 SUBPROVIDER – IRF	517	79, 546	•			41.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	3, 459	158, 007				44.00
200.00 Total (lines 30 through 199)	10, 408	860, 033				200.00

		HEALTH CARE CTE			u of Form CMS-2552	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	JN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/30/2021 2:	pared: 40 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
·		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	<b>1</b>	-				
50. 00 05000 OPERATING ROOM	1, 230, 910				73, 688	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	210, 765				0	52.00
53. 00 05300 ANESTHESI OLOGY	7,641	2, 733, 851	0.00279	95 242, 908	679	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	416, 521	77, 530, 583	0.0053	72 5, 628, 186	30, 235	54.00
56. 00 05600 RADI OI SOTOPE	28, 693	10, 887, 205	0.00263	35 171, 597	452	56.00
50. 00 06000 LABORATORY	223, 962	59, 360, 841	0.0037	73 4, 486, 762	16, 929	60.00
55. 00 06500 RESPI RATORY THERAPY	79, 456	6, 341, 706	0. 01252	29 659, 666	8, 265	65.00
66. 00 06600 PHYSI CAL THERAPY	176,063	11, 738, 185	0.01499	99 1, 361, 411	20, 420	66.00
59. 00 06900 ELECTROCARDI OLOGY	392, 928	41, 258, 413	0.00952	6, 103, 254	58, 127	69.00
59. 01 06901 PULMONARY	0				0	69.01
59. 02 06902 CARDI OPULMONARY	46, 234	1, 010, 274	0.04576	54 326	15	69.02
59. 03 06903 SLEEP LAB	54, 305				0	69.03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,877	7, 905, 672			1, 107	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 953				3, 203	
73. 00 07300 DRUGS CHARGED TO PATIENTS	157, 390				16, 273	
74. 00 07400 RENAL DI ALYSI S	0					
OUTPATIENT SERVICE COST CENTERS			0.0000		<u> </u>	1
38. 00 08800 RURAL HEALTH CLINIC	55, 982	901, 163	0.06212	22 0	0	88.00
38.01 08801 RURAL HEALTH CLINIC II	126, 667	944, 524			0	
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	•
20. 00 09000 CLINIC	162,659	4, 523, 761			1, 739	
20. 01 09001 I MED	0	0	0.0000		0	
20. 02 09002 ONCOLOGY	338, 962	18, 014, 816			884	
20. 03 09003 0UTPATI ENT CENTER	0		0. 00000		0	
20. 04 09004 HBURG URGENT CARE CLINIC	156, 239	-			139	
20. 05 09005 DIABETES MGMT CLINIC	15, 785				0	
21. 00 09100 EMERGENCY	334, 707				-	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	215, 849					•
OTHER REIMBURSABLE COST CENTERS	213, 049	5,740,752	0.0375	,, 307,370	15, 015	1 /2.00
25. 00 09500 AMBULANCE SERVICES						95.00
26. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 0	0	•

Health Financial Systems ME	MORIAL HOSP & H	IEALTH CARE CT	2	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	
			XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School		n Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	-	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	
40. 00 04000 SUBPROVI DER – I PF	0	0		0 0	0	
41. 00 04100 SUBPROVIDER – IRF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0			3, 624	30.00
31.00 03100 INTENSIVE CARE UNIT		0	4, 09	4 0.00	1, 924	31.00
40. 00 04000 SUBPROVIDER - IPF	0	0	2, 26	6 0.00	884	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	1, 09	0.00	517	41.00
43. 00 04300 NURSERY		0	1, 37	8 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	4, 33	4 0.00	3, 459	44.00
200.00 Total (lines 30 through 199)		0			10, 408	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41. 00 04100 SUBPROVI DER – I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00

Heal th	Financial Systems ME	MORIAL HOSP & H	IEALTH CARE CT	2	In Lie	u of Form CMS-	2552-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER GH COSTS	VICE OTHER PASS	Provider C		Period: From 07/01/2020 To 06/30/2021		pared: 40 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician			I Allied Health	Allied Health	
			Post-Stepdown	J	Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			· · · · · · · · · · · · · · · · · · ·		
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		o o	0	56.00
60.00	06000 LABORATORY	0	0		o o	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		o o	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	•
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69.01	06901 PULMONARY	0	0		0 0	0	69.01
69.02		0	0		0 0	0	
69.03	06903 SLEEP LAB	0	0		0 0	0	
70.00		0	0		0 0	0	
71.00		0	0		0 0	0	
72.00		0	0		0 0	0	
73.00		0	0		0 0	0	
74.00		0	0		0 0	0	
,	OUTPATIENT SERVICE COST CENTERS				<u> </u>		1 / 11 00
88.00		0	0		0 0	0	1 88. 00
88.01	08801 RURAL HEALTH CLINIC II	0	0		0 0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90.00	09000 CLINIC	0	0		0 0	0	
90.01	09001 I MED	0	0		0 0	0	
90.02	09002 ONCOLOGY	0	0		0 0	0	
90.03		0	0		0 0	0	
90.04	09004 HBURG URGENT CARE CLINIC	0	0		0 0	0	
90.05	09005 DI ABETES MGMT CLINIC	0	0		0 0	0	•
91.00		0	0		0 0	0	
92.00		0	0		ō	0	
,2.00	OTHER REIMBURSABLE COST CENTERS				~	0	1 2.00
95 00	09500 AMBULANCE SERVICES						95.00
96.00		0	0		o o	0	
200.00		0	0		0 0	-	200.00

Health Financial Systems M	EMORIAL HOSP & H	HEALTH CARE CT	2	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0115	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020	Part IV	
				To 06/30/2021	Date/Time Pre	pared:
		T: +1 a	e XVIII	Hospi tal	11/30/2021 2: PPS	40 pm
Cast Castas Description				Total Charges		
Cost Center Description	All Other	Total Cost	Total Outpatient	(from Wkst. C,		
	Medical	(sum of cols.			(col. 5 ÷ col.	
	Education Cost		Cost (sum of			
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	( 00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-		1			
50. 00 05000 OPERATI NG ROOM	0	0		0 75, 095, 454		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 808, 890		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 733, 851		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 77, 530, 583	0. 000000	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 10, 887, 205	0.000000	56.00
60. 00 06000 LABORATORY	0	0		0 59, 360, 841	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 341, 706	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 11, 738, 185	0. 000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 41, 258, 413	0. 000000	69.00
69. 01 06901 PULMONARY	0	0		0 0	0.000000	
69. 02 06902 CARDI OPULMONARY	0	0		0 1, 010, 274		
69. 03 06903 SLEEP LAB	0	0		0 1, 648, 499		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 1,010,177	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 7, 905, 672	0.000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 16,087,897	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 116, 401, 037		
	0					
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS		0	1	0 001 1/0	0.000000	00.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0 901, 163		
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 944, 524		88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	89.00
90. 00 09000 CLINIC	0	0		0 4, 523, 761	0. 000000	90.00
90. 01 09001 I MED	0	0		0 0	0. 000000	
90. 02 09002 0NC0L0GY	0	0		0 18, 014, 816	0. 000000	
90. 03 09003 OUTPATIENT CENTER	0	0		0 0	0.000000	90.03
90. 04 09004 HBURG URGENT CARE CLINIC	0	0		0 3, 533, 679	0.000000	90.04
90. 05 09005 DIABETES MGMT CLINIC	0	0		0 119, 763	0. 000000	90.05
91.00 09100 EMERGENCY	0	0		0 50, 222, 599	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 5, 740, 752		92.00
OTHER REIMBURSABLE COST CENTERS	-		·			1
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0.000000	
200.00 Total (lines 50 through 199)	0			0 513, 809, 564		200.00
			I	010,007,004	I	

		EMORIAL HOSP & HE			In Lieu of Form CMS-2			
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider CC	CN: 15-0115	Peri	iod: m 07/01/2020	Worksheet D Part IV	
THROUG	H COSTS				To	06/30/2021	Date/Time Pre	nared
					10	00/00/2021	11/30/2021 2:	40 pm
			Title	XVIII		Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent		Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Through		Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8		Costs (col. 9	
		7)		x col. 10)			x col. 12)	
		9.00	10.00	11.00		12.00	13.00	
	ANCI LLARY SERVI CE COST CENTERS							
50.00	05000 OPERATING ROOM	0. 000000	4, 495, 668		0	17, 992, 276	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	242, 908		0	680, 171	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 628, 186		0	20, 776, 257	0	54.00
56.00	05600 RADI OI SOTOPE	0. 000000	171, 597		0	4, 843, 357	0	56.00
60.00	06000 LABORATORY	0. 000000	4, 486, 762		0	6, 688, 531	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	659, 666		0	637, 707	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 361, 411		0	156, 876	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	6, 103, 254		0	12, 382, 058	0	69.00
69. 01	06901 PULMONARY	0. 000000	0		0	0	0	69.0 ¹
69. 02	06902 CARDI OPULMONARY	0. 000000	326		0	635, 700	0	69.02
69.03	06903 SLEEP LAB	0. 000000	0		0	475, 345	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 000000	1, 272, 117		0	1, 866, 765	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 694, 845		0	4, 428, 860	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	12, 036, 406		0	40, 896, 156	0	73.00
74.00	07400 RENAL DIALYSIS	0, 000000	12,000,100		0	0,070,100	0	74.00
/ 1. 00	OUTPATIENT SERVICE COST CENTERS	0.000000		<u> </u>		0		1 1.00
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	0	88. 00
88.01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0	ō	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0, 000000	0		0	0	0	89.00
90.00	09000 CLINIC	0. 000000	48, 375		0	1, 703, 078	0	90.00
90.01	09001 I MED	0. 000000	0,070		0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	90.01
90.02	09002 ONCOLOGY	0. 000000	47,004		0	7, 582, 620	0	90.02
90.02 90.03	09003 OUTPATIENT CENTER	0.000000	-, 004 0		0	,, 302, 920	0	90.02
90.03 90.04	09004 HBURG URGENT CARE CLINIC	0. 000000	3, 134		0	280, 333	0	90.04
90.04 90.05	09005 DI ABETES MGMT CLINIC	0. 000000	3, 134		0	200, 333	0	90.05
90.00 91.00	09100 EMERGENCY	0. 000000	4, 441, 609		0	10, 754, 696	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	367, 376		0	755, 022	0	91.00
/2.00	OTHER REIMBURSABLE COST CENTERS	0.000000	307, 370	<u> </u>	<u> </u>	155, 022	0	72.00
95.00	09500 AMBULANCE SERVICES					I		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	96.00
				1		01	0	1 70.00

APPORT	Financial Systems ME IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	MORIAL HOSP & VACCINE COST	Provider C		Peri od:	Worksheet D	2552-10
					From 07/01/2020	Part V	nored.
					To 06/30/2021	Date/Time Pre 11/30/2021 2:	40 nm
			Title	× XVIII	Hospi tal	PPS	
				Charges	noopi tui	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	()	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS	-		•			
50.00	05000 OPERATING ROOM	0. 263544	17, 992, 276	1	0 0	4, 741, 756	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1. 180996	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 644891	680, 171		0 0	438, 636	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 087281	20, 776, 257		0 0	1, 813, 372	54.00
56.00	05600 RADI OI SOTOPE	0. 086748	4, 843, 357		0 0	420, 152	56.00
60.00	06000 LABORATORY	0. 168759	6, 688, 531		0 0	1, 128, 750	60.00
65.00	06500 RESPI RATORY THERAPY	0. 423843			0 0	270, 288	
66.00	06600 PHYSI CAL THERAPY	0. 321497			0 0	50, 435	
69.00	06900 ELECTROCARDI OLOGY	0. 163987			0 0	2, 030, 497	
69.01	06901 PULMONARY	0. 000000			0 0	0	1
69.02	06902 CARDI OPULMONARY	0. 295873			0 0	188, 086	
69.03	06903 SLEEP LAB	0. 312352			0 0	148, 475	
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 195552			0 0	365,050	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 391448			0 0	1, 733, 668	
	07300 DRUGS CHARGED TO PATIENTS	0. 211708			0 57,831	8, 658, 043	
74.00	07400 RENAL DIALYSIS	0. 000000			0 0	0,000,010	
/ 11 00	OUTPATIENT SERVICE COST CENTERS	0.000000	<u> </u>				1
88.00	08800 RURAL HEALTH CLINIC						88.00
88.01	08801 RURAL HEALTH CLINIC II						88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000 CLINIC	0. 260485	1, 703, 078		0 0	443, 626	
90.01	09001 I MED	0. 000000			0 0	0	90.01
90.02	09002 ONCOLOGY	0. 282106			0 0	2, 139, 103	
90.03	09003 OUTPATIENT CENTER	0. 000000			0 0	0	
90.04	09004 HBURG URGENT CARE CLINIC	0. 570671			0 0	159, 978	
90.05	09005 DIABETES MGMT CLINIC	1. 033767			0 0	0	
91.00	09100 EMERGENCY	0. 160540			0 101	1, 726, 559	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 426743			0 0	322, 200	
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 469690			0		95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0, 000000			0 0	0	
200.00			133, 535, 808		0 57,932	26, 778, 674	
					0 0	20,	201.00
201.00							
201.00	Only Charges				Ŭ Ŭ		

	EMORIAL HOSP & HI				u of Form CMS-2552-1	
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider CO	JN: 15-0115	Period: From 07/01/2020	Worksheet D Part V	
				To 06/30/2021	Date/Time Pr	
		Title	XVIII	Hospi tal	<u>11/30/2021 2</u> PPS	. 40 pili
	Cost			10301 tu	115	
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins. I	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
3.00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
66. 00 05600 RADI OI SOTOPE	0	0				56.00
0. 00 06000 LABORATORY	0	0				60.00
5. 00 06500 RESPI RATORY THERAPY	0	0				65.00
6. 00 06600 PHYSI CAL THERAPY	0	0				66.00
9.00 06900 ELECTROCARDI OLOGY	0	0				69.00
9. 01 06901 PULMONARY	0	0				69.01
99. 02 06902 CARDI OPULMONARY	0	0				69.02
99.03 06903 SLEEP LAB	0	0				69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	0	12, 243 0				73.00
74. 00 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	U	0				74.00
88. 00 08800 RURAL HEALTH CLINIC	1					88.00
38. 01 08800 RURAL HEALTH CLINIC II						88.0
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
20. 00 09000 CLINIC	0	0				90.00
20. 01 09001 I MED	0	0				90.0
0. 02 09002 0NCOLOGY	0	0				90.02
0. 03 09003 OUTPATIENT CENTER	0	0				90.03
0. 04 09004 HBURG URGENT CARE CLINIC	0	0				90.04
0. 05 09005 DIABETES MGMT CLINIC	0	0				90.05
21. 00 09100 EMERGENCY	0	16				91.00
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0					95.00
26.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00 Subtotal (see instructions)	0	12, 259				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	12, 259				202.00

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTF	R	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0115	Period:	Worksheet D	
				From 07/01/2020	Part II	
		Component (	CCN: 15-S115	To 06/30/2021	Date/Time Pre	pared:
		T: +1 -		Subprovider -	11/30/2021 2:	40 pm
		IITIE	XVIII	IPF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	5	· · · · ·	
	26)		í í			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			•			
50.00 05000 OPERATING ROOM	1, 230, 910			91 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	210, 765	1, 808, 890	0. 1165	16 0	0	52.00
53.00 05300 ANESTHESI OLOGY	7,641	2, 733, 851		95 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	416, 521	77, 530, 583			626	54.00
56. 00 05600 RADI OI SOTOPE	28, 693				0	
60. 00 06000 LABORATORY	223, 962				928	60.00
65. 00 06500 RESPI RATORY THERAPY	79, 456				6	65.00
66. 00 06600 PHYSI CAL THERAPY	176,063				312	
69. 00 06900 ELECTROCARDI OLOGY	392, 928				239	69.00
69. 01 06901 PULMONARY	0				0	69.01
69. 02 06902 CARDI OPULMONARY	46, 234	-			0	69.02
69. 03 06903 SLEEP LAB	54, 305				0	69.02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 877	7, 905, 672			0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 953				0	72.00
72.00 07200 TMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	13, 953				399	72.00
					399	
74. 00 07400 RENAL DI ALYSI S	0	0	0.0000	000	0	74.00
0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	EE 000	001 1(2	0.0(21)	22	0	00.00
	55, 982					
88.01 08801 RURAL HEALTH CLINIC II	126, 667				0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90. 00 09000 CLINIC	162, 659	4, 523, 761			0	90.00
90. 01 09001 I MED	0	0	0.0000		0	90.01
90. 02 09002 ONCOLOGY	338, 962				3	90.02
90. 03 09003 OUTPATI ENT CENTER	0	-	0.0000		0	90.03
90. 04 09004 HBURG URGENT CARE CLINIC	156, 239				0	90.04
90.05 09005 DIABETES MGMT CLINIC	15, 785				0	90.05
91.00 09100 EMERGENCY	334, 707	50, 222, 599			1, 523	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 740, 752	0.0000	0 00	0	92.00
OTHER REIMBURSABLE COST CENTERS	1			-		
95. 00 09500 AMBULANCE SERVI CES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.0000		0	96.00
200.00 Total (lines 50 through 199)	4, 236, 699	513, 809, 564		932, 785	4, 036	200.00

Health Financial Systems ME	MORIAL HOSP & H	EALTH CARE CT	2	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Component	CCN: 15-S115	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/30/2021 2:	pared: 40 pm
		Title	e XVIII	Subprovider -	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Scho	IPF ol Allied Health	Allied Health	
		Post-Stepdown	liter of fig conto	Post-Stepdown	ni i ou nour en	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 PULMONARY	0	0		0 0	0	69.01
69. 02 06902 CARDI OPULMONARY	0	0		0 0	0	69.02
69. 03 06903 SLEEP LAB	0	0		0 0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
0UTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	00.00
88. 01 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00 88.01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0			0	90.00
90. 01 09001 I MED	0	0			0	90.00
90. 02 09002 0NC0L0GY	0	0			0	90.01
90. 03 09003 0UTPATI ENT CENTER	0	0			0	90.02
90. 04 09004 HBURG URGENT CARE CLINIC	0	0			0	90.04
90. 05 09005 DI ABETES MGMT CLINIC	0	0		0 0	0	90.05
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	-	0	1 2.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00
						-

Health Financial Systems ME	EMORIAL HOSP & I	HEALTH CARE CT	र	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0115	Period:	Worksheet D	
THROUGH COSTS		Company	00N 1E 011E	From 07/01/2020	Part IV	
		Component	CCN: 15-S115	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		Title	xviii	Subprovider -	PPS	
		iii ti c		IPF	110	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATING ROOM	0	0		0 75, 095, 454		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 808, 890		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 733, 851	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 77, 530, 583	0.000000	54.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 10, 887, 205	0.000000	56.00
60. 00 06000 LABORATORY	0	0		0 59, 360, 841	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 341, 706	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 11, 738, 185		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 41, 258, 413	0.000000	69.00
69. 01 06901 PULMONARY	0	0		0 0	0.00000	69.01
69. 02 06902 CARDI OPULMONARY	0	0		0 1, 010, 274	0.00000	69.02
69. 03 06903 SLEEP LAB	0	0		0 1, 648, 499	0.000000	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 7, 905, 672	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 16, 087, 897	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 116, 401, 037	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 901, 163	0.00000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 944, 524	0.000000	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	89.00
90. 00 09000 CLINIC	0	0		0 4, 523, 761	0.000000	90.00
90. 01 09001 I MED	0	0		0 0	0.000000	90.01
90. 02 09002 ONCOLOGY	0	0		0 18, 014, 816	0.000000	90.02
90. 03 09003 OUTPATI ENT CENTER	0	0		0 0	0.000000	90.03
90. 04 09004 HBURG URGENT CARE CLINIC	0	0		0 3, 533, 679	0.000000	90.04
90.05 09005 DIABETES MGMT CLINIC	0	0		0 119, 763	0.00000	90.05
91.00 09100 EMERGENCY	0	0		0 50, 222, 599	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 5, 740, 752	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0.000000	96.00
200.00 Total (lines 50 through 199)	0	0		0 513, 809, 564		200.00

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	MEMORIAL HOSP & HE	Provi der C		Peri od:	eu of Form CMS- Worksheet D	2552-10
THROUGH COSTS	LINICE UTILL FASS	FIOVIDEI CO	3N. 13-0113	From 07/01/2020		
		Component (	CCN: 15-S115	To 06/30/2021	Date/Time Pre	pared:
					11/30/2021 2:	40 pm
		litle	XVIII	Subprovider -	PPS	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	l o	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	116, 604		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
50. 00 06000 LABORATORY	0. 000000	245, 860		0 0	0	60.00
55. 00 06500 RESPI RATORY THERAPY	0. 000000	468		0 0	0	65.00
56. 00 06600 PHYSI CAL THERAPY	0. 000000	20, 786		0 0	0	66.00
59. 00 06900 ELECTROCARDI OLOGY	0. 000000	25, 089		0 0	0	
59. 01 06901 PULMONARY	0. 000000	0		0 0	0	69.01
59. 02 06902 CARDI OPULMONARY	0. 000000	0		0 0	0	69.02
59. 03 06903 SLEEP LAB	0. 000000	0		0 0	0	69.03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	370		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	294, 922		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS					<b>T</b>	
38.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0		
38.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	-	
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	
90. 00 09000 CLINIC	0. 000000	0		0 0	0	
90. 01 09001 I MED	0. 000000	0		0 0	0	
20. 02 09002 0NCOLOGY	0. 000000	160		0 0	0 0	1
PO. 03 09003 OUTPATI ENT CENTER	0. 000000	0		0 0	0 0	
PO. 04 09004 HBURG URGENT CARE CLINIC	0. 000000	0		0 0	0 0	90.04
PO. 05 09005 DIABETES MGMT CLINIC	0. 000000	0		0 0	0	90.05
91. 00 09100 EMERGENCY	0. 000000	228, 526		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0		96.00
200.00 Total (lines 50 through 199)		932, 785	1	0 0		200.00

Health Financial Systems ME	EMORIAL HOSP & I	HEALTH CARE CT	2	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Peri od:	Worksheet D	
				From 07/01/2020	Part II	
		Component	CCN: 15-T115	To 06/30/2021	Date/Time Pre	pared:
		T: +1 -		Cultura estada est	11/30/2021 2:	40 pm
		IITIE	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· ·	$(col \cdot 1 \div col$		column 4)	
	Part II, col.	8)	2)	i ondi goo		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS					•	
50. 00 05000 OPERATI NG ROOM	1, 230, 910	75, 095, 454	0. 01639	91 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	210, 765	1, 808, 890	0. 1165	16 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	7,641	2, 733, 851	0.00279	95 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	416, 521	77, 530, 583	0.0053	72 15, 591	84	54.00
56. 00 05600 RADI OI SOTOPE	28, 693	10, 887, 205	0.00263	35 0	0	56.00
60. 00 06000 LABORATORY	223, 962	59, 360, 841	0.0037	73 34,067	129	60.00
65. 00 06500 RESPI RATORY THERAPY	79, 456	6, 341, 706	0. 01252	29 568	7	65.00
66. 00 06600 PHYSI CAL THERAPY	176,063	11, 738, 185	0.01499	666, 545	9, 998	66.00
69. 00 06900 ELECTROCARDI OLOGY	392, 928		0.00952	3, 046	29	69.00
69. 01 06901 PULMONARY	0	0	0.0000	0 00	0	69.01
69. 02 06902 CARDI OPULMONARY	46, 234	1, 010, 274	0.04576	64 0	0	69.02
69. 03 06903 SLEEP LAB	54, 305	1, 648, 499	0. 03294	42 0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 877	7, 905, 672	0.0008	70 1, 369	1	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 953		0.00086	67 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	157, 390	116, 401, 037	0.0013	52 126, 590	171	73.00
74.00 07400 RENAL DI ALYSI S	0	0	0.0000			74.00
OUTPATIENT SERVICE COST CENTERS					•	
88.00 08800 RURAL HEALTH CLINIC	55, 982	901, 163	0.06212	22 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	126, 667	944, 524	0. 13410	07 0	0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 00	0	89.00
90. 00 09000 CLI NI C	162, 659	4, 523, 761	0. 03595	57 0	0	90.00
90. 01 09001 I MED	0	0	0.0000	0 00	0	90.01
90. 02 09002 ONCOLOGY	338, 962	18, 014, 816	0. 0188	16 0	0	90.02
90. 03 09003 OUTPATI ENT CENTER	0	0	0.0000	0 00	0	90.03
90.04 09004 HBURG URGENT CARE CLINIC	156, 239	3, 533, 679	0. 0442	14 0	0	90.04
90.05 09005 DIABETES MGMT CLINIC	15, 785	119, 763	0. 13180	02 0	0	90.05
91.00 09100 EMERGENCY	334, 707	50, 222, 599	0.00666	54 1, 300	9	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 740, 752	0.0000	0 00	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0.0000	0 00	0	96.00
200.00 Total (lines 50 through 199)	4, 236, 699	513, 809, 564	1	849, 076	10, 428	200. 00

Health Financial Systems ME	MORIAL HOSP & H	IEALTH CARE CTF	2	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		CN: 15-0115 CCN: 15-T115	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/30/2021 2:	epared:
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description		Post-Stepdown		ol Allied Health Post-Stepdown	Allied Health	
	Cost	Adj ustments		Adj ustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	20	2.00	54	3.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60,00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 PULMONARY	0	0		0 0	0	
69. 02 06902 CARDI OPULMONARY	0	0		0 0	0	
69. 03 06903 SLEEP LAB	0	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS				<u> </u>		1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89,00
90. 00 09000 CLINIC	0	0		0 0	0	90,00
90. 01 09001 I MED	0	0		0 0	0	90, 01
90. 02 09002 ONCOLOGY	0	0		0 0	0	90.02
90. 03 09003 OUTPATI ENT CENTER	0	0		0 0	0	90.03
90. 04 09004 HBURG URGENT CARE CLINIC	0	0		0 0	0	90.04
90. 05 09005 DI ABETES MGMT CLINIC	0	0		0 0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	Ū.		0	0	
OTHER REI MBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
	1 -1		'	1		

Health Financial Systems M	EMORIAL HOSP & I	HEALTH CARE CT	२	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C	CN: 15-0115	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020	Part IV	
		Component	CCN: 15-T115	To 06/30/2021		
		T: +1 a	e XVIII	Subprovider -	11/30/2021 2: PPS	40 pm
		nue		IRF	PP5	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	)	0 75, 095, 454	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0 1, 808, 890	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 733, 851	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0 77, 530, 583	0.000000	54.00
56. 00 05600 RADI 0I SOTOPE	0	c c		0 10, 887, 205		56.00
60. 00 06000 LABORATORY	0	l d		0 59, 360, 841	0.000000	1
65. 00 06500 RESPIRATORY THERAPY	0			0 6, 341, 706		1
66. 00 06600 PHYSI CAL THERAPY	0			0 11, 738, 185		1
69. 00 06900 ELECTROCARDI OLOGY	0			0 41, 258, 413		1
69. 01 06901 PULMONARY	0			0 41, 230, 413	0.000000	1
69. 02 06902 CARDI OPULMONARY	0			0 1, 010, 274		1
69. 03 06903 SLEEP LAB	0			0 1, 648, 499		1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 1, 048, 499		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			s s		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 7, 905, 672 0 16, 087, 897	0. 000000	
	0					1
	0			0 116, 401, 037		1
74.00 07400 RENAL DI ALYSI S	0	0		0 0	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS				001.1/0	0.00000	0.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0 901, 163		
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 944, 524		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	01000000	
90. 00 09000 CLI NI C	0	0		0 4, 523, 761	0.000000	1
90. 01 09001 I MED	0	0		0 0	0.00000	1
90. 02 09002 ONCOLOGY	0	0		0 18, 014, 816		1
90. 03 09003 OUTPATI ENT CENTER	0	0		0 0	0.00000	1
90. 04 09004 HBURG URGENT CARE CLINIC	0	0		0 3, 533, 679		1
90. 05 09005 DIABETES MGMT CLINIC	0	0		0 119, 763		1
91.00 09100 EMERGENCY	0	0		0 50, 222, 599		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 5, 740, 752	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	)	0 0	0.000000	96.00
200.00 Total (lines 50 through 199)	0	0		0 513, 809, 564		200.00
			-			-

	MEMORIAL HOSP & HE			-		u of Form CMS-2	2002-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	Provider CO	CN: 15-0115		iod: m 07/01/2020	Worksheet D Part IV	
THROUGH COSTS		Component (	CCN: 15-T115	To	06/30/2021	Date/Time Pre	pared.
		oomponone (			00,00,2021	11/30/2021 2:	40 pm
		Title	e XVIII	Su	bprovider - IRF	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati ent		Outpati ent	Outpati ent	
· · · · · · · · · · · · · · · · · · ·	Ratio of Cost	Program	Program		Program	Program	
	to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	-	Costs (col. 9	
	7)		x col. 10)			x col. 12)	
	9.00	10.00	11.00		12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATING ROOM	0. 000000	0		0	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	15, 591		0	0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0	0	0	56.00
60. 00 06000 LABORATORY	0. 000000	34, 067		0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	568		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	666, 545		0	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	3, 046		0	0	0	69.00
69. 01 06901 PULMONARY	0. 000000	0		0	0	0	69.01
69. 02 06902 CARDI OPULMONARY	0. 000000	0		0	0	0	69.02
69. 03 06903 SLEEP LAB	0. 000000	0		0	0	0	69.03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 369		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	126, 590		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0	0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	0	89.00
90. 00 09000 CLINIC	0. 000000	0		0	0	0	90.00
90. 01 09001 I MED	0. 000000	0		0	0	0	90.01
90. 02 09002 ONCOLOGY	0. 000000	0		0	0	0	90.02
90. 03 09003 OUTPATI ENT CENTER	0. 000000	0		0	0	0	90.03
90. 04 09004 HBURG URGENT CARE CLINIC	0. 000000	0		0	0	0	90.04
90.05 09005 DIABETES MGMT CLINIC	0. 000000	0		0	0	0	90.05
91. 00 09100 EMERGENCY	0. 000000	1, 300		0	219	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVI CES							95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	96.00
200.00 Total (lines 50 through 199)		849, 076	1	0	219		200.00

PPORTI ONMENT (	al Systems ME DF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	EALTH CARE CTF	CN: 15-0115	Period:	Worksheet D	2552-10
					From 07/01/2020 To 06/30/2021	Part V Date/Time Pre 11/30/2021 2:	epared: 40 pm
			Title	XVIII	Subprovider - IRF	PPS	
				Charges		Costs	
Cos	st Center Description	Cost to Charge	PPS Reimbursed	¥	Cost	PPS Services	
	· · · · · · · · · · · · · · · · · · ·	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	· · ·	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI LLAR	Y SERVICE COST CENTERS	-		•			
50. 00 05000 OPI	ERATING ROOM	0. 263544	0		0 0	0	50.00
52. 00 05200 DEI	LIVERY ROOM & LABOR ROOM	1. 180996	0	(	0 0	0	52.00
	ESTHESI OLOGY	0. 644891	0		0 0	0	53.00
	DI OLOGY-DI AGNOSTI C	0.087281	0	(	0 0	0	54.00
	DI OI SOTOPE	0.086748	0	(	0 0	0	56.00
0. 00 06000 LAI		0, 168759	0	(	0 0	0	60.00
	SPI RATORY THERAPY	0. 423843	0		0 0	0	
	YSI CAL THERAPY	0. 321497	0		0 0	0	
	ECTROCARDI OLOGY	0. 163987	0		0 0	0	
9.01 06901 PU		0. 000000	0		0 0	0	
	RDI OPULMONARY	0. 295873	0		0 0	0	
9.03 06903 SLI		0. 312352	0		0 0	0	
	ECTROENCEPHALOGRAPHY	0. 000000	-		0 0	0	
	DI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 195552	0			0	
	PL. DEV. CHARGED TO PATIENTS	0. 391448	0			0	
	UGS CHARGED TO PATIENTS	0. 211708			703	0	
	NAL DIALYSIS	0. 000000	0		0 0	0	
	NT SERVICE COST CENTERS	0.000000	0	· · · · ·	5 0	0	/ /4.0
	RAL HEALTH CLINIC	1		1			88. 0
	RAL HEALTH CLINIC II						88.0
	DERALLY QUALIFIED HEALTH CENTER						89.0
0.00 09000 CL		0. 260485	o		0 0	0	
0.01 09001 I MI		0. 200485	0			0	
0.02 09002 0N		0. 282106	0			0	
	TPATIENT CENTER	0. 282100				0	
	URG URGENT CARE CLINIC	0. 570671	0			0	
	ABETES MGMT CLINIC	1. 033767				0	
0.05 09003 D17			219				
	ERGENCY SERVATION BEDS (NON-DISTINCT PART)	0. 160540 0. 426743	219			35	
	IMBURSABLE COST CENTERS	0. 420743	0			0	<u>1</u> 92.00
	BULANCE SERVICES	0. 469690					95.00
	RABLE MEDICAL EQUIP-RENTED	0. 409090	o		0 0	o	
	btotal (see instructions)	0.00000	219		703		200. 0
	· ,		219				
	se DRD Clinic Lab Sorvices Dreament				<u>ר ר</u>		1201 0
201.00 Les	ss PBP Clinic Lab. Services-Program Ly Charges				0 0		201.00

		EMORIAL HOSP & F	IEALTH CARE CT	2	In Lie	u of Form CMS	-2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0115	Peri od:	Worksheet D	
			Component	CCN: 15-T115	From 07/01/2020 To 06/30/2021	Part V Date/Time Pr	onarod
			component	CCN. 13-1113	10 00/ 30/ 2021	11/30/2021 2	
			Title	× XVIII	Subprovider -	PPS	
					I RF		
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.) 6.00	<u>(see inst.)</u> 7.00	-			
	NCILLARY SERVICE COST CENTERS	0.00	7.00				
	D5000 OPERATING ROOM	0	0				50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	•			52.00
	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	05600 RADI OLOGI - DI AGNOSTI C	0	0				56.00
	06000 LABORATORY	0	0	•			60.00
	06500 RESPI RATORY THERAPY	0	0				65.00
	06600 PHYSI CAL THERAPY	0	0				66.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	06901 PULMONARY	0	0				69.01
	06902 CARDI OPULMONARY	0	0				69.02
	06903 SLEEP LAB	0	0				69.03
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	149				73.00
	07400 RENAL DI ALYSI S	0	0				74.00
-	DUTPATIENT SERVICE COST CENTERS			1			
	08800 RURAL HEALTH CLINIC						88.00
	08801 RURAL HEALTH CLINIC II						88.01
	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
	09000 CLINIC	0	0				90.00
	09001   MED	0	0				90.01
	09002 ONCOLOGY	0	0				90.02
90.03	09003 OUTPATI ENT CENTER	0	0				90.03
	09004 HBURG URGENT CARE CLINIC	0	0				90.04
	09005 DIABETES MGMT CLINIC	0	0				90.05
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	THER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0					95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00	Subtotal (see instructions)	0	149				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
		1		1			1
202.00	Only Charges Net Charges (line 200 - line 201)	0	149				202.00

APPORTIONMENT OF MEDI	CAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C	CN: 15-0115	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/30/2021 2:	
			Titl	e XIX	Hospi tal	Cost	
				Charges		Costs	
Cost Cen	ter Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERV	I CE COST CENTERS	· ·					
50.00 05000 OPERATI NO	G ROOM	0. 263544	0	787, 26	0 8	0	50.00
52.00 05200 DELI VERY	ROOM & LABOR ROOM	1. 180996	C		0 0	0	52.00
53.00 05300 ANESTHES	OLOGY	0. 644891	0	103, 61	0	0	53.00
54.00 05400 RADI OLOG	Y-DI AGNOSTI C	0. 087281	0	1, 171, 25	52 0	0	54.00
56.00 05600 RADI 0I SO	ΓΟΡΕ	0. 086748	C	90, 46	6 0	0	56.00
60.00 06000 LABORATO	RY	0. 168759	0	760, 00	0 0	0	60.00
65. 00 06500 RESPI RAT		0. 423843				0	
66. 00 06600 PHYSI CAL		0. 321497				0	
69.00 06900 ELECTROC		0. 163987				0	
69.01 06901 PULMONAR		0. 000000			0 0	0	
69. 02 06902 CARDI OPUI		0. 295873				0	
69.03 06903 SLEEP LA		0. 312352				0	
70.00 07000 ELECTROE		0. 000000		0, 1.	0 0	0	
	SUPPLIES CHARGED TO PATIENTS	0. 195552		65, 51		0	
	/. CHARGED TO PATIENTS	0. 391448				0	
	ARGED TO PATIENTS	0. 211708				0	
74.00 07400 RENAL DI		0. 000000			0 0	0	
	VICE COST CENTERS	0.000000			0 0	0	1 7 4.00
88.00 08800 RURAL HE			1				88.00
88. 01 08801 RURAL HE							88.01
	Y QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	COALTTED HEALTH CENTER	0. 260485		123, 37	12 0	0	
90. 01 09001 I MED		0. 000000		125, 57	0 0	0	
90. 02 09002 ONCOLOGY		0. 282106		285, 50		0	
90. 03 09003 0UTPATI EI		0. 202100		203, 50		0	
	GENT CARE CLINIC	0. 570671		80, 43		0	
90. 05 09005 DI ABETES		1. 033767				0	
91. 00 09100 EMERGENC		0. 160540				0	1
	ON BEDS (NON-DISTINCT PART)	0. 426743	-	.,		0	
	ABLE COST CENTERS	0. 420743		07, 59	0	0	72.00
		0. 469690		241.02	20		95.00
						0	
	MEDICAL EQUIP-RENTED (see instructions)	0. 000000			0 0		
200 00 00		1	ı U	7, 767, 57	70 0	0	200.00
							201 00
1 1	Clinic Lab. Services-Program				0 0		201.00

Health Financial Systems ME APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	MORIAL HOSP & H VACCINE COST	Provi der C		Peri od: From 07/01/2020 To 06/30/2021	u of Form CMS Worksheet D Part V Date/Time Pr 11/30/2021 2	epared:
		Titl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	I			
ANCI ELART SERVICE COST CENTERS           50.00         05000         OPERATING ROOM           52.00         05200         DELIVERY ROOM & LABOR ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           56.00         05600         RADI OLOGY-DI AGNOSTI C           56.00         06600         LABORATORY           65.00         06600         RADI OLOGY-TI AGNOSTI C           56.00         06600         RADI OLOGY-DI AGNOSTI C           66.00         06600         RADI OLOGY-TI AGNOSTI C           66.00         06600         RADI OLOGY           69.00         06600         RESPI RATORY THERAPY           69.00         06900         ELECTROCARDI OLOGY           69.01         06901         PULMONARY           69.02         CARDI OPULMONARY           69.03         06902         CARDI OPULMONARY           69.03         06903         SLEEP           71.00         OT100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200         IMPL.         DEV.	207, 480 0 66, 820 102, 228 7, 848 128, 257 4, 380 19, 340 46, 331 0 1, 061 1, 715 0 12, 812 13, 783					50.00 52.00 53.00 54.00 56.00 60.00 66.00 66.00 69.01 69.02 69.03 70.00 71.00 72.00
73. 00 07200 TMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	446, 990	0				72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS 74. 00 07400 RENAL DIALYSIS	446, 990	0				73.00
OUTPATIENT SERVICE COST CENTERS	0	0				/4.00
88.00         08800         RURAL         HEALTH         CLINIC           88.01         08801         RURAL         HEALTH         CLINIC         II           89.00         08900         FEDERALLY         QUALIFIED         HEALTH         CENTER           90.00         09000         CLINIC         II         GUAL         GUAL	32, 137 0	0 0				88.00 88.01 89.00 90.00 90.01
90. 02 09002 0NCOLOGY 90. 03 09003 0UTPATI ENT CENTER 90. 04 09004 HBURG URGENT CARE CLINIC	80, 542 0 45, 899	0 0 0				90. 02 90. 03 90. 04
90. 05 09005 DI ABETES MGMT CLINIC 91. 00 09100 EMERGENCY	2, 560 235, 913	0				90. 05 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	24, 578	0				92.00
OTHER         REI MBURSABLE         COST         CENTERS           95.00         09500         AMBULANCE         SERVI CES           96.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED	123, 025	0				95.00 96.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program Only Charges	1, 603, 699 0	0				200. 00 201. 00
202.00 Net Charges (line 200 - line 201)	1, 603, 699	0				202.00

MEMORIAL HOSP & HEALTH CARE CTR		In Lieu
Provider CCN: 15-0115	Peri od:	١

	Financial Systems MEMORIAL HOSP & HE/			u of Form CMS-2	
JMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre 11/30/2021 2:-	parec
		Title XVIII	Hospi tal	PPS	40 pi
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
	Inpatient days (including private room days and swing-bed day			11, 297	1.0
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room dave	11, 297 0	2.
00	do not complete this line.	iys). Thiyou have only pr	rvate room days,	0	J. 1
00	Semi-private room days (excluding swing-bed and observation b			8, 651	4.
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)	5.			
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	31 of the cost	0	7.
00	reporting period Total swing-bed NF type inpatient days (including private roc	om davs) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)	-		-	
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	3, 624	9.
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII c	only (including private r	room davs)	0	10.
	through December 31 of the cost reporting period (see instruct	ctions)	5	-	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.
	through December 31 of the cost reporting period		ie room days)	Ũ	12.
00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.
00	Total nursery days (title V or XIX only)	an (excluding swing-bed	uays)	0	
00	Nursery days (title V or XIX only)			0	16.
	SWING BED ADJUSTMENT		C 11-2 1	0.00	1 1 7
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 c	or the cost	0.00	17.
00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18.
00	reporting period Medicaid rate for swing-bed NF services applicable to service	as through December 31 of	the cost	0.00	10
	reporting period	-			
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20.
. 00	Total general inpatient routine service cost (see instruction	าร)		10, 459, 469	21.
00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	
00	5 x line 17) Swing had agat appliable to SNE type capilogs ofter December	21 of the east reporting	a posted (line (	0	22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 Of the cost reportin	ig period (Time 6	0	23.
00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.
00	7 x line 19)			0	25
	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (inne 8	0	25.
	Total swing-bed cost (see instructions)			0	26.
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 459, 469	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation hed ch	ardes)	0	28.
	Private room charges (excluding swing-bed charges)	and observation bed ci	lai ges)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	30.
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
00	Average per diem private room cost differential (line 34 x li			0.00	35.
	Private room cost differential adjustment (line 3 x line 35)	and private rear "	fforontial (11-	10 450 460	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTEPENTIAL (LINE	10, 459, 469	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
	Adjusted general inpatient routine service cost per diem (see			925.86	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		3, 355, 317 0	
	Total Program general inpatient routine service cost (line 39			3, 355, 317	

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0115	Period: From 07/01/2020	Worksheet D-1	1	
					To 06/30/2021	Date/Time Pre		
			Title	XVIII	Hospi tal	11/30/2021 2: PPS	40 p	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost	npatient Days		÷	(col. 3 x col.		
		1.00	2.00	col. 2) 3.00	4.00	4)		
. 00	NURSERY (title V & XIX only)	0	0				42	
	Intensive Care Type Inpatient Hospital Units							
00	INTENSIVE CARE UNIT	5, 143, 544	4, 094	1, 256. 3	36 1, 924	2, 417, 237		
. 00	CORONARY CARE UNIT						44	
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45	
	OTHER SPECIAL CARE (SPECIFY)						40	
. 00	Cost Center Description							
						1.00		
00	Program inpatient ancillary service cost (W			>		9, 463, 779		
00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ns)		15, 236, 333	3 49	
00	Pass through costs applicable to Program in	patient routine s	services (from	Wkst D sur	of Parts L and	495, 396	5 50	
	)		····			,		
. 00	Pass through costs applicable to Program in	patient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	275, 567	7 51	
00	and IV)	EQ and E1)						
. 00 . 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-nhy	sician anest	netist and	770, 963 14, 465, 370		
	medical education costs (line 49 minus line							
	TARGET AMOUNT AND LIMIT COMPUTATION							
. 00	Program di scharges					0.00		
. 00								
. 00 . 00	5							
. 00								
.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							) 58 ) 59	
	. ,							
. 00	Lesser of lines 53/54 or 55 from prior year					0.00		
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					C	) 61	
	amount (line 56), otherwise enter zero (see		5 (11185 54 X	007, UI 176 OI	the target			
. 00	Relief payment (see instructions)					C	62	
. 00	Allowable Inpatient cost plus incentive payr	ment (see instruc	ctions)			C	63	
00	PROGRAM INPATIENT ROUTINE SWING BED COST		- 01 C II					
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Decen	nber 31 of the	cost reporti	ng period (See	C	64	
. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the c	ost reporting	period (See	l c	65	
	instructions)(title XVIII only)							
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVII	l only). For	C	) 66	
00	CAH (see instructions)	a agata through	December 21	f the east m	posting posied			
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	le costs through	December 31 C	i the cost re	eporting period		67	
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	ecember 31 of	the cost repo	orting period	0	68	
	(line 13 x line 20)				5 1			
. 00	Total title V or XIX swing-bed NF inpatient					0	) 69	
00	PART III - SKILLED NURSING FACILITY, OTHER N					[		
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70	
. 00	Program routine service cost (line 9 x line		ne /o : Trne	2)			72	
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73	
. 00	Total Program general inpatient routine serv	•					74	
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, A	Part II, column		75	
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76	
. 00	Program capital -related costs (line 9 x line						77	
. 00	Inpatient routine service cost (line 74 min						78	
. 00	Aggregate charges to beneficiaries for exces						79	
00	Total Program routine service costs for com		ost limitation	(line 78 mir	nus line 79)		80	
00	Inpatient routine service cost per diem limi		<b>,</b>				81	
00	Inpatient routine service cost limitation ( Reasonable inpatient routine service costs						82	
. 00	Program inpatient ancillary services (see in	•	<i>&gt;)</i>				84	
. 00	Utilization review - physician compensation		ıs)				85	
. 00	Total Program inpatient operating costs (sur	n of lines 83 thr					86	
	PART IV - COMPUTATION OF OBSERVATION BED PAS							
<i>.</i> .		- 1				2,646	5  87	
. 00 . 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		Line 2			925.86		

Health Financial Systems ME	MORIAL HOSP & HEALTH CARE CTR			In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1		
			To 06/30/2021	Date/Time Pre 11/30/2021 2:	pared: 40 pm		
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	921, 563	10, 459, 469	0. 08810	3 2, 449, 826	215, 849	90.00	
91.00 Nursing School cost	0	10, 459, 469	0.00000	2, 449, 826	0	91.00	
92.00 Allied health cost	0	10, 459, 469	0.00000	2, 449, 826	0	92.00	
93.00 All other Medical Education	0	10, 459, 469	0.00000			93.00	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre 11/30/2021 2:4	pare
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		2, 266	1 1
00 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed day		ivate room days,	2, 266 0	2
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be			2 2//	4
00 00	Total swing-bed SNF type inpatient days (including private room reporting period	r 31 of the cost	2, 266 0		
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	5		0	8
00	Total inpatient days including private room days applicable to newborn days) (see instructions)	0 0	0	884	
. 00 . 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on	i ons)	3 /	0	
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX	ter 0 on this line)	3 /	0	
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	3 ( 31	5 /	0	
	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Program			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service:	s through December 31 o	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	2, 803, 693 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	g period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		0 2, 803, 693	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min		tions)	0.00	34
	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost at 07 reference line 2()	nd private room cost di	fferential (line	0 2, 803, 693	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROCEAM INDALENT OPERATING COST REFORE DASS THROUGH COST AD UN	CTMENTS			
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see			1, 237. 29	3.5
	Program general inpatient routine service cost per diem (see			1, 093, 764	
	Medically necessary private room cost applicable to the Program			0	
		+ line 40)		-	

OMPUT	Financial Systems ME ATION OF INPATIENT OPERATING COST	MORIAL HOSP & H		CN: 15-0115	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-S115	From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Title	e XVIII	Subprovider -	11/30/2021 2: PPS	40 p
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Cost		col. 2)		(col. 3 x col. 4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	) 42.
. 00	Intensive Care Type Inpatient Hospital Units			<u>,                                     </u>			/ 12.
	INTENSIVE CARE UNIT	0	C	0.	00 00	C	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
	SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1.00 161,905	5 48
	Total Program inpatient costs (sum of lines 4	11 through 48)(	see instructio	ons)		1, 255, 669	9 49
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	127, 084	1 50
00	<pre>III) Dass through costs applicable to Program input</pre>	tiont ancillar	w convigos (fr	com Wkct D	sum of Dorte II	4 024	E 1
. 00	Pass through costs applicable to Program inpa and IV)		y SELVICES (T	UNI WASE. D, S	sum of Pails II	4, 036	
. 00	Total Program excludable cost (sum of lines !					131, 120	
8. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	5 1	lated, non-phy	sician anesti	netist, and	1, 124, 549	/ 53
	Program di scharges					C	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)				1: 52)	0	
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (i	ine 56 minus	TINE 53)		
	Lesser of lines 53/54 or 55 from the cost rep	portina period	endi na 1996. u	updated and co	ompounded by the		
	market basket	51	5		, p		
	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C	) 61
	amount (line 56), otherwise enter zero (see i		5 (11165 54 X	00), 01 1% 0	i the target		
. 00	Relief payment (see instructions)	,				c c	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			C	) 63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost report	ng period (See	l c	64
	instructions)(title XVIII only)	0			0.1		
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	is after Decemb	er 31 of the c	cost reporting	g period (See	C	) 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVI	ll only). For	C	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	C	67
	(line 12 x line 19)	0					
. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	C	68
	Total title V or XIX swing-bed NF inpatient i					C C	69
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				)		70
	Adjusted general inpatient routine service co	2		•	)		71
	Program routine service cost (line 9 x line 1			_,			72
	Medically necessary private room cost applica						73
	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			Dort II column		74
. 00	26, line 45)	outifie service		ioi ksheet b, i	art II, corumn		/3
	Per diem capital-related costs (line 75 ÷ lin						76
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
	Aggregate charges to beneficiaries for excess		rovi der record	ds)			79
	Total Program routine service costs for compa				nus line 79)		80
	Inpatient routine service cost per diem limit						81
	Inpatient routine service cost limitation (li						82
	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		5)				83
	Utilization review - physician compensation		ins)				85
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	
	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2			0.00	
v. UU	Observation bed cost (line 87 x line 88) (see	•					89

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
		Component (	CCN: 15-S115	To 06/30/2021	Date/Time Prep 11/30/2021 2:4	pared: 40 pm
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	325, 765	2, 803, 693	0. 11619	1 0	0	90.00
91.00 Nursing School cost	0	2, 803, 693	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 803, 693	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 803, 693	0.00000	0 0	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-T115 Title XVIII	Peri od: From 07/01/2020 To 06/30/2021 Subprovi der -	Worksheet D-1 Date/Time Prep 11/30/2021 2:4 PPS	par
	Cost Center Description		IRF	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 097 1, 097	
	Private room days (excluding swing-bed and observation bed da		ivate room davs	1, 097	
	do not complete this line.	P		-	
00	Semi-private room days (excluding swing-bed and observation b			1, 097	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	1 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			0	
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	517	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including privato r	nom davs)	0	10
. 00	through December 31 of the cost reporting period (see instruc		oom days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		a room dave)	0	12
. 00	through December 31 of the cost reporting period	ix only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT		1		
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 c	f the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction	·	ing pariod (line	1, 399, 696	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	ber 31 of the cost report	ing period (ine	0	
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	g period (line 6	0	23
~~~	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)			_	
	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0 1, 399, 696	
1	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(THE 21 MINUS THE 20)		1, 399, 090	21
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· Lino 28)		0 0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)	- 1111e 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
1	Average per diem private room cost differential (line 34×11	ine 31)		0.00	35
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line)	1, 399, 696	
	27 minus line 36)			., 57.7, 670	ľ
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 275. 93	20
	Program general inpatient routine service cost per drem (see			659,656	
	Medically necessary private room cost applicable to the Progr			0	
	Total Program general inpatient routine service cost (line 39	$P \pm \text{line}(40)$		659, 656	41

OMPUTA	Financial Systems ME TION OF INPATIENT OPERATING COST	MORIAL HOSP & H		CN: 15-0115	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T115	From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Title	e XVIII	Subprovider -	11/30/2021 2: PPS	40 p
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
	NURSERY (title V & XIX only)	0	С	0.	00 0	0) 42.
	ntensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	(0.	00 0	0	43.
	CORONARY CARE UNI T						44.
	BURN INTENSIVE CARE UNIT						45.
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46.
. 00	Cost Center Description	I I					47
. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	. Line 200)			1.00) 48
. 00	PASS THROUGH COST ADJUSTMENTS			ons)		909, 076	
. 00 🛛	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	79, 546	50
	III) Pass through costs applicable to Program inpa	atient ancillar	y services (fr	rom Wkst. D, s	sum of Parts II	10, 428	3 51
	and IV)		-				
	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non-nh	vsician anoch	hetist and	89, 974 819, 102	
	medical education costs (line 49 minus line {				netrst, and	019,102	
	FARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	55
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	orting period	ending 1996 i	indated and c	ompounded by the		
	market basket	sor tring period	charng 1770, c		sinpounded by the	0.00	
	Lesser of lines 53/54 or 55 from prior year o					0.00	
	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% o	r the target		
	Relief payment (see instructions)	hati detrona)				0	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost report	ing period (See	0	64
	instructions)(title XVIII only)	0			01		
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	g period (See	0) 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	65)(title XVI	ll only). For	0	66
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	0	67
	(line 12 x line 19)	, anota oftan D	combox 21 of	the east ran	erting period		
	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 01	the cost rep	bring period	0	68
	Total title V or XIX swing-bed NF inpatient m PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
	Skilled nursing facility/other nursing facili)		70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line)	· ·	(line 14	no 25)			72
	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital-related cost allocated to inpatient i	•			Part II, column		75
	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
	Program capital-related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der rocer	te)			78
	Total Program routine service costs for compa				nus line 79)		80
	Inpatient routine service cost per diem limit						81
. 00	Inpatient routine service cost limitation (li	ne 9 x line 81	· .				82
	Reasonable inpatient routine service costs (s		s)				83
	Program inpatient ancillary services (see ins		nc)				84
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
- H	PART IV - COMPUTATION OF OBSERVATION BED PASS		- Jugit 03)			1	
	Total observation bed days (see instructions)					0	
	Adjusted general inpatient routine cost per o	•	line 2)			0.00	
. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
		Component (To 06/30/2021	Date/Time Prep 11/30/2021 2:4	pared: 40 pm
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	168, 786	1, 399, 696	0. 12058	8 0	0	90.00
91.00 Nursing School cost	0	1, 399, 696	0.00000	0 0	0	91.00
92.00 Allied health cost	0	1, 399, 696	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 399, 696	0.00000	0 0	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre 11/30/2021 2:-	par
		Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	1	-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s. excluding newborn)		4, 334	1 1
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.	bed and newborn days)	ivate room days,	4, 334 0	2
00 00	Semi-private room days (excluding swing-bed and observation by Total swing-bed SNF type inpatient days (including private room)	er 31 of the cost	4, 334 0		
00	reporting period Total swing-bed SNF type inpatient days (including private row reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to newborn days) (see instructions)			3, 459	
. 00 . 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII or	tions)	3 /	0	
. 00	December 31 of the cost reporting period (if calendar year, end) Swing-bed NF type inpatient days applicable to titles V or XI	nter 0 on this line)		-	
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI.	5 (51	5,7	0	
	after December 31 of the cost reporting period (if calendar your days applicable to the Program days applicable to the Progr			0	
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service: reporting period	s through December 31 of	the cost	0.00	19
	Medicaid rate for swing-bed NF services applicable to service: reporting period		he cost	0.00	
. 00 . 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December 5 x line 17)		ing period (line	2, 455, 650 0	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19) $$			0	[
. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	period (line 8	0	
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 2, 455, 650	
. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)	1.1		0	
	General inpatient routine service cost/charge ratio (line 27 -	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	nuc line 22) (cas instant	tions)	0.00	
	Average per diem private room charge differential (line 32 min	, ,	. (1 0115)	0.00	
	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 2 x line 25)	ne 31)		0.00	
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	0 2, 455, 650	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	USTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see				38
	Program general inpatient routine service cost (line 9 x line				39
. 00	Frogram general impatrent routine service cost (ime + x ime	00)			

MPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0115	Peri od:	Worksheet D-1	2552
		Component (CCN: 15-5305	From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Title	XVIII	Skilled Nursing	11/30/2021 2: PPS	40
				Facility		
Cost Center Description	Total Inpatient CostIr	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
.00 <u>NURSERY (title V & XIX only)</u> Intensive Care Type Inpatient Hospital Uni	ts					42
. 00 INTENSIVE CARE UNIT						43
. OO CORONARY CARE UNI T						44
. 00 BURN INTENSIVE CARE UNIT . 00 SURGICAL INTENSIVE CARE UNIT						45
. 00 OTHER SPECIAL CARE (SPECIFY)						40
Cost Center Description				-		
.00 Program inpatient ancillary service cost	(Wkst D-3 col 3	line 200)			1.00	48
.00 Total Program inpatient costs (sum of lin			ns)			49
PASS THROUGH COST ADJUSTMENTS					1	
.00 Pass through costs applicable to Program	inpatient routine se	ervices (from	WKST. D, SU	m of Parts I and		50
.00 Pass through costs applicable to Program	inpatient ancillary	services (fr	om Wkst. D,	sum of Parts II		51
and IV) .00 Total Program excludable cost (sum of lin	as 50 and 51					52
.00 Total Program excludable cost (sum of fin .00 Total Program inpatient operating cost ex	,	ated, non-phy	sician anest	hetist, and		52
medical education costs (line 49 minus li				,		
TARGET AMOUNT AND LIMIT COMPUTATION .00 Program di scharges					1	54
.00 Target amount per discharge						55
.00 Target amount (line 54 x line 55)						56
. 00 Difference between adjusted inpatient ope	rating cost and targ	get amount (I	ine 56 minus	line 53)		57
.00 Bonus payment (see instructions) .00 Lesser of lines 53/54 or 55 from the cost	reporting pariod or	ading 1004 u	ndated and a	ompounded by the		58
.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period er	idi ng 1996, u	puateu anu c	ompounded by the		5
.00 Lesser of lines 53/54 or 55 from prior ye	ar cost report, upda	ated by the m	arket basket			60
.00 If line 53/54 is less than the lower of l						6
which operating costs (line 53) are less amount (line 56), otherwise enter zero (s		(TINES 54 X	60), or 1% o	r the target		
.00 Relief payment (see instructions)	,					62
. 00 Allowable Inpatient cost plus incentive p	ayment (see instruct	tions)				63
.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine	costs through Decemb	per 31 of the	cost report	ing period (See		64
instructions)(title XVIII only)	Ū.			0 1		
.00 Medicare swing-bed SNF inpatient routine	costs after December	r 31 of the c	ost reportin	g period (See		65
instructions)(title XVIII only) .00 Total Medicare swing-bed SNF inpatient ro	utine costs (line 64	4 plus line 6	5)(title XVI	ll only) For		66
CAH (see instructions)						
.00 Title V or XIX swing-bed NF inpatient rou	tine costs through [December 31 o	f the cost r	eporting period		67
(line 12 x line 19) .00 Title V or XIX swing-bed NF inpatient rou	tine costs after Dec	cember 31 of	the cost rep	ortina period		68
(line 13 x line 20)				5 1		
.00 Total title V or XIX swing-bed NF inpatie PART III - SKILLED NURSING FACILITY, OTHER						69
. 00 Skilled nursing facility/other nursing fa)	2, 455, 650	70
.00 Adjusted general inpatient routine servic	e cost per diem (lir				566.60	
.00 Program routine service cost (line 9 x li			no 2E)		1, 959, 869	
.00 Medically necessary private room cost app .00 Total Program general inpatient routine s	0	•	ne 30)		0 1, 959, 869	
.00 Capital-related cost allocated to inpatie	•		orksheet B,	Part II, column	0	
26, line 45) .00 Per diem capital-related costs (line 75 ÷	line 2)				0.00	76
.00 Program capital-related costs (line 9 x l					0.00	
.00 Inpatient routine service cost (line 74 m	· · · · · · · · · · · · · · · · · · ·				0	78
.00 Aggregate charges to beneficiaries for ex					0	
.00 Total Program routine service costs for c .00 Inpatient routine service cost per diem	•	st limitation	(IINE /8 mi	nus line /9)	0.00	
.00 Inpatient routine service cost per drem r					0.00	
.00 Reasonable inpatient routine service cost	s (see instructions))			1, 959, 869	83
.00 Program inpatient ancillary services (see		- >			992, 828	
.00 Utilization review - physician compensati .00 Total Program inpatient operating costs (0 2, 952, 697	
PART IV - COMPUTATION OF OBSERVATION BED I						1
. 00 Total observation bed days (see instruction					0	
.00 Adjusted general inpatient routine cost p	or diem (line 27 ≟ l	ine 2)			0.00	1 88

Health Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTF	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0115	Period: From 07/01/2020	Worksheet D-1	
		Component	CCN: 15-5305	To 06/30/2021	Date/Time Prep 11/30/2021 2:4	oared: 40 pm
		Title	e XVIII	Skilled Nursing	PPS	
	1	_		Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	C	0	0.0000	0 0	0	90.00
91.00 Nursing School cost	C	0	0.0000	0 0	0	91.00
92.00 Allied health cost	C	0	0.0000	0 0	0	92.00
93.00 All other Medical Education	C	0	0.00000	0 00	0	93.00

				-		0.011	 	-
MEMORI AL	HOSP	&	HEAL	_TH	CARE	CTR		

In Lieu of Form CMS-2552-10

	Financial Systems MEMORIAL HOSP & HE		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115	Peri od:	Worksheet D-1	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	nared
			10 00,00,2021	11/30/2021 2:4	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1 00	
	PART I – ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		11, 297	1.00
2.00	Inpatient days (including private room days, excluding swing	bed and newborn days)		11, 297	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line.			0.454	
1.00	Semi-private room days (excluding swing-bed and observation b		an 21 of the east	8, 651	4.00 5.00
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	Som days) through becemb	er si of the cost	0	5. UC
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)			-	
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.00
	reporting period				
3.00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line)	to the Drogram (avaludin	a owing had and	1/1	9.00
<i>.</i> 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the program (excluding	y swing-bed and	161	9.00
0.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room davs)	0	10.00
	through December 31 of the cost reporting period (see instruc		j-)	-	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva	te room days)	0	12.00
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including priva	to room dave)	0	13.00
3.00	after December 31 of the cost reporting period (if calendary)			0	13.00
4.00	Medically necessary private room days applicable to the Progr			0	14. OC
5.00	Total nursery days (title V or XIX only)		5 /	1, 378	15.00
6.00	Nursery days (title V or XIX only)			64	16.00
	SWING BED ADJUSTMENT		.		
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17.00
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	cos after December 21 of	the cost	0.00	18.00
8.00	reporting period	ces al tel December 31 01	the cost	0.00	10.00
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.00
	reporting period	5			
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period	`		40.450.440	01 00
21.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting pariod (line	10, 459, 469 0	21.00 22.00
.2.00	5 x line 17)	bei 31 01 the cost repor	ting period (inte	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)			0	25 00
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 459, 469	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TTHE 28)		0. 000000 0. 00	31.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	34.00
	Average per diem private room cost differential (line 34 x li		-	0.00	35. OC
35.00	Private room cost differential adjustment (line 3 x line 35)			0	36. OC
36.00		and private room cost d	ifferential (line	10, 459, 469	37.00
	General inpatient routine service cost net of swing-bed cost	and private room cost u			
36.00	27 minus line 36)				
36.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	•	·		
36.00 37.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS		Q25 86	38 00
36. 00 37. 00 38. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see	JUSTMENTS e instructions)		925. 86 149. 063	
36.00 37.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS e instructions) e 38)		925. 86 149, 063 0	38. 00 39. 00 40. 00

JIVIPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	1
					To 06/30/2021	Date/Time Pre	
			Title	e XIX	Hospi tal	11/30/2021 2: Cost	40 p
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Costl	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	1, 125, 670	1, 378	816.8			42
	Intensive Care Type Inpatient Hospital U						
. 00	INTENSIVE CARE UNIT	5, 143, 544	4, 094	1, 256. 3	6 84	105, 534	43
. 00	CORONARY CARE UNIT						44
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						40
. 00	Cost Center Description						
						1.00	
. 00	Program inpatient ancillary service cost			``````````````````````````````````````		491, 526	
. 00	Total Program inpatient costs (sum of li PASS THROUGH COST ADJUSTMENTS	nes 41 through 48)(s	see instruction	15)		798, 404	49
. 00	Pass through costs applicable to Program	inpatient routine s	services (from	Wkst D sum	of Parts L and	C	50
)		(····			_	
. 00	Pass through costs applicable to Program	inpatient ancillary	y services (fro	om Wkst. D, s	um of Parts II	C) 51
. 00	and IV) Total Program excludable cost (sum of li	nes 50 and 51				c c	52
3. 00 3. 00	Total Program inpatient operating cost e		ated non-phys	sician anesth	etist and		
	medical education costs (line 49 minus l		atoa, non phy		otrot, and		
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	Program discharges					C	
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient op	erating cost and tar	rget amount (Li	ne 56 minus	line 53)		
. 00	Bonus payment (see instructions)	or atting cost and tar	got anount (n				
. 00	Lesser of lines 53/54 or 55 from the cos	t reporting period e	ending 1996, u	odated and co	mpounded by the	0.00	59
~~	market basket						
0. 00 . 00	Lesser of lines 53/54 or 55 from prior y If line 53/54 is less than the lower of				the amount by	0.00	
. 00	which operating costs (line 53) are less						
	amount (line 56), otherwise enter zero (the target		
2.00	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive PROGRAM INPATIENT ROUTINE SWING BED COST		ctions)			C) 63
. 00	Medicare swing-bed SNF inpatient routine		mber 31 of the	cost reporti	na period (See	C	64
	instructions)(title XVIII only)	oboto thi dugn booon		ooot roporti	ng por loa (ooo		
. 00	Medicare swing-bed SNF inpatient routine	costs after Decembe	er 31 of the co	ost reporting	period (See	C) 65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient r	outino costs (lino 4	4 plus lips 4	=) (+; + ~ V)/		c c	
o. 00	CAH (see instructions)	outine costs (inne d	54 prus rine os		i oniy). For		66
. 00	Title V or XIX swing-bed NF inpatient ro	utine costs through	December 31 of	f the cost re	porting period	c c	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient ro	utine costs after De	ecember 31 of	the cost repo	rting period	C	68
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpati	ent routine costs (1	ine 67 + line	68)		C) 69
. 00	PART III - SKILLED NURSING FACILITY, OTH						1 01
. 00	Skilled nursing facility/other nursing f	acility/ICF/IID rout	tine service co	ost (line 37)			70
. 00	Adjusted general inpatient routine servi		ne 70 ÷ line 2	2)			71
. 00	Program routine service cost (line 9 x l		(line 14 v li)	25)			72
. 00 . 00	Medically necessary private room cost ap Total Program general inpatient routine		•	10 30)			73
. 00	Capital -related cost allocated to inpati	•		orksheet B, P	art II, column		75
	26, line 45)			-			
. 00	Per diem capital -related costs (line 75	-					76
. 00 . 00	Program capital-related costs (line 9 x Inpatient routine service cost (line 74						77
00	Aggregate charges to beneficiaries for e	,	rovi den ineconde	5)			79
00	Total Program routine service costs for	• •		· · ·	us line 79)		80
00	Inpatient routine service cost per diem	•			· ·		81
00	Inpatient routine service cost limitatio	• • • • • •					82
. 00	Reasonable inpatient routine service cos		5)				83
. 00 . 00	Program inpatient ancillary services (se Utilization review - physician compensat)				84
. 00	Total Program inpatient operating costs						86
	PART IV - COMPUTATION OF OBSERVATION BED	•	g			1	
. 00	Total observation bed days (see instruct	i ons)				2, 646	
8.00	Adjusted general inpatient routine cost Observation bed cost (line 87 x line 88)		line 2)			925.86	
00						2, 449, 826	

Health Financial Systems ME	MEMORIAL HOSP & HEALTH CARE CTR					In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1				
				To 06/30/2021	Date/Time Prepared: 11/30/2021 2:40 pm				
		Title XIX		Hospi tal	Cost				
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on				
		(from line 21)	column 2	Observati on	Bed Pass				
				Bed Cost (from	Through Cost				
				line 89)	(col. 3 x col.				
					4) (see				
					instructions)				
	1.00	2.00	3.00	4.00	5.00				
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST								
90.00 Capital-related cost	921, 563	10, 459, 469	0. 08810	8 2, 449, 826	215, 849	90.00			
91.00 Nursing School cost	0	10, 459, 469	0.00000	2, 449, 826	0	91.00			
92.00 Allied health cost	0	10, 459, 469	0.00000	2, 449, 826	0	92.00			
93.00 All other Medical Education	0	10, 459, 469	0.00000			93.00			

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre 11/30/2021 2:4	par	
		Title XIX	Subprovider - IPF	Cost		
Cost Center Description						
	PART I - ALL PROVIDER COMPONENTS				-	
00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		2, 266	1 1	
00 00	D Inpatient days (including private room days, excluding swing-bed and newborn days)				2	
00	do not complete this line.	3). If you have only pr	rvate room days,	0		
00 Semi-private room days (excluding swing-bed and observation bed days) 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost					4	
reporting period 70 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost					6	
00	reporting period (if calendar year, enter 0 on this line)					
reporting period 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost					1	
reporting period (if calendar year, enter 0 on this line)						
00	newborn days) (see instructions)					
	00 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)					
	00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)				11	
	0 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	
. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)				13	
	Medically necessary private room days applicable to the Progra	m (excluding swing-bed	days)	0		
00 Total nursery days (title V or XIX only) 00 Nursery days (title V or XIX only)				1, 378 64	16	
SWING BED ADJUSTMENT 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost				0.00	17	
reporting period 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost				0.00	18	
reporting period 0.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				0.00	19	
reporting period 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost				0.00	20	
. 00	reporting period 00 Total general inpatient routine service cost (see instructions)					
	00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)				21 22	
00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)				0	23	
00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line					24	
. 00	5 11 51 1				25	
	x line 20) 00 Total swing-bed cost (see instructions)				26	
. 00	00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0		
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)		0			
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0. 000000		
) Average private room per diem charge (line 29 + line 3)			0.00		
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00		
	Average per diem private room cost differential (line 34 x lin			0.00	35	
00 Private room cost differential adjustment (line 3 x line 35) 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line				0 2, 803, 693		
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			_, 500, 070		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS				
	Adjusted general inpatient routine service cost per diem (see			1, 237. 29	38	
2.00 Program general inpatient routine service cost (line 9 x line 38)			880, 950			
0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			0			
	Total Program general inpatient routine service cost (line 39			880, 950	1 4.	

OMPUT	Financial Systems ME ATION OF INPATIENT OPERATING COST	MORIAL HOSP & H		CN: 15-0115	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-S115	From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Ti tl	e XIX	Subprovider -	11/30/2021 2: Cost	40 p
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Cost		col . 2)		(col. 3 x col. 4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00) 42.
	Intensive Care Type Inpatient Hospital Units	~		1 -		-	
	INTENSIVE CARE UNIT	0	C	0.0	0 00	0 0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
	SURGICAL INTENSIVE CARE UNIT						40
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wks					C	
	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(see instructio	ons)		880, 950) 49
	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	v services (fr	rom Wkst. D. s	sum of Parts II	0	51
	and IV)			/ `			
2.00 3.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non-nby	sician anest	netist and		
	medical education costs (line 49 minus line §		natea, non-phy				1 33
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, i	updated and co	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	rost report un	dated by the r	market hasket		0.00	0 60
	If line 53/54 is less than the lower of lines				the amount by		
	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			C) 63
	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	cost reporting	n period (See	0) 65
	instructions) (title XVIII only)						
o. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line 6	55)(title XVII	l only). For	C	66
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost re	eporting period	c	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68
9.00	(line 13 x line 20)	autina aasta (line (7 . line		0.1		
	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					C) 69
0. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service o	cost (line 37))		70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line 7 Medically processary private room cost applied	,	(lino 14 y li	po 25)			72
	Medically necessary private room cost applica Total Program general inpatient routine servi						73
	Capital -related cost allocated to inpatient i	•			Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
	Program capital-related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minus		novi d				78
	Aggregate charges to beneficiaries for excess				aus line 70)		79
	Total Program routine service costs for compa Inpatient routine service cost per diem limit				IUS ITTE /9)		80
	Inpatient routine service cost per drem rimi)				82
	Reasonable inpatient routine service costs (s						83
. 00	Program inpatient ancillary services (see ins	structions)					84
	Utilization review - physician compensation						85
	Total Program inpatient operating costs (sum		rough 85)				86
	<u>PART IV - COMPUTATION OF OBSERVATION BED PASS</u> Total observation bed days (see instructions)					c	87
	Adjusted general inpatient routine cost per o		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	•					89

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
		Component (To 06/30/2021	Date/Time Prep 11/30/2021 2:4	pared: 40 pm
		Ti tl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	325, 765	2, 803, 693	0. 11619	1 0	0	90.00
91.00 Nursing School cost	0	2, 803, 693	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 803, 693	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 803, 693	0.00000	0 0	0	93.00

		Component CCN: 15-T115 Title XIX	From 07/01/2020 To 06/30/2021 Subprovi der -	Date/Time Prep 11/30/2021 2:4 Cost	
	Cost Center Description		I RF	1.00	
	PART I - ALL PROVIDER COMPONENTS				
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs excluding newborn)		1, 097	1.0
. 00 . 00 . 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d do not complete this line.	-bed and newborn days)	ivate room days,	1, 097 0	2. (
. 00 . 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	1, 097 0	4. 5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.
. 00	Total swing-bed NF type inpatient days (including private roreporting period	om days) through December	31 of the cost	0	7.
. 00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)			0	
. 00 0. 00	Total inpatient days including private room days applicable newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	0 0	Ū į	0	
1.00	through December 31 of the cost reporting period (see instrusion Swing-bed SNF type inpatient days applicable to title XVIII σ	ctions) only (including private r	5 ,		11.
2.00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period		e room days)	0	12.
3. 00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13.
5.00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)			0 1, 378	15.
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0.00	16.
	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				
	Medicare rate for swing-bed SNF services applicable to servi- reporting period Medicaid rate for swing-bed NF services applicable to servic			0. 00 0. 00	
	reporting period Medicaid rate for swing-bed NF services applicable to service	5		0.00	20
1.00 2.00	reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ing period (line	1, 399, 696 0	
3.00	Swing-bed cost applicable to SNF type services after Decembe	·		0	
4.00	x line 18) Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 1, 399, 696	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	ed and observation bed ch	arges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	30.
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 \div line 4)			0.00	
	Average per diem private room charge differential (line 32 m $$		tions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		fferential (line	0 1, 399, 696	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
3. 00	Adjusted general inpatient routine service cost per diem (se			1, 275. 93	38
00 0	Program general inpatient routine service cost (line 9 x lin	e 38)		0	39
9.00	5 5 1				

COMPUT	Financial Systems ME ATION OF INPATIENT OPERATING COST	MORIAL HOSP & H		CN: 15-0115	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T115	From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Titl	e XIX	Subprovider -	11/30/2021 2: Cost	40 p
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
	NURSERY (title V & XIX only)	0	C	0.	00 00	C) 42.
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.	00 00		43.
1.00	CORONARY CARE UNI T						44
	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46
. 00	Cost Center Description			<u>I</u>			
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1.00 C) 48
. 00	Total Program inpatient costs (sum of lines 4			ons)		C	
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	m of Parts I and	C	50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	v services (fr	om Wkst D	sum of Parts II	c c	51
	and IV)		J 301 VI CO3 (11	om most. D _i :	Sam of rarts II		
2.00 3.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non nh	cician anosti	notist and		
	medical education costs (line 49 minus line §		rateu, non-phy		istist, dilu		1 33
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					c	54
	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					C	
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	C	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1006 i	undated and co	ompounded by the	0.00	
. 00	market basket	bor tring period	ending 1990, t		shipounded by the	0.00	
0. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	narket basket		0.00	60 60
I. 00	If line 53/54 is less than the lower of lines					C) 61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	f the target		
2.00	Relief payment (see instructions)	11311 4011 0113)				c	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			C	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reporti	na period (See	c	64
	instructions)(title XVIII only)	0			0.1		04
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	g period (See	C) 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVI	ll only). For	C	66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost re	eporting period) 67
	(line 12 x line 19)	0					
3. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	C	68
	Total title V or XIX swing-bed NF inpatient i					с с	69
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70
	Adjusted general inpatient routine service co	2					71
	Program routine service cost (line 9 x line 7	,					72
	Medically necessary private room cost applica						73
-	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			Part II, column		74
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
	Program capital -related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minus						78
	Aggregate charges to beneficiaries for excess						79
	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost limitation	ı (IIne 78 mii	nus line 79)		80
	Inpatient routine service cost per drem finite Inpatient routine service cost limitation (li)				81
	Reasonable inpatient routine service costs (s		* .				83
	Program inpatient ancillary services (see ins		_				84
	Utilization review - physician compensation						85
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86
	Total observation bed days (see instructions)					C	87
3. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			0.00	88 0
. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				[C) 89

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
		Component (To 06/30/2021		pared: 40 pm
		Ti tl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	168, 786	1, 399, 696	0. 12058	8 0	0	90.00
91.00 Nursing School cost	0	1, 399, 696	0.00000	0 0	0	91.00
92.00 Allied health cost	0	1, 399, 696	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 399, 696	0. 00000	0 0	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre 11/30/2021 2:4	pare
		Title XIX	Skilled Nursing Facility	Cost	40 p
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		L.		
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		4, 334	1 1.
. 00 . 00 . 00	Inpatient days (including private room days, excluding swing be Private room days (excluding swing-bed and observation bed day do not complete this line.	ed and newborn days)	ivate room days,	4, 334 4, 334 0	2. 3.
. 00 . 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	4, 334 0	4. 5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7.
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8.
00	Total inpatient days including private room days applicable to newborn days) (see instructions)	0 1 0	Ū	100	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on	i ons)	5,	0	
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX	ter 0 on this line)	3 /		12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	<i>y</i>	3,	0	
. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ar, enter O on this lin m (excluding swing-bed	e) days)	0	14
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 378 64	15 16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	s through December 31 o	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	2, 455, 650 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 2, 455, 650	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and obconvetion had			1 20
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	anu uuservation bed Ch	ai yes)	0	
. 00	Semi-private room charges (excluding swing bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
. 00	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00	34
	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nd private room cost di	fferential (line	2, 455, 650	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU:	STMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see				38
	Program general inpatient routine service cost (line 9 x line				39
	Medically necessary private room cost applicable to the Progra				40
00					1

MPUTATION OF INPATIENT OPERATING COST		ALTH CARE CTR Provider CO		Period:	Worksheet D-1	2552
		Component (CCN: 15-5305	From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Titl	e XIX	Skilled Nursing	11/30/2021 2: Cost	40 p
Cost Costor Description	Tatal			Facility		
Cost Center Description	Total Inpatient CostIn	Total npatient Days	col. 2)	÷	Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	12
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	ts					42.
. OO INTENSIVE CARE UNIT						43.
. OO CORONARY CARE UNIT 5. OO BURN INTENSIVE CARE UNIT						44.
0. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (1.00	48.
0.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(se	e instructio	ns)			49
0. 00 Pass through costs applicable to Program i	npatient routine se	ervices (from	Wkst. D, su	m of Parts I and		50
.00 Pass through costs applicable to Program i and IV)	npatient ancillary	services (fr	om wkst. D,	sum or Parts II		51
.00 Total Program excludable cost (sum of line	,					52
c. 00 Total Program inpatient operating cost exc medical education costs (line 49 minus line)		ated, non-phy	sician anest	hetist, and		53
TARGET AMOUNT AND LIMIT COMPUTATION	ie 52)					
. 00 Program di scharges						54
5.00 Target amount per discharge 5.00 Target amount (line 54 x line 55)						55
7.00 Difference between adjusted inpatient oper	rating cost and targ	get amount (I	ine 56 minus	line 53)		57
8.00 Bonus payment (see instructions)	0			,		58
.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period er	nding 1996, u	pdated and c	ompounded by the		59
0.00 Lesser of lines 53/54 or 55 from prior year	ar cost report, upda	ated by the m	arket basket			60
.00 If line 53/54 is less than the lower of li						61
which operating costs (line 53) are less t amount (line 56), otherwise enter zero (se		(TINES 54 X	60), or 1% o	r the target		
. 00 Relief payment (see instructions)	,					62
Allowable Inpatient cost plus incentive pa	ayment (see instruct	tions)				63
PROGRAM INPATIENT ROUTINE SWING BED COST .00 Medicare swing-bed SNF inpatient routine c	costs through Decemb	per 31 of the	cost report	ing period (See		64
instructions)(title XVIII only)						
6.00 Medicare swing-bed SNF inpatient routine of instructions) (title XVIII only)	costs after December	- 31 of the c	ost reportin	g period (See		65
0. 00 Total Medicare swing-bed SNF inpatient rou	utine costs (line 64	1 plus line 6	5)(title XVI	II only). For		66
CAH (see instructions) COO Title V or XIX swing-bed NF inpatient rout	ting costs through [locombor 21 o	f the cost r	oporting poriod		67
(line 12 x line 19)	time costs through t	becember 31 0	i the cost i	eportring perrou		
00 Title V or XIX swing-bed NF inpatient rout	tine costs after Dec	cember 31 of	the cost rep	orting period		68
(line 13 x line 20) 0.00 Total title V or XIX swing-bed NF inpatier	nt routine costs (li	ne 67 + line	68)			69
PART III - SKILLED NURSING FACILITY, OTHER					1	
0.00 Skilled nursing facility/other nursing fac)	2, 455, 650	
.00 Adjusted general inpatient routine service 2.00 Program routine service cost (line 9 x lin		ie /U ÷ line	∠)		566.60 56,660	
0.00 Medically necessary private room cost appl		(line 14 x li	ne 35)		0	73
. 00 Total Program general inpatient routine se			orkchost D	Dort II column	56, 660	
 Conductory Conductory Conductor	n routine service o	COSTS (TROM W	ULKSNEET B,	Part II, COLUMN	197, 957	75
0.00 Per diem capital-related costs (line 75 ÷					45.68	
7.00 Program capital-related costs (line 9 x li 8.00 Inpatient routine service cost (line 74 mi	· · · · · · · · · · · · · · · · · · ·				4, 568 52, 092	
0.00 Aggregate charges to beneficiaries for exc		ovider record	s)		0	
0.00 Total Program routine service costs for co	omparison to the cos			nus line 79)	52, 092	80
.00 Inpatient routine service cost per diem li					0.00	
 00 Inpatient routine service cost limitation 00 Reasonable inpatient routine service costs 	• • •)			0 4, 568	
. 00 Program inpatient ancillary services (see					0	
0.00 Utilization review - physician compensation					0	
D. 00 <u>Total Program inpatient operating costs</u> (s PART IV - COMPUTATION OF OBSERVATION BED F		bugn 85)			4, 568	86
						-
. 00 Total observation bed days (see instruction	ons)				0	87

Health Financial Systems ME	EMORIAL HOSP &	HEALTH CARE	CTR	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi de	r CCN: 15-0115	Period: From 07/01/2020	Worksheet D-1	
		Compone	nt CCN: 15-5305	To 06/30/2021	Date/Time Pre 11/30/2021 2:	pared: 40 pm
		-	itle XIX	Skilled Nursing Facility	Cost	
Cost Center Description	Cost	Routine Co (from line 2.00		 Total Observation Bed Cost (from 	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	1				
90.00 Capital-related cost 91.00 Nursing School cost	0		0 0.000		0	90.00 91.00
92.00 Allied health cost 93.00 All other Medical Education			0 0.000 0 0.000	000 0	0	92.00 93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-0115	Peri od:	Worksheet D-3	2552
			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	pare
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	<u> </u>
		1.00	2.00	3.00	-
		1	4 415 01/	1	1 20
00 03000 ADULTS & PEDIATRICS			4, 415, 216		30
00 03100 I NTENSI VE CARE UNI T			3, 798, 496		31
00 04000 SUBPROVIDER - IPF			0		40
00 04100 SUBPROVIDER - IRF			0		41
					43
ANCI LLARY SERVICE COST CENTERS 00 05000 OPERATI NG ROOM		0. 26354	44 4, 495, 668	1, 184, 806	50
00 05200 DELIVERY ROOM & LABOR ROOM		1. 1809		1, 184, 806 0	52
00 05300 ANESTHESI OLOGY		0. 64489			
00 05400 RADI OLOGY - DI AGNOSTI C		0.08728			
00 05600 RADI 0L0G1-DI AGNOSTI C		0.0872		14, 886	
00 06000 LABORATORY		0. 16875			
00 06500 RESPIRATORY THERAPY		0. 42384			
00 06600 PHYSI CAL THERAPY 00 06900 ELECTROCARDI OLOGY		0. 32149		437, 690 1, 000, 854	
01 06901 PULMONARY		0. 10398		1,000,854	
02 06902 CARDI OPULMONARY		0. 2958		96	
03 06902 CARDI OPOLIMONART		0. 3123		90	
00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				-	1
		0. 1955			
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.3914			
00 07300 DRUGS CHARGED TO PATIENTS		0. 21170			
00 07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS		0.0000	0 00	0	74
00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88
01 08801 RURAL HEALTH CLINIC II		0.00000		0	
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
00 09000 CLINIC		0. 26048		-	
01 09001 I MED		0. 20040		12,001	
02 09002 0NC0L0GY		0. 28210		13, 260	
03 09003 0UTPATI ENT CENTER		0. 28210		13,200	
04 09004 HBURG URGENT CARE CLINIC		0. 5706		-	
05 09005 DI ABETES MGMT CLINIC		1.03376		0	
00 09100 EMERGENCY		0. 16054			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 42674			
OTHER REIMBURSABLE COST CENTERS		0.42074	-5 507, 370	130,773	1 72
00 09500 AMBULANCE SERVICES					95
00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	0	0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)		0.0000	45, 060, 644		
Less PBP Clinic Laboratory Services-Program only charges (line 61)		10,000,044	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	200
2.00 Net charges (line 200 minus line 201)			45, 060, 644		201

Health Financial Systems		OSP & HEALTH CARE CT Provider C	CN: 15-0115	Peri od:	u of Form CMS-: Worksheet D-3	
			CCN: 15-S115	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	pared
		Title	e XVIII	Subprovider - IPF	PPS	•
Cost Center	Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	SERVICE COST CENTERS		1			
30.00 03000 ADULTS & PED						30.0
31. 00 03100 I NTENSI VE CA 40. 00 04000 SUBPROVI DER				1 222 100		31.0
40.00 04000 SUBPROVIDER 41.00 04100 SUBPROVIDER				1, 323, 100		40.0
43.00 04300 NURSERY						41.0
ANCI LLARY SERVI CE	COST CENTERS					43.0
50. 00 05000 OPERATING RO			0. 26354	14 0	0	50. C
52. 00 05200 DELIVERY ROO			1. 18099		0	
53. 00 05300 ANESTHESI OLO			0. 64489		0	
54.00 05400 RADI OLOGY-DI			0.08728		10, 177	
56. 00 05600 RADI 0I SOTOPE			0.08674		0	
60. 00 06000 LABORATORY			0. 16875		41, 491	60.0
65. 00 06500 RESPI RATORY	THERAPY		0. 42384	468	198	65.0
56. 00 06600 PHYSI CAL THE	RAPY		0. 32149	97 20, 786	6, 683	66.0
59. 00 06900 ELECTROCARDI	DLOGY		0. 16398	37 25, 089	4, 114	
69.01 06901 PULMONARY			0.0000		0	
59. 02 06902 CARDI OPULMON	ARY		0. 2958		0	
59.03 06903 SLEEP LAB			0. 31235		0	
70.00 07000 ELECTROENCEP			0.00000		0	
	LIES CHARGED TO PATIENTS		0. 19555		72	
72.00 07200 I MPL. DEV. C 73.00 07300 DRUGS CHARGE			0.39144		0	
73.00 07300 DRUGS CHARGE 74.00 07400 RENAL DIALYS			0. 21170		62, 437 0	
OUTPATIENT SERVICE			0.00000	0	0	74.0
88. 00 08800 RURAL HEALTH			0.0000	00	0	88. 0
38. 01 08801 RURAL HEALTH			0.0000		0	
39.00 08900 FEDERALLY QU	ALIFIED HEALTH CENTER		0.00000	00	0	89.
20. 00 09000 CLINIC			0. 26048	35 0	0	90.
0. 01 09001 I MED			0.0000	0 0	0	90.
0. 02 09002 0NC0L0GY			0. 28210		45	
90. 03 09003 OUTPATI ENT C			0.0000		0	
0. 04 09004 HBURG URGENT			0. 57067		0	
0. 05 09005 DI ABETES MGM	F CLINIC		1.03376		0	
91.00 09100 EMERGENCY			0. 16054		36, 688	
	BEDS (NON-DI STI NCT PART)		0. 42674	43 0	0	92. (
OTHER REIMBURSABLE 95.00 09500 AMBULANCE SE			1			95.0
95.00 09500 AMBULANCE SE 96.00 09600 DURABLE MEDI			0.00000	0 0	0	
	f lines 50 through 94 and 96 through	h 98)	0.00000	932, 785	161, 905	
	nic Laboratory Services-Program only			932, 785	101, 903	200.0
	(line 200 minus line 201)	, sharges (inite 01)	1	932, 785		201.0

NPATIENT ANCILLARY SERVICE COST APPORTI	ONMENT	Provider C	CN: 15-0115	Period:	Worksheet D-3	;
			CCN: 15-T115	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	parec
		Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description			Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CE	NTERS		1			
0. 00 03000 ADULTS & PEDIATRICS						30.
1. 00 03100 I NTENSI VE CARE UNI T 0. 00 04000 SUBPROVI DER – I PF						31.0
0. 00 04000 SUBPROVIDER - IPF 1. 00 04100 SUBPROVIDER - IRF				(AE 01(40.
3.00 04300 NURSERY				645, 216		41.
ANCI LLARY SERVICE COST CENTERS						43.1
0. 00 05000 OPERATING ROOM			0. 26354	14 0	0	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM			1. 18099		0	
3. 00 05300 ANESTHESI OLOGY			0. 64489		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 08728		1, 361	
6. 00 05600 RADI OI SOTOPE			0. 08674		0	
0. 00 06000 LABORATORY			0. 16875		5, 749	
5. 00 06500 RESPI RATORY THERAPY			0. 42384		241	
6. 00 06600 PHYSI CAL THERAPY			0. 32149		214, 292	
9. 00 06900 ELECTROCARDI OLOGY			0. 16398		500	
9. 01 06901 PULMONARY			0.00000		0	
9. 02 06902 CARDI OPULMONARY			0. 29587		0	
9. 03 06903 SLEEP LAB			0. 31235		0	
0. 00 07000 ELECTROENCEPHALOGRAPHY			0.0000		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO	PATI ENTS		0. 19555	52 1, 369	268	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIE			0. 39144		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS			0. 21170		26, 800	73.
4. 00 07400 RENAL DIALYSIS			0.00000		0	74.
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC			0.00000		0	
8.01 08801 RURAL HEALTH CLINIC II			0.00000		0	
9.00 08900 FEDERALLY QUALIFIED HEALTH	ENTER		0.00000		0	
0. 00 09000 CLINIC			0. 26048		0	
0. 01 09001 I MED			0.0000		0	1
0. 02 09002 ONCOLOGY			0. 28210		0	
0. 03 09003 OUTPATI ENT CENTER			0.0000		0	
0. 04 09004 HBURG URGENT CARE CLINIC			0. 57067		0	
0. 05 09005 DIABETES MGMT CLINIC			1.03376		0	
1.00 09100 EMERGENCY			0. 16054		209	
2.00 09200 OBSERVATI ON BEDS (NON-DI STI I	ICT PART)		0. 42674	43 0	0	92.
5.00 09500 AMBULANCE SERVICES			1			95.
6. 00 09600 DURABLE MEDICAL EQUIP-RENTEI			0. 00000	0 0	0	
00.00 Total (sum of lines 50 throu			0.0000	849,076	249, 420	
01.00 Less PBP Clinic Laboratory		aos (line 41)		849, 0/6	249, 420	200.
UI. UU LESS POP UTITIL LADUTATORY 3	CINCES-FIUGIANI UNIV CNAL		1	0		1201.

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTI Provider C	CN: 15-0115	Peri od:	u of Form CMS-: Worksheet D-3	
		CCN: 15-5305	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	pared
	Title	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS					30.0
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF					31.0
40. 00 04000 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF					40.0
43. 00 04300 NURSERY					41.0
ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00 05000 OPERATI NG ROOM		0. 2635	44 0	0	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 1809		0	
53. 00 05300 ANESTHESI OLOGY		0. 6448		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0872		3, 068	
56. 00 05600 RADI 0I SOTOPE		0. 0867	48 0	0	56.0
60. 00 06000 LABORATORY		0. 1687	59 420, 316	70, 932	60.0
65. 00 06500 RESPI RATORY THERAPY		0. 4238		1, 905	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 3214		555, 690	
69. 00 06900 ELECTROCARDI OLOGY		0. 1639		7, 037	
69. 01 06901 PULMONARY		0.0000		0	
59. 02 06902 CARDI OPULMONARY		0. 2958		0	
		0. 3123		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1955		4, 338 0	
73.00 07200 TMPL. DEV. CHARGED TO PATIENTS		0. 3914		349, 858	
74. 00 07400 RENAL DIALYSIS		0.0000			
OUTPATIENT SERVICE COST CENTERS		0.0000	0	0	1 / 4. (
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 0
38.01 08801 RURAL HEALTH CLINIC II		0.0000	00	0	88. 0
39. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER		0.0000	00	0	89. (
20. 00 09000 CLINIC		0. 2604	85 0	0	90.
20. 01 09001 I MED		0.0000		0	1
20. 02 09002 0NCOLOGY		0. 28210		0	
PO. 03 09003 OUTPATIENT CENTER		0.0000		0	
20. 04 09004 HBURG URGENT CARE CLINIC		0. 5706		0	
20. 05 09005 DIABETES MGMT CLINIC		1.0337		0	
91.00 09100 EMERGENCY		0. 1605		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 4267	43 0	0	92. (
95. 00 09500 AMBULANCE SERVICES		1			95.0
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	0 0	0	
200.00 Total (sum of lines 50 through 94 and	1 96 through 98)	0.0000	3, 906, 057	992, 828	
201.00 Less PBP Clinic Laboratory Services-P		1	0		201.0
202.00 Net charges (line 200 minus line 201)			3, 906, 057		202.0

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE C			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONN		CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Pre 11/30/2021 2:	pared:
	Tit	tle XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	st Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS				
30. 00 03000 ADULTS & PEDIATRICS			465, 355		30.00
31.00 03100 INTENSIVE CARE UNIT			232, 124		31.00
40. 00 04000 SUBPROVI DER – I PF			200, 678		40.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
43. 00 04300 NURSERY			111, 450		43.00
ANCI LLARY SERVI CE COST CENTERS			- T		
50.00 05000 OPERATI NG ROOM		0. 2635		40, 005	
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 1809		0	
53.00 05300 ANESTHESI OLOGY		0. 6448		64, 844	•
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.0872		23, 433	
56. 00 05600 RADI OI SOTOPE		0. 0867		958	•
60. 00 06000 LABORATORY		0. 1687	59 322, 912	54, 494	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 4238		21, 853	
66. 00 06600 PHYSI CAL THERAPY		0. 3214	97 51, 673	16, 613	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1639	87 184, 450	30, 247	69.00
69. 01 06901 PULMONARY		0.0000	00 0	0	69.01
69. 02 06902 CARDI OPULMONARY		0. 2958	73 0	0	69.02
69. 03 06903 SLEEP LAB		0. 3123	52 0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENTS	0. 1955	52 26, 437	5, 170	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3914	48 55, 094	21, 566	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2117	08 774, 319	163, 930	73.00
74.00 07400 RENAL DIALYSIS		0.0000	00 0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0. 8383	10 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		1.0198	64 0	0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENT	ER	0.0000	00 0	0	89.00
90. 00 09000 CLINIC		0. 2604	85 1, 196	312	90.00
90. 01 09001 I MED		0.0000	00 0	0	90.01
90. 02 09002 ONCOLOGY		0. 2821	06 6, 664	1, 880	90.02
90. 03 09003 OUTPATI ENT CENTER		0.0000	00 0	0	90.03
90.04 09004 HBURG URGENT CARE CLINIC		0. 5706	71 322	184	90.04
90.05 09005 DIABETES MGMT CLINIC		1.0337	67 0	0	90.05
91.00 09100 EMERGENCY		0. 1605	40 282, 572	45, 364	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)	0. 4267	43 1, 578	673	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	96.00
200.00 Total (sum of lines 50 through	94 and 96 through 98)		2, 290, 650	491, 526	200.00
	ices-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus lir			2, 290, 650		202.00

NPATI E	Financial Systems MEMORIAL HOSP & HEALT NT ANCILLARY SERVICE COST APPORTIONMENT F		CN: 15-0115	Peri od:	u of Form CMS-2 Worksheet D-3	
			CCN: 15-S115	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	pared
		Ti tl	e XIX	Subprovider - IPF	Cost	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1			
	03000 ADULTS & PEDI ATRI CS					30.
	03100 I NTENSI VE CARE UNI T					31.
	04000 SUBPROVIDER - IPF			200, 950		40.
	04100 SUBPROVIDER - IRF					41.
						43.
	ANCI LLARY SERVI CE COST CENTERS		0. 2635	44 0	0	50.
	D5200 DELIVERY ROOM & LABOR ROOM		1. 1809		0	
	05300 ANESTHESI OLOGY		0. 6448		0	
	05400 RADI OLOGY-DI AGNOSTI C		0.0448		0	
	D5600 RADI OLOGI - DI AGNOSTI C		0.0872		0	
	D6000 LABORATORY		0. 1687		0	60
	D6500 RESPIRATORY THERAPY		0. 4238		0	65
	D6600 PHYSI CAL THERAPY		0. 4238		0	
	D6900 ELECTROCARDI OLOGY		0. 1639		0	69
	D6901 PULMONARY		0.0000		0	
	06902 CARDI OPULMONARY		0. 2958		0	
	D6903 SLEEP LAB		0. 3123		0	
	D7000 ELECTROENCEPHALOGRAPHY		0.0000		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1955		0	
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3914		0	
	D7300 DRUGS CHARGED TO PATIENTS		0. 2117		0	
	07400 RENAL DI ALYSI S		0.0000		0	
	DUTPATIENT SERVICE COST CENTERS		0.0000			1
	D8800 RURAL HEALTH CLINIC		0. 8383	10 0	0	88
	08801 RURAL HEALTH CLINIC II		1.0198		0	
9.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000		0	89
0.00	09000 CLINIC		0. 2604	85 0	0	90
0. 01 0	09001 I MED		0.0000	00 0	0	90
	D9002 ONCOLOGY		0. 2821		0	90
0. 03 0	09003 OUTPATIENT CENTER		0.0000	00 0	0	90
0. 04 0	09004 HBURG URGENT CARE CLINIC		0. 5706	71 0	0	90
0. 05 0	D9005 DIABETES MGMT CLINIC		1.0337	67 0	0	90
1.00 0	D9100 EMERGENCY		0. 1605	40 0	0	91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4267	43 0	0	92
	OTHER REIMBURSABLE COST CENTERS			1		
	09500 AMBULANCE SERVI CES					95
6.00 0	09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	96
00.00	Total (sum of lines 50 through 94 and 96 through 98)			0	0	200
01.00	Less PBP Clinic Laboratory Services-Program only charges ((line 61)		0		201
02.00	Net charges (line 200 minus line 201)		1	0		202

	Financial Systems MEMORIAL HOSP & HEALTH ATION OF REIMBURSEMENT SETTLEMENT Pr	rovi der CCN: 15-0115	Peri od: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	11/30/2021 2: PPS	40 pm
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (see	0 3, 869, 203	
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	on or after October	1 (see	12, 074, 986	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	di scharges occurri ng	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	di scharges occurri ng	on or after	0	1.04
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00
2.01	Outlier payment for discharges for Model 4 BPCI (see instruction	s)		0	2.01
2.03	Outlier payments for discharges occurring prior to October 1 (se	-		14, 805	
2.04	Outlier payments for discharges occurring on or after October 1	(see instructions)		14, 299	
3.00	Managed Care Simulated Payments			3, 421, 916	
4.00	Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment	ng period (see instru	ictions)	88.45	4.00
5.00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)	ecent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	criteria for an add-c	on to the cap for	0.00	6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified und ACA \S 5503 reduction amount to the IME cap as specified under 42			0.00 0.00	7.00 7.01
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(0.00	8.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	from a closed teachi	ng hospi tal	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (see	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current	year from your recor	ds	0.00	•
11.00 12.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00	•
13.00	Total allowable FTE count for the prior year.			0.00	
14.00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	otember 30, 1997,	0.00	•
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			9.35	•
17.00	Adjustment for residents displaced by program or hospital closur	e			17.00
18.00 19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			9. 35 0. 105709	
20.00	Prior year resident to bed ratio (see instructions)			0. 105704	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 105614	
22.00	IME payment adjustment (see instructions)			893, 273	22.00
22. 01	IME payment adjustment - Managed Care (see instructions)	C 11 1014		191, 713	22.01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 o Number of additional allopathic and osteopathic IME FTE resident		FR 412.105	0.00	23.00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the low instructions)	er of line 23 or line	e 24 (see	0.00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			893, 273 191, 713	
30. 00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruc	tions)	2.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)		/	17.64	1
32.00	Sum of Lines 30 and 31			19.97	32.00
33.00	Allowable disproportionate share percentage (see instructions)				33.00
	Disproportionate share adjustment (see instructions)			228, 400	1 34 00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Pre 11/30/2021 2:4	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncomponsated Care Adjustment		1.00	2.00	
5.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		8 350 599 096	8, 290, 014, 521	35.0
	Factor 3 (see instructions)		0. 000149452	0. 000159904	
	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se			
	instructions)				
	Pro rata share of the hospital uncompensated care payment amo		313, 707	991, 480	
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di		1, 305, 187		36. (
D. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6		0		40. (
0.00	instructions)		0		101
			Before 1/1	On/After 1/1	
			1.00	1.01	
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0	0	41. (
1. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-	-DRGs 652, 682 683 684	0	0	41.0
	an 685. (see instructions)	002, 000, 004		Ū	
	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	82, 683, 684 an 685. (see	0		43.
4.00	instructions) Ratio of average length of stay to one week (line 43 divided	by Line 41 divided by 7	0. 000000		44.
4.00	days)	by The 41 divided by 7	0.00000		44.
5.00	Average weekly cost for dialysis treatments (see instructions	s)	0.00	0.00	45.
	Total additional payment (line 45 times line 44 times line 41	1.01)	0		46.
	Subtotal (see instructions)		18, 400, 153		47.
8.00	Hospital specific payments (to be completed by SCH and MDH, s only. (see instructions)	small rural hospitals	0		48.
				Amount	
				1.00	
	Total payment for inpatient operating costs (see instructions			18, 591, 866	
	Payment for inpatient program capital (from Wkst. L, Pt. I ar			1, 296, 968	
	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li			0 237, 349	51. 52.
	Nursing and Allied Health Managed Care payment	The 49 see That detrons).		237, 349	53.
	Special add-on payments for new technologies			104, 244	
4.01	Islet isolation add-on payment			0	54.
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	69)		0	55.
	Cost of physicians' services in a teaching hospital (see intr			0	56.
7.00	Routine service other pass through costs (from Wkst. D, Pt. I	III, column 9, lines 30 t	hrough 35).	0	57.
3.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58.
9.00	Total (sum of amounts on lines 49 through 58)			20, 230, 427	
0. 00	Primary payer payments			9, 420	
1.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		20, 221, 007	
	Deductibles billed to program beneficiaries			2, 021, 324	
3.00	Coinsurance billed to program beneficiaries			1,855	
	Allowable bad debts (see instructions)			40, 710	
	Adjusted reimbursable bad debts (see instructions)	tructions)		26, 462	65. 66
5.00	Allowable bad debts for dual eligible beneficiaries (see inst			23, 751	66. 67
5.00 5.00	Subtotal (line 61 plus line 65 minus lines 62 and 62)		ee instructions)	18, 224, 290 0	67. 68.
5.00 5.00 7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	annlicable to MS_DDCc (c	co macruons)		69.
5.00 5.00 7.00 8.00	Credits received from manufacturers for replaced devices for		s)	0	
5.00 5.00 7.00 8.00 9.00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).		s)	0	
5.00 5.00 7.00 8.00 9.00 9.00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(For SCH see instruction			70. 70.
5.00 5.00 7.00 8.00 9.00 9.00 9.00 9.50	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction		0	70. 70.
5.00 6.00 7.00 8.00 9.00 9.00 0.00 0.50 0.87	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	(For SCH see instruction		0 0	70. 70. 70.
5. 00 5. 00 7. 00 3. 00 9. 00 9. 00 9. 00 9. 00 9. 87 9. 88	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	(For SCH see instruction		0 0 0	70. 70. 70. 70.
5. 00 5. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 80 9. 87 9. 88 9. 89 9. 90	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	(For SCH see instruction		0 0 0	70. 70. 70. 70. 70. 70.
5. 00 5. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 87 9. 88 9. 89 9. 90 9. 90 9. 91	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (\$410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	(For SCH see instruction		0 0 0 0 0	70. 70. 70. 70. 70. 70. 70.
5. 00 6. 00 7. 00 3. 00 9. 00 0. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	(For SCH see instruction		0 0 0 0 0 0 0 0	70. 70. 70. 70. 70. 70. 70. 70.
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (\$410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	(For SCH see instruction		0 0 0 0 0	70. 70. 70. 70. 70. 70. 70. 70.

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN Title 2		Period: From 07/01/2020 To 06/30/2021 Hospital	Worksheet E Part A Date/Time Prep 11/30/2021 2:4 PPS	
		in the A		(yyyy)	Amount	
		-		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter	in column 0		2020	44,080	70.9
70. 97	the corresponding federal year for the period prior to 10/1, Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a) in column O		2021	180, 126	
70.98 70.99 71.00 71.01 71.02 71.03	Low Volume Payment-3 HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments	s 69 & 70)			0 154, 058 18, 333, 707 0 0 16, 933, 946	70.9 71.0 71.0 71.0 71.0
	Interim payments-PARHM				10, 933, 940	72.0
	Tentative settlement (for contractor use only)				0	
73. 01 74. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.	.02, 72, and			1, 399, 761	73.0
74. 01 75. 00	73) Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accord CMS Pub. 15-2, chapter 1, §115.2	dance with			0	74.0 75.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sur plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2	m of 2.03			0	90. 0
	Operating outlier reconciliation adjustment amount (see ins	tructions)			0	
	Capital outlier reconciliation adjustment amount (see instru				0	93.0
	The rate used to calculate the time value of money (see ins:	· · · ·			0.00	
	Time value of money for operating expenses (see instructions				0	95.0
	Time value of money for capital related expenses (see instru				0	
·				Prior to 10/1	On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			C	0	100. 0
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)	`		0.000000000		
	HVBP adjustment amount for HSP bonus payment (see instruction	ons)		C	<u> </u>	102. 0
	HRR Adjustment for HSP Bonus Payment					
				0.0000	0 0000	
103.00	HRR adjustment factor (see instructions)	>		0.0000		
103.00 104.00	HRR adjustment amount for HSP bonus payment (see instruction			0.0000 C		
103.00 104.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons	stration) Adjust			0 0	104. 0
103.00 104.00 200.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.	stration) Adjust			0 0	104. 0
103.00 104.00 200.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	stration) Adjust period under the			0	104. 0 200. 0
103.00 104.00 200.00 201.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Li	stration) Adjust period under the				104. 0 200. 0 201. 0
103.00 104.00 200.00 201.00 202.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions)	stration) Adjust period under the				104. 0 200. 0 201. 0 202. 0
103.00 104.00 200.00 201.00 202.00 203.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period)	stration) Adjust period under the ine 49)	e 21st	C		104. 0 200. 0 201. 0 202. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount	stration) Adjust period under the ine 49)	e 21st	C	o o	104. 0 200. 0 201. 0 202. 0 203. 0 204. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 204.00 205.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	stration) Adjust period under the ine 49) in first year of	e 21st	C	o o	104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
03.00 04.00 200.00 201.00 202.00 203.00 203.00 204.00 205.00 206.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	stration) Adjust period under the ine 49) in first year of	e 21st	C	o o	104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
03.00 04.00 200.00 201.00 202.00 203.00 203.00 205.00 206.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement	stration) Adjust period under the ine 49) in first year of 5)	e 21st	C	0 0 trati on	104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
03.00 04.00 200.00 201.00 202.00 203.00 203.00 205.00 206.00 207.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	stration) Adjust period under the ine 49) in first year of 5) structions)	e 21st	C	o o	104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0
03.00 04.00 200.00 201.00 202.00 203.00 205.00 206.00 206.00 207.00 208.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. 7	stration) Adjust period under the ine 49) in first year of 5) structions)	e 21st	C	o o	104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 205. 0 206. 0 206. 0 207. 0 208. 0
03.00 04.00 200.00 201.00 202.00 203.00 205.00 205.00 206.00 207.00 207.00 208.00 209.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. / Adjustment to Medicare IPPS payments (see instructions)	stration) Adjust period under the ine 49) in first year of 5) structions)	e 21st	C	D O	104. 0 200. 0 201. 0 202. 0 203. 0 205. 0 206. 0 206. 0 207. 0 208. 0 209. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 206.00 207.00 208.00 207.00 208.00 209.00 210.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. / Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	stration) Adjust period under the ine 49) in first year of 5) structions) A, line 59)	e 21st	C	o o	104.0 200.0 201.0 202.0 203.0 204.0 205.0 206.0 207.0 208.0 207.0 208.0 209.0 210.0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 206.00 207.00 208.00 209.00 209.00 210.00 211.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. / Adjustment to Medicare IPPS payments (see instructions)	stration) Adjust period under the ine 49) in first year of 5) structions) A, line 59)	e 21st	C	o o	104. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 205.00 206.00 207.00 208.00 209.00 210.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. / Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions Comparision of PPS versus Cost Reimbursement	stration) Adjust period under the ine 49) in first year of 5) structions) A, line 59) s)	e 21st	C	o o	104. 0 200. 0 202. 0 203. 0 203. 0 205. 0 206. 0 207. 0 208. 0 209. 0 209. 0 210. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 205.00 205.00 206.00 207.00 208.00 209.00 211.00 211.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. / Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (see instructions Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	stration) Adjust period under the ine 49) in first year of 5) structions) A, line 59) s)	e 21st	C	o o	104.0 200.0 202.0 203.0 204.0 205.0 206.0 207.0 208.0 209.0 210.0 211.0 211.0
03.00 04.00 100.00 101.00 102.00 103.00 104.00 105.00 106.00 107.00 108.00 109.00 110.00 111.00 122.00 13.00	HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. / Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	stration) Adjust period under the ine 49) in first year of 5) structions) A, line 59) s) e 211)	e 21st	C	o o	104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 207. 0 207. 0 207. 0 207. 0 207. 0 201. 0

	Financial Systems LUME CALCULATION EXHIBIT 4	ME	MORIAL HOSP & H	HEALTH CARE CTR Provider CC		eriod:	u of Form CMS-2 Worksheet E	
					FI Te	rom 07/01/2020 06/30/2021	Part A Exhibi Date/Time Pre 11/30/2021 2:4	pared
		W/S E, Part A	Amounts (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line 0	<u>E, Part A)</u> 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier		0		0	4.00	0	1. (
01	payments DRG amounts other than outlier payments for discharges	1.01	3, 869, 203	0	3, 869, 203		3, 869, 203	1. (
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	12, 074, 986	О		12, 074, 986	12, 074, 986	1. (
	occurring on or after October 1							
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1.
04	DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1	1.04	0	0		Ο	0	1.
00	Outlier payments for	2.00						2.
01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2.
02	Outlier payments for discharges occurring prior to	2.03	14, 805	0	14, 805		14, 805	2.
03	October 1 (see instructions) Outlier payments for discharges occurring on or	2.04	14, 299	0		14, 299	14, 299	2.
	after October 1 (see instructions)							
00	Operating outlier	2. 01	0	0	0	0	0	3.
00	reconciliation Managed care simulated payments	3.00	3, 421, 916	0	927, 392	2, 494, 524	3, 421, 916	4
0	Indirect Medical Education Adju		0 105/14	0 105/14	0 105/14	0 105/14		
00	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 105614 893, 273		0. 105614 216, 772	0. 105614 676, 501	893, 273	5
)1	instructions) IME payment adjustment for managed care (see	22. 01	191, 713	О	51, 957	139, 756	191, 713	6
	instructions)	interest for the	Add on for Co	ation 422 of th	o MMA			
0	Indirect Medical Education Adju IME payment adjustment factor (see instructions)	27.00	0. 000000		<u>e mma</u> 0. 000000	0. 000000		7
00	IME adjustment (see instructions)	28.00	0	0	0	0	0	
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	893, 273		216, 772	676, 501	893, 273	
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	191, 713	0	51, 957	139, 756	191, 713	9
~~	Disproportionate Share Adjustme		0.0570	0.0570	0.0572	0.0572		1 10
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0573	0. 0573	0. 0573	0. 0573		10
00	Disproportionate share adjustment (see instructions)	34.00	228, 400		55, 426	172, 974	228, 400	
01	Uncompensated care payments Additional payment for high per	36.00 centage of ESF	1, 305, 187 D beneficiary		313, 707	991, 480	1, 305, 187	1 ''
00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0		12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	18, 400, 153 0	0 0	4, 469, 913 0	13, 930, 240 0	18, 400, 153 0	13
00	(see instructions) Total payment for inpatient operating costs (see	49.00	18, 591, 866	О	4, 521, 870	14, 069, 996	18, 591, 866	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 296, 968	О	326, 908	970, 060	1, 296, 968	16

	Financial Systems	IVIE	WORTAL HUJF & I	Provider CC		Period:	eu of Form CMS-2 Worksheet E	2002-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC		From 07/01/2020 To 06/30/2021		pared:
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	104, 244	0		0 104, 244	104, 244	
17.01	Net organ aquisition cost							17.0
17.02	Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.02
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation adjustment amount (see	93.00	0	0		0 0	0	18.00
19.00	instructions) SUBTOTAL			0	4, 848, 77	8 15, 144, 300	19, 993, 078	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1, 203, 478	0	303, 34	3 900, 135	1, 203, 478	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0		0 0	0	20. 0 ⁻
21.00	Capital DRG outlier payments	2.00	1, 785	0	45	0 1, 335	1, 785	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 0 [.]
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0762	0. 0762	0.076	2 0. 0762		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	91, 705	0	23, 11	5 68, 590	91, 705	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0 0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 296, 968	0	326, 90	8 970, 060	1, 296, 968	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment	70. 96			0. 00909 44, 08		44, 080	27.00 28.00
	(transfer amount to Wkst. E, Pt. A, line)							
29.00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				180, 126	180, 126	29.0
	Pt. A, line)							100 -
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

	Financial Systems ME TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period:	Worksheet E	+ 5
					From 07/01/2020 To 06/30/2021	Part A Exhibi Date/Time Pre 11/30/2021 2:	pared
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00					1.
01	DRG amounts other than outlier payments for discharges occurring prior to October 1 DRG amounts other than outlier payments for	1.01	3, 869, 203	3, 869, 20		3, 869, 203	
02 03	discharges occurring on or after October 1 DRG for Federal specific operating payment	1.02 1.03	12, 074, 986 0		12, 074, 986	12, 074, 986 0	
55	for Model 4 BPCI occurring prior to October	1.05	0		0	0	'
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1
00	Outlier payments for discharges (see instructions)	2.00					2
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0		
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	14, 805	14,80		14, 805	
03 00	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04 2.01	14, 299		14, 299	14, 299	
00	Operating outlier reconciliation Managed care simulated payments Indirect Medical Education Adjustment	3.00	3, 421, 916		0 0 0 3, 421, 916	-	
00	Amount from Worksheet E, Part A, Line 21 (see instructions)	21.00	0. 105614	0. 10561	4 0. 105614		5
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	893, 273 191, 713	216, 77	2 676, 501 0 191, 713	893, 273 191, 713	
	instructions)						
00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0 0.00000		7
00	IME adjustment (see instructions)	28.00	0		0 0	0	8
01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	
00	Total IME payment (sum of lines 6 and 8)	29.00	893, 273	216, 77		893, 273	
D1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	191, 713		0 191, 713	191, 713	9
00	Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions)	33.00	0. 0573	0. 057	3 0. 0573		10
. 00	Disproportionate share adjustment (see instructions)	34.00	228, 400	55, 42	.6 172, 974	228, 400	11
. 01	Uncompensated care payments	36.00	1, 305, 187	313, 70	991, 480	1, 305, 187	11
. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46. 00	o o		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	18, 400, 153 0	4, 469, 91	3 13, 930, 240 0 0	18, 400, 153 0	
00	instructions) Total payment for inpatient operating costs	49.00	18, 591, 866	4, 469, 91	3 14, 121, 953	18, 591, 866	15
00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 296, 968	326, 90	970, 060	1, 296, 968	16
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	104, 244		0 104, 244	104, 244	17
. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18
00	SUBTOTAL			4, 796, 82	1 15, 196, 257	19, 993, 078	110

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 07/01/2020 To 06/30/2021		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	1, 203, 478	303, 34	3 900, 135	1, 203, 478	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	1, 785	45	i0 1, 335	1, 785	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0762	0. 076	0. 0762		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	91, 705	23, 11	5 68, 590	91, 705	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	1, 296, 968	326, 90	970, 060	1, 296, 968	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4,00	
27.00	0	1.00	2.00	5.00	4.00	27.00
28.00 Low volume adjustment prior to October 1	70, 96	44,080	44, 08	10	44, 080	
29.00 Low volume adjustment on or after October 1	70.97	180, 126		180, 126		
30.00 HVBP payment adjustment (see instructions)	70, 93	39, 269			39, 269	
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	,,	0 0	0	
31.00 HRR adjustment (see instructions)	70. 94	0		0 0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 154, 058	154, 058	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

	Financial Systems MEMORIAL HOSP & HE			eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020		
			To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		Title XVIII	Hospi tal	PPS	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			40.050	1
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru	ucti ons)		12, 259 26, 778, 674	•
3.00	OPPS payments	,		28, 836, 877	
4.00	Outlier payment (see instructions)			17, 239	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	
6.00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
10.00	Organ acqui si ti ons	10, 601. 13, 1116 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			12, 259	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			57, 932	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			57, 932	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable f			0	
17 00	had such payment been made in accordance with 42 CFR §413.13	s(e)		0.000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	•
19.00	Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds l	ine 11) (see	45, 673	
20,00	instructions)		· 10) (00.00
20.00	Excess of reasonable cost over customary charges (complete o instructions)	only if line if exceeds i	The 18) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)			12, 259	21.00
	Interns and residents (see instructions)			0	
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 28, 854, 116	23.00 24.00
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			20,001,110	1 2 1. 00
	Deductibles and coinsurance amounts (for CAH, see instructio	-		0	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on li Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•		5, 028, 308 23, 838, 067	
27.00	instructions)			23, 030, 007	27.00
	Direct graduate medical education payments (from Wkst. E-4,			303, 071	
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29)))		0 24, 141, 138	
	Primary payer payments			16, 665	
32.00	Subtotal (line 30 minus line 31)			24, 124, 473	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV Composite rate ESRD (from Wkst. I-5, line 11)	TCES)		0	33.00
	Allowable bad debts (see instructions)			368, 088	1
	Adjusted reimbursable bad debts (see instructions)			239, 257	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	structions)		332, 788 24, 363, 730	
37.00	MSP-LCC reconciliation amount from PS&R			24, 303, 730	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instructio				39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl		ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			24, 360, 599	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	
40. 02 40. 03	Sequestration adjustment-PARHM pass-throughs				40.02
41.00	Interim payments			24, 242, 279	41.00
41.01	Interim payments-PARHM				41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00
43.00	Balance due provider/program (see instructions)			118, 320	43.00
43.01	Balance due provider/program-PARHM (see instructions)			-	43.01
44.00	Protested amounts (nonallowable cost report items) in accord §115.2	ance with CMS Pub. 15-2,	cnapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR			·	1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91.00 92.00
7Z. UU	Time Value of Money (see instructions)			0.00	•
93.00	The value of money (see this full for s)			0	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020	Worksheet E Part B	
		Component CCN: 15-S115	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		0 0	
00	OPPS payments	· · · · · · · · · · · · · · · · · · ·		0	3
00 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4
00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
00	Line 2 times line 5			0	
00 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00 0	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9
0. 00 . 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	10
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			0	1''
	Reasonabl e charges				
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
. 00	Total reasonable charges (sum of lines 12 and 13)	The obj		0	
00	Customary charges	normant for convision on	a abarra basi a	0	1 10
. 00 . 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	15
	had such payment been made in accordance with 42 CFR §413.13(5		
7.00 8.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	
. 00	Excess of customary charges over reasonable cost (complete or	nlyifline 18 exceeds li	ne 11) (see	0	
). 00	instructions) Excess of reasonable cost over customary charges (complete or	alvifling 11 ovcoods li	no 19) (coo	0	20
. 00	instructions)	If y IT THE IT exceeds IT	The To) (See	0	
. 00	Lesser of cost or charges (see instructions)			0	
2.00 3.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		0	22
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	20)		0	
5.00 5.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lir	-	uctions)	0	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	0	27
3. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28
00.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29
. 00	Subtotal (sum of lines 27 through 29)			0	30
. 00 2. 00	Primary payer payments Subtotal (line 30 minus line 31)			0	31
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
8.00 .00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
. 00	Adjusted reimbursable bad debts (see instructions)			0	35
. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			0	37
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	าร)			39
97 9. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	aced devices (see instruc	tions)	0	39
. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39
. 00	Subtotal (see instructions)			0	40
). 01). 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40
0.02	Sequestration adjustment-PARHM pass-throughs			0	40
. 00	Interim payments			0	
. 01 . 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41
. 01	Tentative settlement-PARHM (for contractor use only)				42
3.00 2.01	Balance due provider/program (see instructions)			0	43
8. 01 4. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	43
	TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount (see instructions)			0	
. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
3.00	Time Value of Money (see instructions)			0.00	
. 00	Total (sum of lines 91 and 93)			0	94

ALCUL	Financial Systems MEMORIAL HOSP & HEA	ALTH CARE CTR Provi der CCN: 15-0115	Period: From 07/01/2020	u of Form CMS-: Worksheet E Part B	
		Component CCN: 15-T115	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			149	1.
00 00	Medical and other services reimbursed under OPPS (see instruct	ctions)		35 105	
00	OPPS payments Outlier payment (see instructions)			0	3
01	Outlier reconciliation amount (see instructions)			0	4
00 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0. 000 0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 lino 200		0	
0.00	Organ acqui si ti ons	TV, COL. 13, TTHE 200		0	
I. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			149	11
	Reasonable charges				
2.00	Ancillary service charges				12.
3.00 1.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	ine 69)		0 703	
	Customary charges				
5.00 5.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
. 00	had such payment been made in accordance with 42 CFR §413.13(1 5	on a chargebasi s		
7.00 3.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 703	
9.00 9.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds li	ne 11) (see	554	
	instructions)	- ly if line 11 evenede li	no 10) (coo	0	20
). 00	Excess of reasonable cost over customary charges (complete or instructions)	if y ff ffne ff exceeds ff	ne 18) (see	0	20
. 00	Lesser of cost or charges (see instructions)			149	
2.00 3.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
1.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			105	
5. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction			0	25
5.00	Deductibles and Coinsurance amounts (for CAR, see Instruction Deductibles and Coinsurance amounts relating to amount on lir	-	ructions)	0	26
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	254	27
3. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
). 00 I. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			254 0	30
2.00	Subtotal (line 30 minus line 31)			254	
3. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		0	1 22
4. 00	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0	
. 00	Adjusted reimbursable bad debts (see instructions)			0	
5.00 7.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	tructions)		0 254	
3. 00	MSP-LCC reconciliation amount from PS&R			0	38
9.00 9.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructior	ne)		0	39
9.97	Demonstration payment adjustment amount before sequestration	13)		0	
9. 98	Partial or full credits received from manufacturers for repla	aced devices (see instruc	ctions)	0	39
9.99).00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 254	
0. 01	Sequestration adjustment (see instructions)			0	40
). 02). 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40
. 00	Interim payments			253	
. 01	Interim payments-PARHM			^	41
2.00 2.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42
8.00	Balance due provider/program (see instructions)			1	43
3.01 1.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15.2	chapter 1	0	43 44
. 00	§115. 2	ande with owbitub. 19-2,		0	**
). 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90
. 00	Outlier reconciliation adjustment amount (see instructions)			0	
2.00	The rate used to calculate the Time Value of Money			0.00	
3.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93 94

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2020 To 06/30/2021	Date/Time Prep 11/30/2021 2:4	
		Title		Hospi tal	PPS	
		I npati ent	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		16, 853, 4	46	24, 211, 979	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/17/2021	80, 5		30, 300	3.01
3.02 3.03				0	0	3. 02 3. 03
3.03				0	0	3.04
3.05				0	0	3.05
	Provider to Program	11			-	
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.5
3.53				0	0	3.53
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		80, 5	-	30, 300	3.54 3.99
3. 77	3, 50-3, 98)		80, 5	00	30, 300	3. 7
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16, 933, 9	46	24, 242, 279	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5. O´
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program	,			-	
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.92 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
6.00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 399, 7	61	118, 320	6.0
6.02	SETTLEMENT TO PROGRAM			0	0	6.0
7.00	Total Medicare program liability (see instructions)		18, 333, 7		24, 360, 599	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0115 CCN: 15-S115	Period: From 07/01/20 To 06/30/20		epared
		Title	e XVIII	Subprovi der I PF		10 pi
		Inpatien	it Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy		
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		797, 3	76 0	0	
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	
04 05				0	0	
05	Provider to Program			0		/ 3.
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	
53				0	0	
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0 0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		797, 3	76	0	4.
	TO BE COMPLETED BY CONTRACTOR		1			÷
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider		1			
01 02	TENTATI VE TO PROVI DER			0	0	
)2)3				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		47,4	99	0	
02	SETTLEMENT TO PROGRAM		044.0	0	0	
00	Total Medicare program liability (see instructions)		844, 8	75 Contractor		7.
				Number	(Mo/Day/Yr)	
		(C	1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0115 CCN: 15-T115	Period: From 07/01/2020 To 06/30/2021		
		Ti tl e	e XVIII	Subprovider -	PPS	
		Inpatien	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		931, 9	59 0	253 0	1.00 2.00
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
. 02				0	0	3. 02
. 03				0	0	3.03
. 04 . 05				0	0	3.04 3.05
05	Provider to Program			0	0	3.0
50	ADJUSTMENTS TO PROGRAM		1	0	0	3.5
51				0	0	3.5
52				0	0	3.52
53				0	0	3.5
54				0	0	3.54
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.99
00	3.50-3.98)		931, 9	FO	253	4.00
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		931, 9	59	200	4. 00
	TO BE COMPLETED BY CONTRACTOR					
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider		1	-		
. 01 . 02	TENTATI VE TO PROVI DER			0	0	5.01 5.02
02				0	0	5.02
. 05	Provider to Program		1	0	0	5.00
50	TENTATI VE TO PROGRAM			0	0	5.50
. 51				0	0	5.5
52				0	0	5.52
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.99
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
. 01	SETTLEMENT TO PROVIDER			0	1	6.01
. 02	SETTLEMENT TO PROGRAM		9, 1		0	6. 02
. 00	Total Medicare program liability (see instructions)		922, 8		254	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(0	1.00	2.00	
. 00	Name of Contractor		-		2.00	8. (

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Control	CN: 15-0115 CCN: 15-5305	Peri From To	od: 1 07/01/2020 06/30/2021	Worksheet E-1 Part I Date/Time Pre	pared:
		Title	XVIII		led Nursing Facility	11/30/2021 2: PPS	40 pm
		I npati en	t Part A		Par	t B	
		mm/dd/yyyy	Amount	r	mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00 1,635,5	50	3.00	4.00	1.00
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 055, 5	0		0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						3.00
01	ADJUSTMENTS TO PROVIDER			0		0	3.01
02				0		0	
03				0		0	
04 05				0		0	
05	Provider to Program			0		0	3.0
50	ADJUSTMENTS TO PROGRAM			0		0	3.5
51				0		0	
52				0		0	3.5
53				0		0	3.5
54				0		0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3.9
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		1, 635, 5	59		0	4.0
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.0
	Program to Provider		1				-
01	TENTATI VE TO PROVI DER			0		0	
02 03				0 0		0	
55	Provider to Program			0		0	1 5.0
50	TENTATI VE TO PROGRAM			0		0	5.5
51				0		0	5.5
52				0		0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5.9
00	Determined net settlement amount (balance due) based on the cost report. (1)						6. C
01	SETTLEMENT TO PROVIDER		2, 4	52		0	
02	SETTLEMENT TO PROGRAM			0		0	
00	Total Medicare program liability (see instructions)		1, 638, 0		2	0	7.0
				(Contractor Number	NPR Date (Mo/Day/Yr)	
		()		1.00	2.00	

Heal th	Financial Systems MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0115	Peri od:	Worksheet E-	1
			From 07/01/2020		
			To 06/30/2021	Date/Time Pro 11/30/2021 2:	
		Title XVIII	Hospi tal	PPS	40 pili
			nospitai	115	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	is)		32.00

LCUL	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020	Worksheet E-3 Part II	
		Component CCN: 15-S115	To 06/30/2021	Date/Time Pre 11/30/2021 2:	pare 40 r
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	edical education payments)		889, 668	
00 00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments			17, 814 0	2
00	Unweighted intern and resident FTE count in the most recent	cost report filed on or b	efore November	0.00	4
	15, 2004. (see instructions)				
01	Cap increases for the unweighted intern and resident FTE couprogram or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth p	eriod of a "new	0.00	
00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0. 51	7
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education adju	ustment (see instructions)		0.51	8
00	Average Daily Census (see instructions)			6. 208219	
00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	o the power of .5150 -1}.		0.041497	10
00				36, 919	
00 00	J J J J J J J J J J			944, 401 0	1:
00	5 5 1 5 1	.1011)		0	14
. 00	5 1 , ,	structions)		0	
00	15 51 1			944, 401	1
00				0	1
	Subtotal (line 16 less line 17).			944, 401	1
. 00				89, 044	19
. 00	Subtotal (line 18 minus line 19)			855, 357	20
00	Coinsurance			21, 062	2
00	Subtotal (line 20 minus line 21)			834, 295	2
00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		16, 277	2
00	3			10, 580	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		12, 088	
00		、		844, 875	
00		5)		0	2
00				0	28
00	1 5			0	30
50	· · ·	ne)		0	3
99				0	3
. 00		•		844, 875	3
01				0	3
. 02				0	31
	Interim payments			797, 376	32
	Tentative settlement (for contractor use only)			0	33
. 00				47, 499	
. 00	§115. 2	lance with CMS Pub. 15-2,	chapter 1,	0	35
. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2			17, 814	50
. 00	0			17, 814	51
. 00				0.00	
	Time Value of Money (see instructions)				53

LOOL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Peri od:	Worksheet E-3	
		Component CCN: 15-T115	From 07/01/2020 To 06/30/2021	Part III Date/Time Prep 11/30/2021 2:4	
		Title XVIII	Subprovider -	PPS	40 pi
		·		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			910, 302	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	`		0.0000	
00	Inpatient Rehabilitation LIP Payments (see instructions)		21, 301 0	3. 4.
. 00	Outlier Payments Unweighted intern and resident FTE count in the most re	cent cost reporting period en	ding on or prior	0.00	4. 5.
	to November 15, 2004 (see instructions)		0 1		
. 01	Cap increases for the unweighted intern and resident FT program or hospital closure, that would not be counted CFR 412.424(d)(1)(iii)(F)(1) or (2) (see instructions	without a temporary cap adjust		0.00	5.
00	New Teaching program adjustment. (see instructions)			0.00	6.
00	Current year's unweighted FTE count of I&R excluding FT	Es in the new program growth p	eriod of a "new	0.00	7.
~~	teaching program" (see instructions)			0.00	
00	Current year's unweighted I&R FTE count for residents w teaching program" (see instructions)	ithin the new program growth p	eriod of a new	0.00	8
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)		0.00	9
. 00	Average Daily Census (see instructions)	<u>,</u>		3.005479	10
. 00	Teaching Adjustment Factor (see instructions)			0.00000	11
. 00	Teaching Adjustment (see instructions)			0	
. 00	Total PPS Payment (see instructions)			931, 603	
. 00	Nursing and Allied Health Managed Care payments (see in	struction)		0	
. 00	Organ acquisition (DO NOT USE THIS LINE)	- !+		0	15
. 00 . 00	Cost of physicians' services in a teaching hospital (se Subtotal (see instructions)	e instructions)		0 931, 603	
. 00	Primary payer payments			931,003	
. 00	Subtotal (line 17 less line 18).			931, 603	
. 00	Deducti bl es			8, 752	
. 00	Subtotal (line 19 minus line 20)			922, 851	21
. 00	Coinsurance			0	22
. 00	Subtotal (line 21 minus line 22)			922, 851	23
. 00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		0	24
. 00	Adjusted reimbursable bad debts (see instructions)			0	
. 00	Allowable bad debts for dual eligible beneficiaries (se	e instructions)		0	26
. 00	Subtotal (sum of lines 23 and 25)			922, 851	27
. 00 . 00	Direct graduate medical education payments (from Wkst. Other pass through costs (see instructions)	E-4, TTHE 49)		0	
. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
. 50	Pioneer ACO demonstration payment adjustment (see instr	uctions)		0	31
. 99	Demonstration payment adjustment amount before sequestr			0	31
. 00	Total amount payable to the provider (see instructions)			922, 851	32
. 01	Sequestration adjustment (see instructions)			0	32
. 02		tion		0	
. 00	Interim payments			931, 959	
. 00	Tentative settlement (for contractor use only)			0	
. 00 . 00	Balance due provider/program (line 32 minus lines 32.01 Protested amounts (nonallowable cost report items) in a		chapter 1,	-9, 108 0	35 36
	§115.2 TO BE COMPLETED BY CONTRACTOR				
). 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			0	50
. 00	Outlier reconciliation adjustment amount (see instructi				
				0.00	

Heal th	Financial Systems MEMORIAL HOSP & HEA	ALTH CARE CTR	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Peri od:	Worksheet E-3	
		0	From 07/01/2020		
		Component CCN: 15-5305	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH			1.00	
	SERVICES	IER HEALTH SERVICES FOR T	IILE AVIII PARI A	A PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			1, 807, 884	1.00
2.00	Routine service other pass through costs			0	2.00
3.00	Ancillary service other pass through costs			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			1, 807, 884	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine c	costs are included in lin	e 1 of W/S E,		5.00
(00	Part B. This line is now shaded.) Deductible			0	(00
6.00 7.00	Coinsurance			-	6.00 7.00
7.00 8.00	Allowable bad debts (see instructions)			169, 614 3, 772	7.00 8.00
8.00 9.00	Reimbursable bad debts for dual eligible beneficiaries (see i	netructione)		3, 772	
9.00 10.00	Adjusted reimbursable bad debts for dual engible beneficialities (see i	listi ucti olis)		2,452	9.00 10.00
11.00	Utilization review			2,452	10.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 1	0 and 11)(soo instructio	nc)	1, 640, 722	12.00
12.00	Inpatient primary payer payments		115)	2, 711	
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 711	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instruction	e)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration	13)		0	14.99
15.00	Subtotal (see instructions			1, 638, 011	
15.01	Sequestration adjustment (see instructions)			0	15.01
15.02	Demonstration payment adjustment amount after sequestration			0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0	15.75
16.00	Interim payments			1, 635, 559	16.00
17.00	Tentative settlement (for contractor use only)			0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.0)2, 15.75, 16, and 17)		2,452	18.00
19.00	Protested amounts (nonallowable cost report items) in accorda §115.2		2, chapter 1,	0	19.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Pre 11/30/2021 2:	pared
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOD TITLES V OD V		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	VICES FOR TITLES V OR A	IN SERVICES		-
00	Inpatient hospital/SNF/NF services		798, 404		1 1. (
00	Medical and other services		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1, 603, 699	2.0
00	Organ acquisition (certified transplant centers only)		0		3. (
00	Subtotal (sum of lines 1, 2 and 3)		798, 404	1, 603, 699	4. (
00	Inpatient primary payer payments		0		5.0
00	Outpatient primary payer payments			0	6. (
00	Subtotal (line 4 less sum of lines 5 and 6)		798, 404	1, 603, 699	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges Routine service charges		0		8.
00	Ancillary service charges		2, 290, 650	7, 767, 570	
0.00	Organ acquisition charges, net of revenue		2, 2, 0, 000	.,	10.
. 00	Incentive from target amount computation		0		11.
. 00	Total reasonable charges (sum of lines 8 through 11)		2, 290, 650	7, 767, 570	12.
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.
~~	basi s				
. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		on U	0	14.
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413. 13(e)	0. 000000	0. 000000	15.
	Total customary charges (see instructions)		2, 290, 650	7, 767, 570	
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	1, 492, 246	6, 163, 871	
	line 4) (see instructions)	,		-,, -	
. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	ne 0	0	18.
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	19.
	Cost of physicians' services in a teaching hospital (see instr		709 404	1 (02 (00	20.
. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		798, 404	1, 603, 699	21.
. 00	Other than outlier payments		0	0	22.
	Outlier payments		0	0	
. 00	Program capital payments		0	-	24.
. 00	Capital exception payments (see instructions)		0		25.
. 00	Routine and Ancillary service other pass through costs		0	0	26.
. 00	Subtotal (sum of lines 22 through 26)		0	0	27.
	Customary charges (title V or XIX PPS covered services only)		0	0	28.
. 00	Titles V or XIX (sum of lines 21 and 27)		798, 404	1, 603, 699	29.
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 20
. 00 . 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0 798, 404	0 1, 603, 699	30. 31.
. 00	Deductiblies		798, 404	1, 003, 099	31.
. 00	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35.
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	798, 404	1, 603, 699	36.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)		-798, 404	-1, 603, 699	
. 00	Subtotal (line 36 ± line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.
. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
. 00	Interim payments		0	0	
. 00	Balance due provider/program (line 40 minus line 41)	as with CMC Dut 15 C	0	0	
. 00	Protested amounts (nonallowable cost report items) in accordan chapter 1, §115.2	ICE WITH UMS PUB 15-2,	0	0	43.

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-011	F	eriod: rom 07/01/2020	Worksheet E-3 Part VII	
		Component CCN: 15-S1		o 06/30/2021	Date/Time Prep 11/30/2021 2:4	
		Title XIX		Subprovider - IPF	Cost	
				Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALT	H SERVICES FOR TITLES V O	RXIX	1 1	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			I		
00	Inpatient hospital/SNF/NF services			880, 950		1
00	Medical and other services				0	
00 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)			880, 950	0	
00	Inpatient primary payer payments			000, 930	0	5
00	Outpatient primary payer payments			0	0	
00	Subtotal (line 4 less sum of lines 5 and 6)			880, 950	Ő	
	COMPUTATION OF LESSER OF COST OR CHARGES					
ľ	Reasonabl e Charges					
00	Routine service charges			0		8
00	Ancillary service charges			0	0	
	Organ acquisition charges, net of revenue			0		10
	Incentive from target amount computation			0		1
	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES			0	0	12
	Amount actually collected from patients liable for paymen	t for services on a charg	P	0	0	1:
	basi s	it for services on a charg	0	0	Ű	
. 00	Amounts that would have been realized from patients liabl	e for payment for service	s on	0	0	14
ſ	a charge basis had such payment been made in accordance w	ith 42 CFR §413.13(e)				
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000	0. 000000	1!
	Total customary charges (see instructions)			0	0	
. 00	Excess of customary charges over reasonable cost (complet	e only if line 16 exceeds		0	0	1
00	line 4) (see instructions)	a anly if line 4 avagada	1100	000 050	0	1
. 00	Excess of reasonable cost over customary charges (complet 16) (see instructions)	e only if the 4 exceeds	rine	880, 950	0	18
. 00	Interns and Residents (see instructions)			0	0	10
	Cost of physicians' services in a teaching hospital (see	instructions)		0	ō	
	Cost of covered services (enter the lesser of line 4 or l	-		0	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only	y be completed for PPS pr	ovi de	rs.		
	Other than outlier payments			0	0	
	Outlier payments			0	0	
	Program capital payments			0		24
	Capital exception payments (see instructions)			0		25
	Routine and Ancillary service other pass through costs			0	0	
	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services on			0	0	
	Titles V or XIX (sum of lines 21 and 27)	(y)		0	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0		2
. 00	Excess of reasonable cost (from line 18)			880, 950	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 a	ind 6)		0	0	
. 00	Deducti bl es			0	0	32
. 00	Coinsurance			0	0	
-	Allowable bad debts (see instructions)			0	0	
-	Utilization review			0	_	3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 3	iz and 33)		0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	
. 00 . 00	Subtotal (line $36 \pm line 37$) Direct graduate medical education payments (from Wkst. E-	4)		0	0	3
.00	Total amount payable to the provider (sum of lines 38 and			0	0	
. 00	Interim payments	,		0	0	
-	Balance due provider/program (line 40 minus line 41)			0	0	
						43

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020	Worksheet E-3 Part VII	
		Component CCN: 15-T115	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		Title XIX	Subprovider - IRF	Cost	
		4	I npati ent	Outpati ent	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR A	IX SERVICES		1
0	Inpatient hospital/SNF/NF services		0		1.
0	Medical and other services		0	0	
0	Organ acquisition (certified transplant centers only)		0		
0	Subtotal (sum of lines 1, 2 and 3)		0	0	
0	Inpatient primary payer payments		0		ĮĮ
0	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
_	Reasonabl e Charges				Ι.
00	Routi ne servi ce charges		0	0	8
00	Ancillary service charges		0	0	
00 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10
00	Total reasonable charges (sum of lines 8 through 11)		0	0	
50	CUSTOMARY CHARGES		V	0	1'
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	1
	basi s	<u> </u>			
00	Amounts that would have been realized from patients liable for	payment for services o	n 0	0	1
	a charge basis had such payment been made in accordance with 4	42 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
00	Total customary charges (see instructions)		0	0	
00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	0	0	1
00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	vifling 4 overade lin		0	1
00	16) (see instructions)	y II IIIle 4 exceeds IIII	e 0	0	
00	Interns and Residents (see instructions)		0	0	1
00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 1	-	0	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi	ders.		1
00	Other than outlier payments		0	0	2
00	Outlier payments		0	0	
00	Program capital payments		0		2
00	Capital exception payments (see instructions)		0	_	2
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	
00 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		0	0	
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	1 2
00	Excess of reasonable cost (from line 18)		0	0	3
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	0	0	
	Deducti bl es		0	0	
00	Coi nsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0		3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
00	Subtotal (line 36 ± line 37)		0	0	
00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0	^	3
00 00			0	0	
00	Interim payments Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2	0	0	
50	chapter 1, §115.2		0	0	1 1

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2020	Worksheet E-3 Part VII	
		Component CCN: 15-5305	To 06/30/2021	Date/Time Pre 11/30/2021 2:	par 40
		Title XIX	Skilled Nursing Facility	Cost	
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SI			2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ERVICES FOR TITLES V OR A	IN SERVICES		1
00	Inpatient hospital/SNF/NF services		4, 568		1 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		4, 568	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		4, 568	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
~~	Reasonabl e Charges				Ι.
00	Routi ne servi ce charges		0	0	8
00 . 00	Ancillary service charges Organ acquisition charges, net of revenue		0	0	10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	
. 00	CUSTOMARY CHARGES				1
. 00	Amount actually collected from patients liable for payment f	or services on a charge	0	0	1:
	basi s	Ũ			
. 00	Amounts that would have been realized from patients liable f	or payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
	Total customary charges (see instructions)		0	0	1
. 00	Excess of customary charges over reasonable cost (complete of	nly if line 16 exceeds	0	0	1
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete o	nlvifling 4 avcads lin	e 4, 568	0	1
. 00	16) (see instructions)	In y 11 1111e 4 exceeds 1111	4, 506	0	
.00	Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line	-	0	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi	ders.		
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		2
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
. 00 . 00	Titles V or XIX (sum of lines 21 and 27)		0	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		V	0	2
. 00	Excess of reasonable cost (from line 18)		4, 568	0	3
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	0	0	
	Deducti bl es	·	0	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	3
. 00	Utilization review		0		3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	nd 33)	0	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)	,	0	-	3
. 00	Total amount payable to the provider (sum of lines 38 and 39))	0	0	
. 00	Interim payments Relance due provider(program (Lipe 40 minus Lipe 41)		Ŭ	0	4
. 00 . 00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accord	ance with CMS Dub 15 2	0	0	
	in orested amounts (nonarrowable cost report ritems) III accord	ande with Gwb Fub 15-2,	0	0	1 4

	nancial Systems MEMORIAL HOSP & HI RADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C		Peri od:	u of Form CMS-2 Worksheet E-4	
	EDUCATI ON COSTS			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:4	pared:
		Title	XVIII	Hospi tal	PPS	40 pili
					1.00	
CO	MPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
	nweighted resident FTE count for allopathic and osteopathic nding on or before December 31, 1996.	c programs for	cost reporti	ng periods	0.00	1.00
2.00 Ur	nweighted FTE resident cap add-on for new programs per 42 (1) (see instr	ructions)	0.00	2.0
	mount of reduction to Direct GME cap under section 422 of M		6412 70 (m)	(000	0.00	3.0
	rect GME cap reduction amount under ACA §5503 in accordance nstructions for cost reporting periods straddling 7/1/2011)		9413.79 (11).	(See	0.00	3.0
1.00 Ac	djustment (plus or minus) to the FTE cap for allopathic and ME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f	d osteopathic	programs due	to a Medicare	0.00	4.0
4.01 AC	CA Section 5503 increase to the Direct GME FTE Cap (see instraddling 7/1/2011)		cost reporti	ng periods	0.00	4.0
1.02 AC	CA Section 5506 number of additional direct GME FTE cap slo eriods straddling 7/1/2011)	ots (see inst	ructions for	cost reporting	0.00	4.0
5.00 FT	TE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 p 02 plus applicable subscripts	olus or minus	line 4 plus l	ines 4.01 and	0.00	5.00
6.00 Ur	weighted resident FTE count for allopathic and osteopathic ecords (see instructions)	c programs for	the current	year from your	0.00	6.00
	nter the lesser of line 5 or line 6				0.00	7.00
			Primary Care		Total	
3.00 We	eighted FTE count for physicians in an allopathic and osted	pathic	1.00	2.00 00 0.00	3.00	8.00
	rogram for the current year.	opatili c	0.0	0.00	0.00	0.0
	fline 6 is less than 5 enter the amount from line 8, other ultiply line 8 times the result of line 5 divided by the an	0.00	9.0			
-	eighted dental and podiatric resident FTE count for the cur	rrent year		0.00		10.0
	nweighted dental and podiatric resident FTE count for the c	current year		0.00		10.0
	otal weighted FTE count otal weighted resident FTE count for the prior cost reporti	ng yoar (soo	0. (0. (11.0 12.0
lir	nstructions)	0,				
ye	otal weighted resident FTE count for the penultimate cost r ear (see instructions)	. 0	0.0			13.0
	olling average FTE count (sum of lines 11 through 13 divide djustment for residents in initial years of new programs	ed by 3).	0. (9. 2			14.0 15.0
	nweighted adjustment for residents in initial years of new	programs	9.2			15.0
	djustment for residents displaced by program or hospital cl		0. (16.0
	weighted adjustment for residents displaced by program or osure	hospi tal	0. (0. 00		16.0
-	djusted rolling average FTE count		9.2	0. 63		17.0
	er resident amount		105, 000. (18.0
19.00 Ap	oproved amount for resident costs		969, 15	66, 150	1, 035, 300	19.0
					1.00	
	dditional unweighted allopathic and osteopathic direct GME ec. $413.79(c)(4)$	FTE resident	cap slots red	eived under 42	0.00	20. 0
	rect GME FTE unweighted resident count over cap (see instr	ructions)			0.00	21.0
	lowable additional direct GME FTE Resident Count (see inst				0.00	
1	nter the locality adjustment national average per resident	amount (see i	nstructions)		0.00	
	ultiply line 22 time line 23 otal direct GME amount (sum of lines 19 and 24)				0 1, 035, 300	24.0 25.0
<u>-0.00 10</u>		npatient Part	Managed Care	e Managed Care	Total	25.0
		A	Prior to 1/	0n or after 1/1		
		1.00	2.00	2.01	3.00	
26.00 Ir	MPUTATION OF PROGRAM PATIENT LOAD patient Days (see instructions) (Title XIX - see S-2	6, 949	1, 72	22 0		26.00
	art IX, line 3.02, column 2) otal Inpatient Days (see instructions)	16, 477	16, 47	77 16, 477		27.0
	atio of inpatient days to total inpatient days	0. 421739				27.0
	rogram direct GME amount	436, 626			544, 824	29.0
	ercent reduction for MA DGME		4.0	07 4.07		29.0
	eduction for direct GME payments for Medicare Advantage		4,40	04 0	4, 404	
31 OO ING	et Program direct GME amount				540, 420	1310

Heal th	Financial Systems MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0115	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 07/01/2020 To 06/30/2021	Date/Time Pre	narod
			10 00/30/2021	11/30/2021 2:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	EDUCATION COSTS)		1 00 11 74		
32.00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	a 23, Tines 74	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	74 and 94)	0	33.00	
34.00	Ratio of direct medical education costs to total charges (line	74 anu 74)	0,000000		
35.00	Medicare outpatient ESRD charges (see instructions)		0.000000	35.00	
36.00	Medicare outpatient ESRD direct medical education costs (line		0	36.00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII				
	Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		21, 168, 831	37.00	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39.00
40.00	Primary payer payments (see instructions)			12, 131	40.00
41.00		s line 40)		21, 156, 700	41.00
	Part B Reasonable Cost			07.004.705	
42.00	Reasonable cost (see instructions)			27, 031, 785	
43.00	Primary payer payments (see instructions)			16, 786	
44.00 45.00	Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44)			27, 014, 999 48, 171, 699	
45.00	Ratio of Part A reasonable cost to total reasonable cost (lin	$a 11 \pm 1$ in $a 15$		48, 171, 899	
40.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 560806	47.00
17.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	,		0.000000	17.00
48.00	Total program GME payment (line 31)			540, 420	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		237, 349	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			303, 071	
			,		

	E SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-0115	Peri od:	Worksheet G	
und-t <u>:</u> nLy)	ype accounting records, complete the General Fund column			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	
-		General Fund	Specific Purpose Fund	Endowment Fund		<u>40 p</u>
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	108, 748, 382		0 0	0	1 1.
00	Temporary investments	74, 327, 955		0 0	0	
00	Notes receivable	0		0 0	0	
	Accounts receivable	21, 101, 195		0 0	0	
	Other receivable	21, 101, 173		0 0	0	
	Allowances for uncollectible notes and accounts receivable			0 0	0	6
	Inventory			0 0	0	
	Prepai d'expenses	0		0 0	0	8
	Other current assets	7, 025, 685		0 0	0	9
	Due from other funds	0		0 0	0	10
	Total current assets (sum of lines 1-10)	211, 203, 217		0 0	0	
	FIXED ASSETS	211,200,21,		<u> </u>	<u> </u>	1
	Land	11, 154, 563		0 0	0	1 12
	Land improvements	0		0 0	0	
	Accumulated depreciation	0		0 0	0	14
	Buildings	121, 605, 691		0 0	0	15
	Accumulated depreciation	-81, 521, 740		0 0	0	16
	Leasehold improvements	30, 809, 760		0 0	0	17
. 00	Accumulated depreciation	0		0 0	0	18
	Fixed equipment	114, 778, 710		0 0	0	19
. 00	Accumulated depreciation	-80, 955, 556		0 0	0	20
. 00	Automobiles and trucks	0		0 0	0	21
. 00	Accumulated depreciation	0		0 0	0	22
. 00	Major movable equipment	0		0 0	0	23
. 00	Accumulated depreciation	0		0 0	0	24
. 00	Minor equipment depreciable	0		0 0	0	25
. 00	Accumulated depreciation	0		0 0	0	26
. 00	HIT designated Assets	0		0 0	0	27
8. 00	Accumulated depreciation	0		0 0	0	28
. 00	Minor equipment-nondepreciable	0		0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	115, 871, 428		0 0	0	30
	OTHER ASSETS					
. 00	Investments	33, 536, 396		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
. 00	Other assets	17, 648, 558		0 0	0	34
5.00	Total other assets (sum of lines 31-34)	51, 184, 954		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	378, 259, 599		0 0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	30, 406, 213		0 0	0	37
	Salaries, wages, and fees payable	33, 271, 879		0 0	0	38
	Payroll taxes payable	0		0 0	0	39
0. 00	Notes and Loans payable (short term)	7, 324, 544		0 0	0	40
. 00	Deferred income	0		0 0	0	41
2.00	Accelerated payments	5, 554, 559				42
. 00	Due to other funds	0		0 0	0	43
1.00	Other current liabilities	2, 862, 118		0 0	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	79, 419, 313		0 0	0	45
	LONG TERM LIABILITIES	-	1			
	Mortgage payable	0		0 0	0	
7.00	Notes payable	67, 575, 000		0 0	0	47
3. 00	Unsecured Loans	0		0 0	0	48
	Other long term liabilities	0		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	67, 575, 000		0 0	0	
	Total liabilities (sum of lines 45 and 50)	146, 994, 313		0 0	0	51
	CAPI TAL ACCOUNTS					
	General fund balance	231, 265, 286				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	231, 265, 286		0 0	0	
	Total liabilities and fund balances (sum of lines 51 and	378, 259, 599	1	0 0	0	60

Heal th	Financial Systems ME	MORIAL HOSP & HE	EALTH CARE CTR		In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0115	Period: From 07/01/2020 To 06/30/2021		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00 206,545,303	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		92, 341, 143				2.00
3.00	Total (sum of line 1 and line 2)		298, 886, 446		C		3.00
4.00 5.00	I DENTIFIED ON TB - FOUNDATION FREESTANDING RHC DEPARTMENTS	-743, 830 -13, 328			0	0	4.00 5.00
6.00	FREESTANDING RHC DEPARTMENTS	-13, 320			0	0	6.00
7.00		0			0	0	7.00
8.00		0			0	0	8.00
9.00		0	757 450		0	0	9.00
10. 00 11. 00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)		-757, 158 298, 129, 288		0		10. 00 11. 00
12.00	HOME OFFICE DEPARTMENTS	66, 864, 002	270, 127, 200		0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00 16.00		0			0	0	15. 00 16. 00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 12–17)	0	66, 864, 002		C	-	18.00
19.00	Fund balance at end of period per balance		231, 265, 286		C		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
			Fidit	T UNU	_		
	F	6.00	7.00	8.00			
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1.00 2.00
2.00	Total (sum of line 1 and line 2)	0			0		2.00
4.00	IDENTIFIED ON TB - FOUNDATION		о		0		4.00
5.00	FREESTANDING RHC DEPARTMENTS		0				5.00
6.00			0				6.00
7.00 8.00			0				7.00 8.00
9.00			0				9.00
10.00	Total additions (sum of line 4–9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00 13.00	HOME OFFICE DEPARTMENTS		0				12.00 13.00
13.00			0				13.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0		18. 00 19. 00
19.00		0			0		19.00
	sheet (line 11 minus line 18)						

	Financial Systems MEMORIAL HOSP & HEA	1			eu of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC		Period: From 07/01/2020 To 06/30/2021		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					
1.00	Hospi tal		21, 018, 9	39	21, 018, 989	1.00
2.00	SUBPROVIDER - IPF		3, 962, 4		3, 962, 465	2.00
3.00	SUBPROVIDER - IRF		1, 405, 2		1, 405, 292	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY		1, 313, 3	02	1, 313, 302	
8.00	NURSING FACILITY					8.00
9.00 10.00	OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9)		27, 700, 0	10	27, 700, 048	9.00 10.00
10.00	Intensive Care Type Inpatient Hospital Services		27,700,0	+0	27, 700, 046	10.00
11.00	INTENSIVE CARE UNIT		9, 347, 4	42	9, 347, 442	11.00
12.00	CORONARY CARE UNI T		,,,,,,,,		,,,,,,,,,	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of 11-15)	lines	9, 347, 4	42	9, 347, 442	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37, 047, 4	90	37, 047, 490	17.00
18.00	Ancillary services		102, 512, 2			18.00
19.00	Outpatient services			0 0	0	19.00
20.00	RURAL HEALTH CLINIC			0 901, 163		
20. 01	RURAL HEALTH CLINIC II			0 944, 524		•
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY		1 242 1	2, 841, 026		
23.00 24.00	AMBULANCE SERVICES CMHC		1, 342, 1	4, 547, 571	5, 889, 690	23.00 24.00
24.00	AMBULATORY SURGICAL CENTER (D. P.)					24.00
26.00	HOSPI CE			0 0	0	26.00
27.00	PHYSI CI ANS			0 57, 289, 691	57, 289, 691	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	140, 901, 8			
	G-3, line 1)					
	PART II - OPERATING EXPENSES		I		1	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			172, 373, 939		29.00
30.00	ADD (SPECIFY)			0		30.00
31. 00 32. 00				0		31.00 32.00
32.00				0		32.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)) (transfer				42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	2) (transfer		172, 373, 939		43.00
	10 WKSL. 0-3, ITTE 4)		I	I	I	I

Heal th	Financial Systems MEMORIAL HOSP & HEA	ALTH CARE CTR	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0115	Peri od:	Worksheet G-3	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	nared
			10 00/00/2021	11/30/2021 2:4	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			647, 911, 068	1.00
2.00	Less contractual allowances and discounts on patients' accoun	nts		411, 818, 042	2.00
3.00	Net patient revenues (line 1 minus line 2)			236, 093, 026	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		172, 373, 939	
5.00	Net income from service to patients (line 3 minus line 4)			63, 719, 087	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			18, 136, 519	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			569, 834	
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			303, 188	
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS			3, 012, 515	
24.50	COVI D-19 PHE Fundi ng			6, 600, 000	
25.00	Total other income (sum of lines 6-24)			28, 622, 056	25.00
26.00	Total (line 5 plus line 25)			92, 341, 143	
	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			92, 341, 143	29.00

	Financial Systems GIS OF HOSPITAL-BASED HOME HEALT		MORIAL HOSP & H	Provider C		Period:	worksheet H	2552-10
				HHA CCN:	15-7222	From 07/01/2020 To 06/30/2021	Date/Time Pre	
						Home Health	11/30/2021 2: PPS	40 pm
		Sal ari es	Employee	Transportati on	Contracted/Pu	Agency I ur Other Costs	Total (sum of	
			Benefits	(see instructions)	chased Servi ces		cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	1		0	1	0	0	1.00
1.00	Fixtures			0				1.00
2.00	Capital Related - Movable Equipment			0		O	0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0 0	0	3.00
4.00 5.00	Transportation Administrative and General	0	0	170 440	56,88	0 0 33 70, 152	2 280 076	
5.00	HHA REIMBURSABLE SERVICES	1, 983, 501	0	170, 440	y 50,80	33 70, 152	2, 280, 976	5.00
6.00	Skilled Nursing Care	0	-	0		0 0		1
7.00 8.00	Physical Therapy Occupational Therapy	0	0	0				
9.00	Speech Pathol ogy	0	0	0		0 0	0	
10.00	Medical Social Services	0	0	0		0 0	0	
11.00 12.00	Home Health Aide Supplies (see instructions)	0	0	0		0 55,954	0 55, 954	
13.00	Drugs	0	0	0		0 1, 293		
14.00		0	0	0		0 0	0	14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0		
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00 19.00	Clinic Health Promotion Activities	0	0	0		0 0		
20.00	Day Care Program	0	0	0		0 0		1
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0	0		0 0		
23.50	Tel emedi ci ne	0	0	0		0 0		
24.00	Total (sum of lines 1-23)	1, 983, 501	0	170, 440			2, 338, 223	3 24.00
		Recl assi fi cati on	Reclassified Trial Balance	Adjustments	Net Expenses			
			(col. 6 +		(col. 8 + col			
		7.00	col.7) 8.00	9.00	9) 10.00	_		-
	GENERAL SERVICE COST CENTERS		0.00	7.00				
1.00	Capital Related - Bldg. &	0	0	0		0		1.00
2.00	Fixtures Capital Related - Movable	0	0	0		0		2.00
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation	0	-	0		0		3.00
5.00	Administrative and General	-1, 808, 658	-			18		5.00
(00	HHA REIMBURSABLE SERVICES		000 55 1			- 4		1 (00
6.00 7.00	Skilled Nursing Care Physical Therapy	933, 554 457, 869		0				6.00 7.00
8.00	Occupational Therapy	257, 804		0	257,80			8.00
9.00	Speech Pathol ogy	13, 179		0	13, 1			9.00
10.00 11.00	Medical Social Services Home Health Aide	8, 399 137, 853		0	8, 39 137, 8			10.00
12.00	Supplies (see instructions)	0		-55, 954		0		12.00
13.00	Drugs	0				0		13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	0	0		14.00
15.00	Home Dialysis Aide Services	0	0	0		0		15.00
	Respiratory Therapy	0	-	0		0		16.00
16.00		0	0	0		0		17.00
17.00	Private Duty Nursing	0	_			V/I		1 10.00
17.00	Private Duty Nursing Clinic Health Promotion Activities	0	0	0		0		19.00
17.00 18.00 19.00 20.00	Clinic Health Promotion Activities Day Care Program	0	0	0		0		19.00 20.00
17.00 18.00 19.00 20.00 21.00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0	0			0 0		19.00 20.00 21.00
17.00 18.00 19.00 20.00 21.00 22.00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0	0			0		19.00 20.00
17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0	0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 280, 9	0 0 0 0		19.00 20.00 21.00 22.00

Heal th	Financial Systems	MEM	MORIAL HOSP & HE	EALTH CARE CTI	R	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider C	CN: 15-0115	Period: From 07/01/2020	Worksheet H-1 Part I	
				HHA CCN:	15-7222	To 06/30/2021	Date/Time Pre	pared:
						Home Health	11/30/2021 2: PPS	40 pm
						Agency I		
			Capital Rela	ated Costs				
		Net Expenses	BIdgs &	Movabl e	Plant	Transportati on	Subtotal	1
		for Cost	Fixtures	Equi pment	Operation &		(col s. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance			
		col. 10)						
		0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
1.00	Fixtures	Ŭ	0				0	1.00
2.00	Capital Related - Movable	0		C			0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	C		0	0	3.00
4.00	Transportati on	0	0	C		0 0	0	4.00
5.00	Administrative and General	472, 318	0	C		0 0	472, 318	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	933, 554	o	0		0 0	933, 554	6.00
6.00 7.00	Physical Therapy	457, 869	0	0	Ó	0 0	933, 554 457, 869	1
8.00	Occupational Therapy	257, 804	Ō	C	þ	0 0	257, 804	8.00
9.00	Speech Pathology	13, 179	0	C		0 0	13, 179	
10.00 11.00	Medical Social Services Home Health Aide	8, 399 137, 853	0	C			8, 399 137, 853	
12.00	Supplies (see instructions)	137,855	0	C	þ	0 0	0	1
13.00	Drugs	0	0	C		0	0	
14.00		0	0	C		0 0	0	14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	C	b	0 0	0	15.00
16.00	Respiratory Therapy	0	Ö	C		0 0	0	
17.00	Private Duty Nursing	0	0	C		0 0	0	
18.00 19.00	Clinic Health Promotion Activities	0	0	C		0 0	0	
20.00	Day Care Program	0	o	C		0 0	0	1
21.00	Home Delivered Meals Program	0	0	C	þ	0 0	0	1
22.00	Homemaker Service	0	0	C		0 0	0	
23.00 23.50	All Others (specify) Telemedicine	0	0			0 0	0	20.00
24.00	Total (sum of lines 1-23)	2, 280, 976	0	C		0 0	2, 280, 976	1
		Admi ni strati ve						
		& General 5.00	<u>4A + 5)</u> 6.00					-
	GENERAL SERVICE COST CENTERS	5.00	0.00		-			
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2.00
2.00	Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	472, 318						4.00 5.00
5.00	HHA REI MBURSABLE SERVI CES	472,310						5.00
6.00	Skilled Nursing Care	243, 791						6.00
7.00 8.00	Physical Therapy Occupational Therapy	119, 569 67, 324	577, 438					7.00
8.00 9.00	Speech Pathol ogy	67, 324 3, 442	325, 128 16, 621					9.00
10.00	Medical Social Services	2, 193	10, 592					10.00
11.00	Home Health Aide	35, 999	173, 852					11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0					12.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES		- 1					
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
18.00	Clinic	0	o					18.00
19.00	Health Promotion Activities	0	О					19.00
20.00	Day Care Program Home Delivered Meals Program	0	0					20.00
21 00	HOUE DELEVELED MEALS PLOULAM	0	U					
21.00 22.00	ũ	0	0					22.00
22. 00 23. 00	Homemaker Service All Others (specify)	0 0	0 0					22.00 23.00
22. 00 23. 00 23. 50	Homemaker Service	0 0 0	0 0 2, 280, 976					

Heal th Financial	Systems
COST ALLOCATION	- HHA STATISTICAL BASIS

MEMORIAL HOSP & HEALTH CARE CTR Provider CCN: 15-0115 Period:

In Lieu of Form CMS-2552-10 Worksheet H-1

COST A	SI ALLUCATION - HHA STATISTICAL BASIS			HHA CCN:	15-7222	From 07/01/2020 To 06/30/2021	Worksheet H-I Part II Date/Time Pre 11/30/2021 2:	
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportatic (MI LEAGE)	onReconciliation	Admi ni strati ve & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS	1			1		r	
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	0		0 -472, 318	1, 808, 658	5.00
(00	HHA REIMBURSABLE SERVICES			0		0 0	000 554	(00
6.00 7.00	Skilled Nursing Care Physical Therapy	0	0	0			933, 554 457, 869	
8.00	Occupational Therapy	0	0	0			257, 804	
9,00	Speech Pathol ogy	0	0	0		0 0	13, 179	
10.00	Medical Social Services	0	0	0)	0 0	8, 399	
11.00	Home Health Aide	0	0	0)	0 0	137, 853	11.00
12.00	Supplies (see instructions)	0	0	0		0 0	0	12.00
13.00	Drugs	0	0	0		0	0	
14.00	DME	0	0	0		0 0	0	14.00
15 00	HHA NONREI MBURSABLE SERVI CES	0		0		0 0	0	15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0			0	15.00 16.00
17.00	Private Duty Nursing	0	0	0				
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0)	0 0	0	19.00
20.00	Day Care Program	0	0	0)	0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22.00
23.00	All Others (specify)	0	0	0		0 0	0	23.00
23.50	Tel emedi ci ne	0	0	0		0 0		23.50
24.00 25.00	Total (sum of lines 1-23) Cost To Be Allocated (per	0	0	0		0 -472, 318	1, 808, 658 472, 318	
25.00	Worksheet H-1, Part I)	0	0	0			4/2,318	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.00000	00	0. 261143	26.00

Heal th	Financial Systems	ME	MORIAL HOSP & H	HEALTH CARE CTR	R	In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS	Provider CO	CN: 15-0115	Period: From 07/01/2020	Worksheet H-2 Part I	
				HHA CCN:	15-7222	To 06/30/2021		pared: 40 pm
						Home Health Agency I	PPS	
			CAPI TAL REL	ATED COSTS		Agency		
	Cost Center Description	HHA Trial	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE	-
		Bal ance (1)			BENEFITS	Subtotal	& GENERAL	
		0	1.00	2.00	DEPARTMENT 4.00	4A	5.00	
1.00	Administrative and General	0	47, 100	22, 728	82, 05			1.00
2.00	Skilled Nursing Care	1, 177, 345	0	0				
3.00 4.00	Physical Therapy Occupational Therapy	577, 438 325, 128		0	98, 47 55, 79			
5.00	Speech Pathol ogy	16, 621	0	0	2,90			
6.00	Medical Social Services	10, 592	0	0	1, 88			
7.00 8.00	Home Health Aide Supplies (see instructions)	173, 852	0	0	26, 33	200, 187	27, 418	1
9.00	Drugs	0	0	0		0 0	0	
10.00	DME	0	0	0		0 0	0	
11.00 12.00	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0		
14.00	Clinic	0	0	0		0 0	0	14.00
15.00	Health Promotion Activities	0	0	0		0 0	0	
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0			0	
18.00	Homemaker Service	0	0	0		0 0	0	
19.00	All Others (specify)	0	0	0		0 0	0	
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2)	0 2, 280, 976	0 47, 100	0 22, 728	471, 36	0 0 6 2, 822, 170	0 386, 536	
20.00	Unit Cost Multiplier: column	2,200,770	47, 100	22,720	471, 30	0. 000000		21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		REPAIRS 6.00	LINEN SERVICE 8.00	9.00	10.00	11.00	ADMI NI STRATI ON 13.00	
1.00	Administrative and General	42,004	0			0 7, 894	0	1
2.00 3.00	Skilled Nursing Care	0	0	0		0 18, 354		
3.00 4.00	Physical Therapy Occupational Therapy	0	0	0		0 7, 964 0 4, 153		1
5.00	Speech Pathology	0	0	0		0 216		
6.00	Medical Social Services	0	0	0		0 229		
7.00 8.00	Home Health Aide Supplies (see instructions)	0	0	0		0 4,485		
9.00	Drugs	0	0	0		0 0	0	
10.00		0	0	0		0 0	-	
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0		0 0	0	
15.00 16.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00	Homemaker Service	0	0	0		0 0	0	18.00
19. 00 19. 50	All Others (specify)	0	0	0		0 0	0	
19.50 20.00	Telemedicine Total (sum of lines 1-19) (2)	42,004	0	8, 190		0 43, 295		1
21.00	Unit Cost Multiplier: column	.2,001		5,.70				21.00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	n Financial Systems			HEALTH CARE CT			eu of Form CMS-2	
ALLOC	ATION OF GENERAL SERVICE COSTS	IO HHA COSI CEN	IERS	Provider Co HHA CCN:	CN: 15-0115 15-7222	Period: From 07/01/2020 To 06/30/2021		pared:
						Home Health	PPS	
					I NTERNS	Agency I & RESIDENTS		
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SERVICES-SAL Y&FRINGES	ARSERVI CES-OTHER 5 PRGM. COSTS	Subtotal	
		14.00	15.00	16.00	21.00	22.00	24.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 9.00\\ 10.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.50\\ 20.00\\ 21.00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	1, 480 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 4, 157 2, 395 1, 269 52 25 1, 489 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			232, 254 1, 592, 957 778, 848 438, 512 22, 469 14, 443 233, 579 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50
	6 decimal places. Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 19.00\\ 19.00\\ 19.50\\ 20.00\\ 21.00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	232, 254 1, 592, 957 778, 848 438, 512 22, 469 14, 443 233, 579 0 0 0 0 0 0 0 0 0 0 0 0 0	120, 089 58, 715 33, 058 1, 694 1, 089 17, 609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 713, 0 837, 5 471, 5 24, 1 15, 5 251, 1 3, 313, 0	63 70 63 32 88 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	Financial Systems		MORIAL HOSP & H				eu of Form CMS-2	
ALLOCA BASI S	TION OF GENERAL SERVICE COSTS 1	IO HHA COSI CEN	TERS STATISTICA	AL Provider C HHA CCN:	CN: 15-0115 15-7222	Period: From 07/01/2020 To 06/30/2021		pared:
						Home Health	PPS	40 piii
		CAPI TAL REL	ATED COSTS			Agency I		
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio	on ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of Lines 1-19)	3, 758 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 758 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	339, 119 842, 760 406, 982 230, 572 12, 009 7, 804 108, 837 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$ \begin{smallmatrix} 0 & 151, 883 \\ 0 & 1, 381, 262 \\ 0 & 675, 913 \\ 0 & 380, 918 \\ 0 & 19, 527 \\ 0 & 12, 480 \\ 0 & 200, 187 \\ 0 & 0 \\$	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\\ \end{array}$
21.00 22.00	Total cost to be allocated Unit cost multiplier	47, 100 12. 533262	22, 728 6. 047898	471, 366 0. 241964		386, 536 0. 136964		
22.00	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A (HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	
1.00	Administrative and General	8.00	9.00 3,758	10.00 C	11.00 12,1	13.00 56 0	14.00 29,872	1.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		28, 20 12, 20 6, 3 3 3 6, 9 6 6 6 43, 2	55 0 54 0 55 0 53 0 53 0 53 0 54 0 53 0 53 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 19.\ 00\\ 19.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$

Heal th	Financial Systems	MEN	MORIAL HOSP & H	IEALTH CARE CTR	R	In Lie	u of Form CMS-	2552-10
ALLOCA BASI S	TION OF GENERAL SERVICE COSTS T	O HHA COST CENT	FERS STATISTICA	AL Provider CO	CN: 15-0115 15-7222	Period: From 07/01/2020 To 06/30/2021	Worksheet H-2 Part II	
				HHA CCN:	15-7222	10 06/30/2021	Date/Time Pre 11/30/2021 2:	40 pm
						Home Health	PPS	•
						Agency I		
				INTERNS &	RESIDENTS			
	Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALAR	SERVICES_OTH	FR		-
	oust center bescription	(COSTED	RECORDS &	Y & FRINGES	PRGM. COSTS			
		REQUIS.)	LIBRARY	(ASSI GNED	(ASSI GNED			
		· · ·	(REVENUE)	TIME)	TIME)			
		15.00	16.00	21.00	22.00			
1.00	Administrative and General	0	0	0		0		1.00
2.00	Skilled Nursing Care	0	1, 258, 028	0		0		2.00
3.00	Physical Therapy	0	724, 873	0		0		3.00
4.00	Occupational Therapy	0	384, 041	0		0		4.00
5.00	Speech Pathol ogy	0	15, 863	0		0		5.00
6.00	Medical Social Services	0	7, 554	0		0		6.00
7.00	Home Heal th Aide	0	450, 667	0		0		7.00
8.00 9.00	Supplies (see instructions)	0	0	0		0		8.00 9.00
9.00 10.00	Drugs DME	0	0	0		0		9.00
11.00	Home Dialysis Aide Services	0	0	0		0		11.00
12.00	Respiratory Therapy	0	0	0		0		12.00
13.00	Private Duty Nursing	0	0	0		0		13.00
14.00	Clinic	0	0	0		0		14.00
15.00	Health Promotion Activities	Ō	0	0		0		15.00
16.00	Day Care Program	0	0	0		0		16.00
17.00	Home Delivered Meals Program	0	0	0		0		17.00
18.00	Homemaker Service	0	0	0		0		18.00
19.00	All Others (specify)	0	0	0		0		19.00
19.50	Tel emedi ci ne	0	0	0		0		19.50
20.00	Total (sum of lines 1–19)	0	2, 841, 026	0		0		20.00
21.00	Total cost to be allocated	0	9, 387	0		0		21.00
22.00	Unit cost multiplier	0. 000000	0. 003304	0. 000000	0.0000	00		22.00

Heal th	Financial Systems	ME	MORIAL HOSP & I	HEALTH CARE CTI	R	In Lie	eu of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST				CN: 15-0115	Peri od:	Worksheet H-3	
				HHA CCN:	15-7222	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/30/2021 2:	
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	AGGREGATE OF TH	IE PROGRAM LIN	MITATION COST, O	R	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							+
1.00	Skilled Nursing Care	2.00	1, 713, 046		1, 713, 0	46 8, 327	205. 72	1.00
2.00	Physical Therapy	3.00						
3.00	Occupational Therapy	4.00						•
4.00 5.00	Speech Pathology Medical Social Services	6. 00			24, 1 15, 5			•
6.00	Home Health Aide	7.00			251, 1			•
7.00	Total (sum of lines 1-6)		3, 313, 062	C				7.00
			1		Program Visi	ts art B		-
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					Deducti bl es			
		0	1.00	2.00	Coi nsurance 3.00	4.00	5.00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		99915	C				8.00
9.00	Physical Therapy		99915	C	-, -,			9.00
10.00 11.00	Occupational Therapy Speech Pathology		99915 99915		1,7	38 74		10.00
12.00	Medical Social Services		99915			27		12.00
13.00	Home Health Aide		99915	C	1, 9	53		13.00
14.00		E 111 0	F	C	12, 4			14.00
	Cost Center Description	From Wkst. H-2 Part I, col.	facility costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.		Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
			1.00	Part II)	0.00	1.00	5.00	
	Supplies and Drugs Cost Compute	0 ations	1.00	2.00	3.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00	0	C	D	0 114, 827	0. 000000	15.00
16.00	Cost of Drugs	9.00				0 0	0. 000000	16.00
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &		
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							-
1.00	Cost Per Visit Computation Skilled Nursing Care	0	5, 322		1	0 1, 094, 842		1.00
2.00	Physical Therapy	0				0 580, 445		2.00
3.00	Occupational Therapy	0				0 322, 416		3.00
4.00	Speech Pathology	0	74 27			0 17,029		4.00
5.00 6.00	Medical Social Services Home Health Aide	0				0 8, 387 0 164, 462		5.00 6.00
7.00	Total (sum of lines 1-6)	0				0 2, 187, 581		7.00
	Cost Center Description		7.00	0.00	6.00			
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11. 00 12. 00	Speech Pathology Medical Social Services							11.00
12.00	Home Heal th Ai de							13.00
14.00	Total (sum of lines 8-13)							14.00

Heal th	Financial Systems	ME	MORIAL HOSP &	HEALTH CARE CTF	2	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-0115	Peri od:	Worksheet H-3	
				HHA CCN:	15-7222	From 07/01/2020 To 06/30/2021		narad.
				THA CON.	15-7222	10 00/30/2021	11/30/2021 2:	
				Title	XVIII	Home Health	PPS	
						Agency I		
		Prog	ram Covered Cha	arges	Cost of			
					Servi ces			
			Dor	rt B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	cost center bescription	Part A		Deductibles &	Part A	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6,00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computa	ations						
15.00	Cost of Medical Supplies	0	0	0		0 0	0	15.00
16.00			0	0		0	0	16.00
	Cost Center Description	Total Program						
		Cost (sum of						
		cols. 9-10)	-					
		12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	AGGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	< Comparison of the second sec	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,094,842						1.00
2.00	Physical Therapy	580, 445						2.00
3.00	Occupational Therapy	322, 416						3.00
4.00	Speech Pathol ogy	17,029						4.00
5.00	Medical Social Services	8, 387						5.00
6.00	Home Health Aide	164, 462						6.00
7.00	Total (sum of lines 1-6)	2, 187, 581						7.00
	Cost Center Description							
		12.00						
	Limitation Cost Computation	1	1					
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathol ogy							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8–13)	I						14.00

Health Financial Systems	ME	MORIAL HOSP & H	HEALTH CARE CT	२	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0115	Period: From 07/01/2020		
			HHA CCN:	15-7222	To 06/30/2021	Date/Time Pre 11/30/2021 2:	pared: 40 pm
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Rati o	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED B	SY SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00 Physical Therapy	66.00	0. 321497	0)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0. 195552	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 211708	0		Ocol. 2, line 1	6. 00	5.00
			•	•	1		

CUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0115	Peri od:	Worksheet H-4	
		HHA CCN:	15-7222	From 07/01/2020 To 06/30/2021	Part I-II Date/Time Pre 11/30/2021 2:	
		Title	XVIII	Home Health Agency I	PPS	
				Par	t B	
			Part A	Not Subject to Deductibles &	Deductibles &	
		-	1.00	Coi nsurance 2.00	Coi nsurance 3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	I OMARY CHARGES		2.00	3.00	-
00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1 1
0	Total charges			0 0		
	Customary Charges	· 1				
0	Amount actually collected from patients liable for payment fo on a charge basis (from your records)	r services		0 0	0	
00	Amount that would have been realized from patients liable for			0 0	0	4
	for services on a charge basis had such payment been made in with 42 CFR §413.13(b)	accordance				
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	5
00	Total customary charges (see instructions)			0 0	0	
00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	(complete		0 0	0	
00	Excess of reasonable cost over customary charges (complete on	lyifline		0 0	0	8
0	1 exceeds line 6)			0 0	0	
00	Primary payer amounts	I		Part A	Part B	0
				Servi ces	Servi ces	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	-
00	Total reasonable cost (see instructions)			0	0	10
00	Total PPS Reimbursement - Full Episodes without Outliers			0	1, 541, 577	
00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0	332, 758 27, 273	
00	Total PPS Reimbursement - PEP Epi sodes			0	2, 891	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	80, 957	
00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00	Total Other Payments			0	0	
00	DME Payments			0	0	
00 00	Oxygen Payments Prosthetic and Orthotic Payments			0	0	
00	Part B deductibles billed to Medicare patients (exclude coins	urance)		0	0	
00	Subtotal (sum of lines 10 thru 20 minus line 21)	di dilec)		0	1, 985, 456	
00	Excess reasonable cost (from line 8)			0	0	
00	Subtotal (line 22 minus line 23)			0	1, 985, 456	24
00	Coinsurance billed to program patients (from your records)				0	2!
00	Net cost (line 24 minus line 25)			0	1, 985, 456	
00	Reimbursable bad debts (from your records)					2
1	Reimbursable bad debts for dual eligible beneficiaries (see i				4 005 454	28
00 00	Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	e 27)		0	1, 985, 456 0	
50	Pioneer ACO demonstration payment adjustment (see instruction	c)		0	0	
99	Demonstration payment adjustment amount before sequestration	3)		0	0	
00	Subtotal (see instructions)			0	1, 985, 456	
01	Sequestration adjustment (see instructions)			0	0	
02	Demonstration payment adjustment amount after sequestration			0	0	3
00	Interim payments (see instructions)			0	1, 985, 457	
00	Tentative settlement (for contractor use only)			0	0	
00	Balance due provider/program (line 31 minus lines 31.01, 32, Protested amounts (nonallowable cost report items) in accorda		D 1 15 0	0	-1 0	34
00						

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-0115		riod: om 07/01/2020	Worksheet H-5	
PRC	IGRAM BENEFI CI ARI ES	HHA CCN:	15-7222	To		Date/Time Prep 11/30/2021 2:4	
					Home Health Agency I	PPS	
		I npati en	t Part A			t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00	-	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0 0		1, 985, 457 0	1
0	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
1	Program to Provider		[0		0	1
)2				0		0	3
)3				0		0	3
)4				0		0	
5	Provider to Program			0		0	
0				0		0	
1				0		0	
2				0		0	
3				0		0	
64 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		0	
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		1, 985, 457	2
_	TO BE COMPLETED BY CONTRACTOR						_
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						Ę
_	Program to Provider			-			_
)1)2				0 0		0	Ę
)2)3				0		0	E
	Provider to Program				1		
0				0		0	Ę
1 2				0 0		0	ļ
29	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	Ę
0	5.50-5.98) Determined net settlement amount (balance due) based on						e
	the cost report. (1)					_	
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0 0		0	6
)2)0	Total Medicare program liability (see instructions)			0		1, 985, 456	-
					Contractor	NPR Date	
					Number	(Mo/Day/Yr)	
0	Name of Contractor	C	J		1.00	2.00	8

ALCULATI O	N OF CAPITAL PAYMENT	Provider CCN: 15-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Pre 11/30/2021 2:-	
		Title XVIII	Hospi tal	PPS	40 p
				1.00	
	I - FULLY PROSPECTIVE METHOD				
	TAL FEDERAL AMOUNT				
	tal DRG other than outlier			1, 203, 478	
	el 4 BPCI Capital DRG other than outlier			0	1
	tal DRG outlier payments			1, 785	
	el 4 BPCI Capital DRG outlier payments	the cost monortine posied (cost incl		0	
	al inpatient days divided by number of days in	the cost reporting period (see inst	ructions)	35.93 9.35	
	per of interns & residents (see instructions) rect medical education percentage (see instruc	ati ana)		9.35 7.62	
			columns 1 and	91, 705	
	rect medical education adjustment (multiply li)(see instructions)	The 5 by the sum of Triles I and 1.01	, corunns r anu	91,705	0
00 Perc	centage of SSI recipient patient days to Medica	are Part A patient days (Worksheet E	, part A line	0.00	7
	(see instructions) centage of Medicaid patient days to total days	(see instructions)		0,00	8
	of lines 7 and 8			0.00	
	wable disproportionate share percentage (see i	instructions)		0.00	
	proportionate share adjustment (see instruction			0.00	
	al prospective capital payments (see instructio			1, 296, 968	1
	<u> </u>			.,,	
				1.00	
	II - PAYMENT UNDER REASONABLE COST				
	gram inpatient routine capital cost (see instru			0	
	gram inpatient ancillary capital cost (see inst	-		0	
	al inpatient program capital cost (line 1 plus	line 2)		0	
	tal cost payment factor (see instructions)			0	
00 Tota	al_inpatient program capital_cost (line 3_x lin	ne 4)		0	5
				1.00	
	III - COMPUTATION OF EXCEPTION PAYMENTS	<u></u>			
	gram inpatient capital costs (see instructions)			0	
	gram inpatient capital costs for extraordinary			0	
	program inpatient capital costs (line 1 minus icable exception percentage (see instructions)			0.00	1 ×
	tal cost for comparison to payments (line 3 x			0.00	
	centage adjustment for extraordinary circumstar	· · · · · · · · · · · · · · · · · · ·		0.00	
	istment to capital minimum payment level for ex		line 6)	0.00	
	tal minimum payment level (line 5 plus line 7)	3		0	
	rent year capital payments (from Part I, line)			0	-
	ent year comparison of capital minimum payment		less line 9)	0	
.00 Carr	yover of accumulated capital minimum payment l sheet L, Part III, line 14)			0	
	comparison of capital minimum payment level to	o capital payments (line 10 plus lin	e 11)	0	12
	rent year exception payment (if line 12 is posi			0	
	yover of accumulated capital minimum payment I			0	
	line 12 is negative, enter the amount on this	1 1 5	5 1		
(if					1
	rent year allowable operating and capital payme	ent (see instructions)		0	15
5.00 Curr 5.00 Curr		tructions)		0	

		WORTAL HUSP & F	EALTH CARE CTE			u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0115	Period: From 07/01/2020	Worksheet M-1	
			Component	CCN: 15-8507	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
					RHC I	Cost	10 piii
		Compensation	Other Costs	Total (col.	1 Reclassi ficati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	380, 806	0				
2.00	Physician Assistant	0	0		0 1, 575	1, 575	
3.00	Nurse Practitioner	0	0		0 192, 654	192, 654	
4.00	Visiting Nurse	0	0		0 0	0	
5.00	Other Nurse	0	0		0 0	0	
6.00	Clinical Psychologist	0	0		0 0	0	
7.00	Clinical Social Worker	0	0		0 0	0	
8.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0 82, 447	82, 447	
10.00	Subtotal (sum of lines 1 through 9)	380, 806	0	380, 80	-40, 157	340, 649	
11.00	Physician Services Under Agreement	0	0		0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement	0	0		0 0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15.00	Medical Supplies	0	340	-	10 0	340	
16.00	Transportation (Health Care Staff)	0	0		0 0	0	
17.00 18.00	Depreciation-Medical Equipment Professional Liability Insurance	0	0		0 0	0	
19.00	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs	0	0		0 0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	340	34		340	
21.00	Total Cost of Health Care Services (sum of	380, 806	340			340, 989	
22.00	lines 10, 14, and 21)	360, 600	340	301, 12	-40, 157	340, 969	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			1
23.00	Pharmacy	0	8, 421	8, 42	21 0	8, 421	23.00
24.00	Dental	0	0, 121	-,	0 0	0	
25.00	Optometry	o	0		0 0	0	
25.01	Tel eheal th	0	0		0 3, 370	3, 370	25.01
25.02	Chronic Care Management	0	0		0 0	0	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	8, 421	8, 42	3, 370	11, 791	28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	54, 049	54, 04	-416	53, 633	
30.00	Administrative Costs	0	36, 195				
31.00	Total Facility Overhead (sum of lines 29 and	0	90, 244	90, 24	4 36, 787	127, 031	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	380, 806	99, 005	479, 81	1 0	479, 811	32.00
	and 31)			1			1

Heal t	h	Fi	nan	ci al	Sys	tems	
	12/	c				DACED	

Heal th	Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CT	R	In Lie	u of Form CMS-	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Peri od:	Worksheet M-1	
					From 07/01/2020		
			Component	CCN: 15-8507	To 06/30/2021	Date/Time Pre	
					DUCI	11/30/2021 2:	40 pm
		Adjustments	Net Expenses		RHC I	Cost	
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7.00	1			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	1			
1.00	Physi ci an	0	63, 973				1.00
2.00	Physician Assistant	0	1, 575				2.00
3.00	Nurse Practitioner	0	192, 654	•			3.00
4.00	Visiting Nurse	0	C				4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	0	1			6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	82, 447	,			9.00
10.00	Subtotal (sum of lines 1 through 9)	0	340, 649	•			10.00
11.00	Physician Services Under Agreement	0	0	•			11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	C C	•			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C C	•			14.00
15.00	Medical Supplies	0	340	•			15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs	_	-				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	340				21.00
22.00	Total Cost of Health Care Services (sum of	0	340, 989	•			22.00
	lines 10, 14, and 21)	-					
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	8, 421				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	3, 370				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	11, 791				28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	53, 633				29.00
30.00	Administrative Costs	-666	72, 732	2			30.00
31.00	Total Facility Overhead (sum of lines 29 and	-666	126, 365	5			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-666	479, 145				32.00
	and 31)						

	Financial Systems MEI	WURIAL HUSP & F	Provider C		Peri od:	u of Form CMS-2 Worksheet M-1	
ANALIS	SIS OF HUSPITAL-DASED KHC/FUHC CUSIS		Provider C	JN. 13-0113	From 07/01/2020	WOLKSHEEL M-1	
			Component	CCN: 15-8508	To 06/30/2021	Date/Time Pre	
					BUO LI	11/30/2021 2:	40 pm
		Composition	0 + h + -		RHC II	Cost	
		Compensation	Other Costs		1 Reclassi fi cati		
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physi ci an	472, 041	0	472, 0	41 - 347, 914	124, 127	1 1.00
2.00	Physician Assistant	0	C		0 0	0	
3.00	Nurse Practitioner	0	C		0 165, 929	165, 929	3.00
1.00	Visiting Nurse	0	C		0 0	0	
5.00	Other Nurse	0	C		0 0	0	5.00
5.00	Clinical Psychologist	0	C		0 0	0	6.00
7.00	Clinical Social Worker	0	C		0 0	0	7.00
3. 00	Laboratory Techni ci an	0	C		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	C		0 114, 402	114, 402	9.0
0.00	Subtotal (sum of lines 1 through 9)	472, 041	C	472, 0	41 -67, 583	404, 458	10.0
1.00	Physician Services Under Agreement	0	C		0 0	0	
2.00	Physician Supervision Under Agreement	0	C		0 0	0	12.0
3.00	Other Costs Under Agreement	0	C		0 0	0	13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.0
15.00	Medical Supplies	0	782	7	82 0	782	15.0
6.00	Transportation (Health Care Staff)	0	0		0 0	0	16.0
7.00	Depreciation-Medical Equipment	0	0		0 0	0	17.0
8.00	Professional Liability Insurance	0	0		0 0	0	18.0
9.00	Other Health Care Costs	0	C		0 0	0	19.0
20.00	Allowable GME Costs						20.0
21.00	Subtotal (sum of lines 15 through 20)	0	782	7	82 0	782	21.0
22.00	Total Cost of Health Care Services (sum of	472, 041	782	472, 8	23 -67, 583	405, 240	22.0
	lines 10, 14, and 21)						1
	COSTS OTHER THAN RHC/FQHC SERVICES	0	11 222	11.0	22	11 222	1 22 0
23.00	Pharmacy Dental	0	11, 322	11, 3	0 0	11, 322	
24.00 25.00	Optometry	0	0		0 0	0	
25.00	Tel eheal th	0	0		0 2,551	2, 551	
25.01	Chronic Care Management	0	0		0 2, 551	2,551	
26.002	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs	0	U		0 0	0	27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	11, 322	11, 3	22 2, 551	13, 873	
0.00	through 27)	0	11, 322	11, 5.	2, 331	15,075	20.0
	FACILITY OVERHEAD			1		L	1
29.00	Facility Costs	0	2, 332	2, 3	32 -5	2, 327	29.0
30.00	Administrative Costs	o	41, 510			106, 547	
31.00	Total Facility Overhead (sum of lines 29 and	0	43, 842				
	30)	Ŭ		,.		, 0, 1	
32.00	Total facility costs (sum of lines 22, 28	472, 041	55, 946	527, 9	87 0	527, 987	32.0
	and 31)			· · ·			

Heal th	Fi	nar	ci al	Sys	tems		
ANIAL VS	10		LUCD		DVCED	DUC	

MEMORIAL HOSP & HEALTH CARE CTR

In Lieu of Form CMS-2552-10

			HEALTH CARE CIR			J OI FORM CNIS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CC	N: 15-0115	Peri od:	Worksheet M-1	1
			Component CO	N. 15_8508	From 07/01/2020 To 06/30/2021	Date/Time Pre	onarod
			component co	311. 15-6506	10 00/30/2021	11/30/2021 2:	
					RHC II	Cost	p
		Adjustments	Net Expenses		1		
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS		· · · · ·		· · · ·		
1.00	Physi ci an	0	124, 127				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	165, 929				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	114, 402				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	404, 458				10.00
11.00	Physician Services Under Agreement	0	404, 430				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	с	0	782				15.00
16.00	Medical Supplies	0	/82				16.00
	Transportation (Health Care Staff)	0	0				
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	782				21.00
22.00	Total Cost of Health Care Services (sum of	0	405, 240				22.00
	lines 10, 14, and 21)						_
~~ ~~	COSTS OTHER THAN RHC/FQHC SERVICES	-	11.000				
23.00	Pharmacy	0	11, 322				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	2, 551				25.01
25. 02	Chronic Care Management	0	0				25. 02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	13, 873				28.00
	through 27)						
	FACILITY OVERHEAD		1				_
29.00	Facility Costs	0	2/02/				29.00
30.00	Administrative Costs	-838					30.00
31.00	Total Facility Overhead (sum of lines 29 and	-838	108, 036				31.00
	30)						
	Total facility costs (sum of lines 22, 28	-838	527, 149				32.00
32.00	and 31)	050	527, 147				02.00

	J	EMORIAL HOSP &				eu of Form CMS-	
LLUCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVICES	Provider C		Period: From 07/01/2020	Worksheet M-2	
			Component (To 06/30/2021		pared
						11/30/2021 2:	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						-
	Positions						
. 00	Physi ci an	0.08					1. (
. 00	Physician Assistant	0. 02					2.0
. 00	Nurse Practitioner	1. 18					3. (
. 00	Subtotal (sum of lines 1 through 3)	1.28			2, 856		
. 00	Visiting Nurse	0.00				0	5.
00	Clinical Psychologist	0.00				0	6.
. 00	Clinical Social Worker	0.00				0	7.
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7.0
	onl y)						
. 00	Total FTEs and Visits (sum of lines 4	1. 28	4, 043			4, 043	8. (
	through 7)						
. 00	Physician Services Under Agreements		0			0	9. (
						4.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			VICES		1.00	
	Total costs of health care services (from W			VICES		340, 989	1 10
	Total nonreimbursable costs (from Wkst. M-1					11, 791	
	Cost of all services (excluding overhead) (,			352, 780	
3.00						0. 966577	
4.00							
5.00	Parent provider overhead allocated to facil					126, 365 276, 309	
5.00	Total overhead (sum of lines 14 and 15)		50 0137			402, 674	
	Allowable GME overhead (see instructions)					402, 074	
	Enter the amount from line 16					402, 674	
	Overhead applicable to hospital-based RHC/F	NHC services (Li	ne 13 v line 1	8)		389, 215	
	Tatal allowable past of bearital based RIC/					307,213	

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 730, 204
 20.00

	Financial Systems N ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	EMORIAL HOSP &	Provider C		Period:	u of Form CMS-2 Worksheet M-2	
ALLUCA	ATTON OF OVERHEAD TO HOSPITAL-BASED RHC/FUHC	SERVICES	Provider C		From 07/01/2020		
			Component		To 06/30/2021		pared:
			'			11/30/2021 2:	
		_			RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						-
	Positions						
. 00	Physi ci an	0.80		4, 200			1.00
. 00	Physician Assistant	0.00					2.00
. 00	Nurse Practitioner	1.40					3.0
. 00	Subtotal (sum of lines 1 through 3)	2. 20			6, 300		
. 00	Visiting Nurse	0.00				0	5.0
. 00	Clinical Psychologist	0.00				0	6.0
. 00	Clinical Social Worker	0.00				0	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC	0.00	0 0			0	7.0
	only)						
. 00	Total FTEs and Visits (sum of lines 4	2. 20	4, 443			6, 300	8.0
	through 7)						
. 00	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			VICES		1.00	
0. 00				VICES		405, 240	10.0
	Total nonreimbursable costs (from Wkst. M-1					13, 873	
			,			419, 113	
2.00	Ratio of hospital -based RHC/FQHC services (0. 966899	
4.00	Total hospital-based RHC/FQHC overhead - (f			no 21)		108, 036	
4.00	Parent provider overhead allocated to facil			110 31)		436, 137	
	Total overhead (sum of lines 14 and 15)	ity (see institud	5110115/			544, 173	
						544, 173	
	Enter the amount from line 16					544, 173	
	Overhead applicable to hospital-based RHC/F	OUC convisors (Li	ing 12 v ling 1	0)		544, 173	
	overnead appricable to hospital-based RHC/F					526, 160	

 20. 00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 931, 400
 20. 00

	Financial Systems MEMORIAL HOSP & HEA ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	LTH CARE CTF Provider C		In Lie Period:	eu of Form CMS-2 Worksheet M-3	
SERVI C				From 07/01/2020		
		Component (CCN: 15-8507	To 06/30/2021	Date/Time Pre 11/30/2021 2:	
		Title	XVIII	RHC I	Cost	
					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from				730, 204	1.00
2.00	Cost of injections/infusions and their administration (from Wi				20, 859	
3.00 4.00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	nus line 2)			709, 345 4, 043	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, 1	ine 9)			4,043	
6.00	Total adjusted visits (line 4 plus line 5)				4, 043	
7.00	Adjusted cost per visit (line 3 divided by line 6)		Cal	culation of Limi	175.45	7.00
			Prior to Jar		On or After	
			1 (Rate Peri 1)	od Jan. 1 (Rate Period 2)	Apr. 1 (Rate Period 3)	
			1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. contractor)	6 or your	86.	31 87.52	0.00	8.00
9.00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		86.	31 87.52	0.00	9.00
10.00	Program covered visits excluding mental health services (from records)	contractor	6	61 662	0	10.00
11.00	Program cost excluding costs for mental health services (line 10)	9 x line	57, 0	51 57, 938	0	11.00
12.00	Program covered visits for mental health services (from contra records)	actor		0 C	0	12.00
13.00	Program covered cost from mental health services (line 9 x lin			0 0	-	
14.00	Limit adjustment for mental health services (see instructions)			0 0	0	
15.00 16.00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 114, 989		15.00 16.00
16.00	Total program charges (see instructions) (from contractor's rea			295, 793		16.00
16. 02	Total program preventive charges (see instructions)(from provi records)			3, 266		16. 02
16.03	Total program preventive costs ((line 16.02/line 16.01) times			1, 270		16.03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 times .80) (Titles V and XIX see instructions.)	3 and 18)		66, 262		16.04
16.05	Total program cost (see instructions)			0 67, 532		16.05
17.00 18.00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from		54 30, 891		17.00 18.00
19.00	contractor records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from		52, 327		19.00
20.00	contractor records)			(7.470		20.00
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		67, 478 14, 066		20. 00 21. 00
22.00	Total reimbursable Program cost (line 20 plus line 21)			81, 544		22.00
	Allowable bad debts (see instructions)			C		23.00
23.01	Adjusted reimbursable bad debts (see instructions)			C		23.01
24.00 25.00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)				24.00 25.00
25.00 25.50	Pioneer ACO demonstration payment adjustment (see instructions)	5)				25.00
25.99	Demonstration payment adjustment amount before sequestration	- /		C		25.99
26.00	Net reimbursable amount (see instructions)			81, 544		26.00
26.01	Sequestration adjustment (see instructions)			C		26.01
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			68, 211		26.02 27.00
28.00	Tentative settlement (for contractor use only)			C		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and		13, 333		29.00
30.00	28) Protested amounts (nonallowable cost report items) in accorda	nce with		C		30.00
50.00	CMS Pub. 15-II, chapter I, §115.2	iss with				00.00

	Financial Systems MEMORIAL HOSP & HEA				workshoot M 2	
SERVI C	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC ES	Provider C		Period: From 07/01/2020	Worksheet M-3	
		Component (CCN: 15-8508	To 06/30/2021	Date/Time Pre 11/30/2021 2:4	
		Title	XVIII	RHC II	Cost	
					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from				931, 400	1.00
2.00	Cost of injections/infusions and their administration (from W				35, 255	2.00
3.00 4.00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	nus line 2)			896, 145 6, 300	3.00 4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)			0, 300	5.00
6.00	Total adjusted visits (line 4 plus line 5)				6, 300	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		Cal	culation of Limi	142.25 t (1)	7.00
					. ,	
			Prior to Jar 1 (Rate Peri		On or After Apr. 1 (Rate	
			1)	Period 2)	Period 3)	
		· ·	1.00	2.00	3.00	0.00
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. contractor)	6 or your	86.	31 87.52	0.00	8.00
9.00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		86.	31 87.52	0.00	9.00
10.00	Program covered visits excluding mental health services (from records)	contractor	7	23 723	0	10.00
11.00	Program cost excluding costs for mental health services (line 10)	9 x line	62, 4	63, 277	0	11.00
12.00	Program covered visits for mental health services (from contra records)	actor		0 0	0	12.00
13.00	Program covered cost from mental health services (line 9 x lin	,		0 0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0 0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 125, 679		15.00 16.00
16.01	Total program charges (see instructions) (from contractor's red			272, 299		16.01
16. 02	Total program preventive charges (see instructions)(from provi records)	der's		432		16. 02
16.03	Total program preventive costs ((line 16.02/line 16.01) times			199		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 times .80) (Titles V and XIX see instructions.)	3 and 18)		67, 291		16. 04
16.05	Total program cost (see instructions)			0 67, 490		16.05
17.00	Primary payer amounts	15		67		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) contractor records)	(TFOM		41, 366		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instruction contractor records)	ns) (from		46, 100		19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			67, 423		20.00
21.00	Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		19, 099		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			86, 522		22.00
	Allowable bad debts (see instructions)			0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)	suctions)		0		23.01
24.00 25.00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		24.00 25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration			0		25.99
26.00	Net reimbursable amount (see instructions)			86, 522		26.00
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0		26.01 26.02
26.02 27.00	Interim payments			67, 627		26.02
28.00	Tentative settlement (for contractor use only)			0,,027		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and		18, 895		29.00
30. 00	28) Protested amounts (nonallowable cost report items) in accordar	nce with		0		30.00
JU. UU	CMS Pub. 15-II, chapter I, §115.2	ICC WILLI		0		1 30.00

COMPUT	ATI ON OF HOSPI TAL-BASED RHC/FQHC VACCI NE COST	Provider CC Component C	CN: 15-0115 CCN: 15-8507	Period: From 07/01/2020 To 06/30/2021	Worksheet M-4 Date/Time Pre 11/30/2021 2:-	pared:
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	340, 649 0. 000390	340, 6 0. 0051			
3.00	Injection/infusion health care staff cost (line 1 x line 2)	133	1, 7	50 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2, 916			0	
5.00 6.00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 049 340, 989			0 340, 989	5.00 6.00
7.00 8.00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	389, 215 0. 008942	1			
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3, 480 6, 529			0 0	
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	16 408.06	67.			12.00
13. 00 13. 01	Number of injection/infusion administered to Program beneficiaries	14	1	23 0	0	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees Program cost of injections/infusions and their	5, 713	8, 3	0		13.0
14.00	administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,713	0, 3	55 0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		20, 8	59		15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		14, 0	66		16. 0

COMPUT	ATI ON OF HOSPI TAL-BASED RHC/FOHC VACCI NE COST	Provider CC Component C	CN: 15-0115 CCN: 15-8508	Period: From 07/01/2020 To 06/30/2021	Worksheet M-4 Date/Time Pre 11/30/2021 2:4	pared:
		Title	XVIII	RHC II	Cost	10 pm
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	404, 458 0. 000799	404, 4 0. 0046			
3.00	Injection/infusion health care staff cost (line 1 x line 2)	323	1, 8	99 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7, 473		44 0	0	
5.00 6.00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	7, 796 405, 240			0 405, 240	1 0.00
7.00 8.00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	526, 160 0. 019238				
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10, 122 17, 918	9, 7 17, 3		0 0	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	41 437. 02 20	2- 71. 1-		0 0.00 0	12.00
13. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14.00	Administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8, 740	10, 3	59 0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		35, 2	55		15.00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		19, 0	99		16.00

Health Financial Systems MEMORIAL HOSP & H	IFALTH CARE CTR	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provider CCN: 15-0115	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 07/01/2020		
	Component CCN: 15-8507	To 06/30/2021	Date/Time Prep	
		RHC I	11/30/2021 2:2	40 pm
			Cost	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	68, 211	1.00
2.00 Interim payments payable on individual bills, either submit	ted or to be submitted to		00,211	2.00
the contractor for services rendered in the cost reporting			Ŭ	2.00
"NONE" or enter a zero	perrou. In none, write			
3.00 List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
revision of the interim rate for the cost reporting period.				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3. 01			0	3. 01
3. 02			0	3. 02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3.50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53			0	3.53
3.54	>		0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.4	2		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transi	ter to Worksheet M-3, line		68, 211	4.00
27) TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after desl	k roviow Also show data o	F		5.00
each payment. If none, write "NONE" or enter a zero. (1)	K TEVIEW. AISO SHOW UATE O			5.00
Program to Provider				
5. 01			0	5.01
5.02			0	5.02
5. 03			0	5.03
Provider to Program				0.00
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.4	98)		0	5.99
6.00 Determined net settlement amount (balance due) based on the	cost report. (1)			6.00
6.01 SETTLEMENT TO PROVIDER	• • •		13, 333	6. 01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			81, 544	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
8.00 Name of Contractor	0	1.00	2.00	8,00

Health Financial Systems MEMORIAL HOSP &	& HEALTH CARE CTR	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0115	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 07/01/2020		
	Component CCN: 15-8508	To 06/30/2021	Date/Time Prep	
		RHC II	11/30/2021 2: 2 Cost	40 pm
			T B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	67,627	1.00
2.00 Interim payments payable on individual bills, either subm	itted or to be submitted to		0,,02,	2.00
the contractor for services rendered in the cost reportin			Ŭ	2.00
"NONE" or enter a zero	51			
3.00 List separately each retroactive lump sum adjustment amou	int based on subsequent			3.00
revision of the interim rate for the cost reporting perio	d. Also show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3. 01			0	3.01
3. 02			0	3. 02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program			-	
3. 50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53			0	3.53
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-	2 00)		0	3. 54 3. 99
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50- 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (tra			67,627	3.99 4.00
27)	Inster to worksheet M-3, Time		07,027	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after d	lesk review. Also show date o	f		5.00
each payment. If none, write "NONE" or enter a zero. (1)				0.00
Program to Provider				
5. 01			0	5.01
5.02			0	5.02
5. 03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-			0	5.99
6.00 Determined net settlement amount (balance due) based on t	he cost report. (1)			6.00
6.01 SETTLEMENT TO PROVIDER			18, 895	6. 01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			86, 522	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
8.00 Name of Contractor	0	1.00	2.00	8.00
	I	I. I.	I I	0.00