This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1322	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/23/2017 12:17 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2017 Time: 12:17 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (14-1322) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	436,888	-490,010	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-131,360	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	305,528	-490,010	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 estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2017 11:53 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 STAHLHUT DRIVE	PO Box:			1.00
2.00	City: LINCOLN	State: IL	Zip Code: 62656	County: LOGAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	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.	0	0	0	0	0	0	24.00
25.00	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, 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.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 11:53 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2017 11:53 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	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 and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
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 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 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)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 11:53 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program 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 your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	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.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
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.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	38,785	0	0	118.01

		1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N	118.02
119.00	DO NOT USE THIS LINE		119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N 120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y	121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N	122.00
	Transplant Center Information		
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N	125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 11:53 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: MEMORIAL HELATH SYSTEM	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	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	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1322	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 11:53 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2017 11:53 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/12/2017	Y	01/12/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2017 11:53 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		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's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY		RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1322	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/22/2017 11:53 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2017 11:53 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	83,441.78	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	83,441.78	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						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)		25	9,150	83,441.78	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance 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 outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2017 11:53 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,396	104	2,901			1.00
2.00	HMO and other (see instructions)	399	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	488	0	619			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		3	25			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,884	107	3,545			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						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		83	467			13.00
14.00	Total (see instructions)	1,884	190	4,012	0.00	259.98	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	259.98	27.00
28.00	Observation Bed Days		2	209			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			25			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	78			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2017 11:53 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	374	36	915	1.00
2.00	HMO and other (see instructions)			95	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						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						13.00
14.00	Total (see instructions)	0.00	0	374	36	915	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance 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)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/22/2017 11:53 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.336154	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,463,936	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,995,237	5.00
6.00	Medicaid charges	24,260,829	6.00
7.00	Medicaid cost (line 1 times line 6)	8,155,375	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,696,202	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	28,804	9.00
10.00	Stand-alone CHIP charges	189,299	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	63,634	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	34,830	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,731,032	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	2,106,840	2,056,199	4,163,039	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	708,223	691,200	1,399,423	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	708,223	691,200	1,399,423	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,168,621	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	400,354	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	768,267	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	258,256	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,657,679	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,388,711	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,050,967	3,050,967	2,336,455	5,387,422	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,311,310	1,311,310	79,304	1,390,614	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	223,299	4,868,699	5,091,998	0	5,091,998	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,806,210	4,743,176	6,549,386	-21,969	6,527,417	5.00
7.00	00700	OPERATION OF PLANT	427,018	712,491	1,139,509	0	1,139,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	182,833	182,833	8.00
9.00	00900	HOUSEKEEPING	419,650	218,414	638,064	-182,833	455,231	9.00
10.00	01000	DIETARY	537,251	372,016	909,267	-630,460	278,807	10.00
11.00	01100	CAFETERIA	0	0	0	627,557	627,557	11.00
13.00	01300	NURSING ADMINISTRATION	430,604	17,692	448,296	-170,758	277,538	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	236,340	312,777	549,117	-263,683	285,434	14.00
15.00	01500	PHARMACY	506,974	1,208,909	1,715,883	-1,176,839	539,044	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	479,144	113,503	592,647	0	592,647	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	167,408	167,408	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,342,712	315,535	1,658,247	660,473	2,318,720	30.00
43.00	04300	NURSERY	0	29	29	124,938	124,967	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	898,504	586,541	1,485,045	-19,673	1,465,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	761,845	137,304	899,149	-785,411	113,738	52.00
53.00	05300	ANESTHESIOLOGY	934,499	276,926	1,211,425	0	1,211,425	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,345,610	581,204	1,926,814	-41,952	1,884,862	54.00
60.00	06000	LABORATORY	835,183	1,139,623	1,974,806	0	1,974,806	60.00
65.00	06500	RESPIRATORY THERAPY	476,104	33,310	509,414	0	509,414	65.00
66.00	06600	PHYSICAL THERAPY	1,528,498	92,544	1,621,042	0	1,621,042	66.00
68.00	06800	SPEECH PATHOLOGY	85,812	90	85,902	0	85,902	68.00
69.00	06900	ELECTROCARDIOLOGY	103,518	41,929	145,447	0	145,447	69.00
69.01	06902	CARDIAC REHABILITATION	132,329	17,444	149,773	0	149,773	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	110,200	110,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	173,201	173,201	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,225,045	1,225,045	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,284,375	3,027,850	4,312,225	-46	4,312,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,393,790	2,393,790	-2,393,790	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,795,479	25,574,073	40,369,552	0	40,369,552	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	14,795,479	25,574,073	40,369,552	0	40,369,552	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-475,620	4,911,802		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-39,223	1,351,391		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-100,198	4,991,800		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,533	6,564,950		5.00
7.00	00700	OPERATION OF PLANT	0	1,139,509		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	182,833		8.00
9.00	00900	HOUSEKEEPING	0	455,231		9.00
10.00	01000	DIETARY	0	278,807		10.00
11.00	01100	CAFETERIA	-148,016	479,541		11.00
13.00	01300	NURSING ADMINISTRATION	0	277,538		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	285,434		14.00
15.00	01500	PHARMACY	0	539,044		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,056	591,591		16.00
17.00	01700	SOCIAL SERVICE	0	167,408		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,318,720		30.00
43.00	04300	NURSERY	0	124,967		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	561	1,465,933		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	113,738		52.00
53.00	05300	ANESTHESIOLOGY	-934,499	276,926		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,884,862		54.00
60.00	06000	LABORATORY	-7,895	1,966,911		60.00
65.00	06500	RESPIRATORY THERAPY	0	509,414		65.00
66.00	06600	PHYSICAL THERAPY	-59,874	1,561,168		66.00
68.00	06800	SPEECH PATHOLOGY	0	85,902		68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,447		69.00
69.01	06902	CARDIAC REHABILITATION	0	149,773		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	110,200		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	173,201		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,225,045		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,341,125	1,971,054		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,069,412	36,300,140		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,069,412	36,300,140		200.00

RECLASSIFICATIONS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/22/2017 11:53 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS STERILE PROCESSING SALARIES					
1.00	OPERATING ROOM	50.00	45,769	57,039		1.00
	0		45,769	57,039		
	B - RECLASS LABOR & DELIVERY EXPENSES					
1.00	NURSERY	43.00	105,859	19,079		1.00
2.00	ADULTS & PEDIATRICS	30.00	559,616	100,857		2.00
	0		665,475	119,936		
	C - RECLASS SOCIAL SERVICE FEES					
1.00	SOCIAL SERVICE	17.00	167,408	0		1.00
	0		167,408	0		
	D - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	21,969		1.00
	0		0	21,969		
	E - RECLASS DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,225,045		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	1,225,045		
	F - RECLASS LAUNDRY EXPENSE					
1.00	LAUNDRY & LINEN SERVICE	8.00	35,416	147,417		1.00
	0		35,416	147,417		
	G - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	110,200		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	173,201		2.00
3.00		0.00	0	0		3.00
	0		0	283,401		
	H - RECLASS CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	371,987	255,570		1.00
	0		371,987	255,570		
	I - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,189,895		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	69,825		2.00
	0		0	2,259,720		
	J - RECLASS BOND AMORTIZATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,927		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,143		2.00
	0		0	134,070		
500.00	Grand Total: Increases		1,286,055	4,504,167		500.00

RECLASSIFICATIONS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/22/2017 11:53 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS STERILE PROCESSING SALARIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	45,769	57,039	0		1.00
	0		45,769	57,039			
	B - RECLASS LABOR & DELIVERY EXPENSES						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	665,475	119,936	0		1.00
2.00		0.00	0	0	0		2.00
	0		665,475	119,936			
	C - RECLASS SOCIAL SERVICE FEES						
1.00	NURSING ADMINISTRATION	13.00	167,408	0	0		1.00
	0		167,408	0			
	D - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,969	0		1.00
	0		0	21,969			
	E - RECLASS DRUG EXPENSE						
1.00	DIETARY	10.00	0	2,903	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	3,350	0		2.00
3.00	PHARMACY	15.00	0	1,176,794	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,952	0		4.00
5.00	EMERGENCY	91.00	0	46	0		5.00
	0		0	1,225,045			
	F - RECLASS LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	35,416	147,417	0		1.00
	0		35,416	147,417			
	G - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	160,875	0		1.00
2.00	PHARMACY	15.00	0	45	0		2.00
3.00	OPERATING ROOM	50.00	0	122,481	0		3.00
	0		0	283,401			
	H - RECLASS CAFETERIA EXPENSE						
1.00	DIETARY	10.00	371,987	255,570	0		1.00
	0		371,987	255,570			
	I - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,259,720	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	2,259,720			
	J - RECLASS BOND AMORTIZATION EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	134,070	14		1.00
2.00		0.00	0	0	14		2.00
	0		0	134,070			
500.00	Grand Total: Decreases		1,286,055	4,504,167			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 2/22/2017 11:53 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	834,848	531,203	0	531,203	63,063	1.00
2.00	Land Improvements	5,976,845	35,538	0	35,538	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	42,116,821	318,163	0	318,163	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,796,012	1,789,539	0	1,789,539	2,152,932	6.00
7.00	HIT designated Assets	2,526,077	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,250,603	2,674,443	0	2,674,443	2,215,995	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,250,603	2,674,443	0	2,674,443	2,215,995	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,302,988	0	1.00
2.00	Land Improvements	6,012,383	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	42,434,984	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,432,619	0	6.00
7.00	HIT designated Assets	2,526,077	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,709,051	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,709,051	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/22/2017 11:53 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see 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	3,050,967	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,311,310	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,362,277	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	3,050,967		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,311,310		2.00
3.00	Total (sum of lines 1-2)	0	4,362,277		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/22/2017 11:53 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	49,750,355	0	49,750,355	0.757131	16,633	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,958,696	0	15,958,696	0.242869	5,336	2.00
3.00	Total (sum of lines 1-2)	65,709,051	0	65,709,051	1.000000	21,969	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related 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 CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	16,633	3,065,400	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,336	1,287,712	0	2.00
3.00	Total (sum of lines 1-2)	0	0	21,969	4,353,112	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related 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 CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,699,842	16,633	0	129,927	4,911,802	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	54,200	5,336	0	4,143	1,351,391	2.00
3.00	Total (sum of lines 1-2)	1,754,042	21,969	0	134,070	6,263,193	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/22/2017 11:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-490,053	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-15,625	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-3,504	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,759	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,098	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,341,125			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,112,445			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-148,016	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,056	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/22/2017 11:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-33,591	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00			0		0.00	0	33.00
33.01	LABORATORY MISCELLANEOUS REVENUE	B	-7,895	LABORATORY	60.00	0	33.01
33.02			0		0.00	0	33.02
33.03	OR MISCELLANEOUS REVENUE	B	561	OPERATING ROOM	50.00	0	33.03
33.04	PHYSICAL THERAPY MISCELLANEOUS REVEN	B	-59,874	PHYSICAL THERAPY	66.00	0	33.04
33.05			0		0.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-25,123	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	CORPORATE OVERHEAD	B	-16,200	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	CRNA SALARIES	A	-934,499	ANESTHESIOLOGY	53.00	0	33.08
33.09	CRNA BENEFITS EXPENSE	A	-89,709	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MARKETING SALARY	A	-41,241	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MARKETING BENEFITS EXPENSE	A	-10,489	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	MARKETING OTHER EXPENSE	A	-16,018	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING EXPENSE	A	-85,521	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LOBBYING EXPENSE	A	-19,365	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PROVIDER TAX	A	-885,571	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PROVIDER TAX ASSISTANCE PAYMENT	A	-20,107	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	FUNDED DEPRECIATION TRUSTEE FEES	A	78,021	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18			0		0.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,069,412				50.00

(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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/22/2017 11:53 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount 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	1.00	CAP REL COSTS-BLDG & FIXT	HO BUILDING CAPITAL	14,433	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO MME CAPITAL	9,993	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	15,657	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,712,957	1,621,148	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	2,227,452	2,246,899	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	80,263	80,263	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,060,755	3,948,310	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.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	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 non-financial) specify:					100.00

(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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1322	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-1 Date/Time Prepared: 2/22/2017 11:53 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	14,433	9		1.00
2.00	9,993	9		2.00
3.00	15,657	0		3.00
4.00	1,091,809	0		4.00
4.01	-19,447	0		4.01
4.02	0	0		4.02
5.00	1,112,445			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.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	MANAGEMENT/HO		6.00
7.00	HOSPITAL		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/22/2017 11:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	5,396	0	5,396	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	1,500	0	1,500	0	0	2.00
3.00	50.00	OPERATING ROOM	19,956	0	19,956	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	228,001	0	228,001	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	720	0	720	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	5,040	0	5,040	0	0	6.00
7.00	69.01	CARDIAC REHABILITATION	5,238	0	5,238	0	0	7.00
8.00	91.00	EMERGENCY	2,550,755	2,341,125	209,630	0	0	8.00
9.00	91.00	EMERGENCY	60,000	0	60,000	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,876,606	2,341,125	535,481		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	69.01	CARDIAC REHABILITATION	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		6.00
7.00	69.01	CARDIAC REHABILITATION	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	2,341,125		8.00
9.00	91.00	EMERGENCY	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,341,125		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,911,802	4,911,802				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,351,391		1,351,391			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,991,800	4,853	0	4,996,653		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,564,950	346,772	360,694	648,621	7,921,037	5.00
7.00	00700	OPERATION OF PLANT	1,139,509	1,538,324	51,448	156,928	2,886,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	182,833	23,768	0	13,015	219,616	8.00
9.00	00900	HOUSEKEEPING	455,231	132,943	0	141,205	729,379	9.00
10.00	01000	DIETARY	278,807	177,866	19,557	54,448	530,678	10.00
11.00	01100	CAFETERIA	479,541	0	44,024	142,990	666,555	11.00
13.00	01300	NURSING ADMINISTRATION	277,538	8,586	0	96,724	382,848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	285,434	98,017	984	70,034	454,469	14.00
15.00	01500	PHARMACY	539,044	53,882	5,070	186,311	784,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	591,591	75,286	0	176,084	842,961	16.00
17.00	01700	SOCIAL SERVICE	167,408	0	0	61,522	228,930	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,318,720	763,687	76,264	699,101	3,857,772	30.00
43.00	04300	NURSERY	124,967	15,431	4,732	38,903	184,033	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,465,933	429,939	210,677	347,017	2,453,566	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	113,738	22,150	4,304	35,416	175,608	52.00
53.00	05300	ANESTHESIOLOGY	276,926	12,610	23,480	0	313,016	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,884,862	311,348	423,846	494,508	3,114,564	54.00
60.00	06000	LABORATORY	1,966,911	187,033	49,239	306,927	2,510,110	60.00
65.00	06500	RESPIRATORY THERAPY	509,414	37,498	15,426	174,967	737,305	65.00
66.00	06600	PHYSICAL THERAPY	1,561,168	210,386	21,308	561,718	2,354,580	66.00
68.00	06800	SPEECH PATHOLOGY	85,902	4,480	0	31,536	121,918	68.00
69.00	06900	ELECTROCARDIOLOGY	145,447	7,425	3,730	38,043	194,645	69.00
69.01	06902	CARDIAC REHABILITATION	149,773	162,394	0	48,631	360,798	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,200	0	0	0	110,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	173,201	0	0	0	173,201	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,225,045	0	0	0	1,225,045	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,971,054	248,755	36,608	472,004	2,728,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,300,140	4,873,433	1,351,391	4,996,653	36,261,771	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,369	0	0	38,369	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	36,300,140	4,911,802	1,351,391	4,996,653	36,300,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL	7,921,037					5.00
7.00	00700	OPERATION OF PLANT	805,584	3,691,793				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,298	29,037	309,951			8.00
9.00	00900	HOUSEKEEPING	203,581	162,416	0	1,095,376		9.00
10.00	01000	DIETARY	148,120	217,298	414	68,000	964,510	10.00
11.00	01100	CAFETERIA	186,045	0	1,090	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	106,859	10,490	0	3,283	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	126,849	119,747	349	37,473	0	14.00
15.00	01500	PHARMACY	218,912	65,828	0	20,600	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,283	91,977	0	28,783	0	16.00
17.00	01700	SOCIAL SERVICE	63,898	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,076,768	932,997	78,106	291,964	920,276	30.00
43.00	04300	NURSERY	51,366	18,851	3,586	5,899	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	684,827	525,256	35,713	164,371	21,334	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,015	27,061	3,265	8,468	0	52.00
53.00	05300	ANESTHESIOLOGY	87,367	15,405	0	4,821	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	869,322	380,374	49,816	119,032	0	54.00
60.00	06000	LABORATORY	700,609	228,498	18	71,505	0	60.00
65.00	06500	RESPIRATORY THERAPY	205,793	45,811	0	14,336	0	65.00
66.00	06600	PHYSICAL THERAPY	657,199	257,028	42,473	80,433	0	66.00
68.00	06800	SPEECH PATHOLOGY	34,029	5,473	0	1,713	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,328	9,071	6,589	2,839	0	69.00
69.01	06902	CARDIAC REHABILITATION	100,704	198,396	0	62,085	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,758	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,343	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	341,928	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	761,543	303,904	78,357	95,102	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,910,328	3,644,918	299,776	1,080,707	941,610	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,709	46,875	0	14,669	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,175	0	22,900	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,921,037	3,691,793	309,951	1,095,376	964,510	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	853,690					11.00
13.00	01300	NURSING ADMINISTRATION	16,982	520,462				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,257	705	764,849			14.00
15.00	01500	PHARMACY	27,016	0	2,585	1,119,248		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,608	0	24	0	1,254,636	16.00
17.00	01700	SOCIAL SERVICE	9,788	13,285	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	170,990	232,378	61,461	0	224,275	30.00
43.00	04300	NURSERY	7,256	9,860	1,046	0	15,799	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,102	100,722	121,131	0	146,998	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,577	8,977	952	0	9,273	52.00
53.00	05300	ANESTHESIOLOGY	19,483	26,479	8,319	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,148	0	50,231	0	61,822	54.00
60.00	06000	LABORATORY	86,700	0	315,550	0	112,653	60.00
65.00	06500	RESPIRATORY THERAPY	38,441	0	4,929	0	29,880	65.00
66.00	06600	PHYSICAL THERAPY	104,546	0	3,535	0	10,304	66.00
68.00	06800	SPEECH PATHOLOGY	4,631	0	0	0	4,121	68.00
69.00	06900	ELECTROCARDIOLOGY	6,638	0	1,513	0	20,607	69.00
69.01	06902	CARDIAC REHABILITATION	9,294	0	1,207	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	49,204	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	77,334	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,119,248	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	94,233	128,056	65,828	0	592,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	853,690	520,462	764,849	1,119,248	1,227,847	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	26,789	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	853,690	520,462	764,849	1,119,248	1,254,636	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	315,901					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	315,901	8,162,888	0	8,162,888		30.00
43.00	04300	NURSERY	0	297,696	0	297,696		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,328,020	0	4,328,020		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	289,196	0	289,196		52.00
53.00	05300	ANESTHESIOLOGY	0	474,890	0	474,890		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,741,309	0	4,741,309		54.00
60.00	06000	LABORATORY	0	4,025,643	0	4,025,643		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,076,495	0	1,076,495		65.00
66.00	06600	PHYSICAL THERAPY	0	3,510,098	0	3,510,098		66.00
68.00	06800	SPEECH PATHOLOGY	0	171,885	0	171,885		68.00
69.00	06900	ELECTROCARDIOLOGY	0	296,230	0	296,230		69.00
69.01	06902	CARDIAC REHABILITATION	0	732,484	0	732,484		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	190,162	0	190,162		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	298,878	0	298,878		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,686,221	0	2,686,221		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	4,847,559	0	4,847,559		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	315,901	36,129,654	0	36,129,654		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	110,622	0	110,622		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,864	0	59,864		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	315,901	36,300,140	0	36,300,140		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
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	0	4,853	0	4,853	4,853	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,857	346,772	360,694	715,323	630	5.00
7.00	00700	OPERATION OF PLANT	11,589	1,538,324	51,448	1,601,361	152	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,768	0	23,768	13	8.00
9.00	00900	HOUSEKEEPING	0	132,943	0	132,943	137	9.00
10.00	01000	DIETARY	0	177,866	19,557	197,423	53	10.00
11.00	01100	CAFETERIA	0	0	44,024	44,024	139	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,586	0	8,586	94	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	98,017	984	99,001	68	14.00
15.00	01500	PHARMACY	0	53,882	5,070	58,952	181	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,286	0	75,286	171	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	60	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,738	763,687	76,264	844,689	678	30.00
43.00	04300	NURSERY	0	15,431	4,732	20,163	38	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,488	429,939	210,677	682,104	337	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,150	4,304	26,454	34	52.00
53.00	05300	ANESTHESIOLOGY	0	12,610	23,480	36,090	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	132	311,348	423,846	735,326	480	54.00
60.00	06000	LABORATORY	67	187,033	49,239	236,339	298	60.00
65.00	06500	RESPIRATORY THERAPY	1,228	37,498	15,426	54,152	170	65.00
66.00	06600	PHYSICAL THERAPY	145	210,386	21,308	231,839	546	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,480	0	4,480	31	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,425	3,730	11,155	37	69.00
69.01	06902	CARDIAC REHABILITATION	0	162,394	0	162,394	47	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	248,755	36,608	285,363	459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,244	4,873,433	1,351,391	6,292,068	4,853	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,369	0	38,369	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,244	4,911,802	1,351,391	6,330,437	4,853	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL	715,953					5.00
7.00	00700	OPERATION OF PLANT	72,813	1,674,326				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,540	13,169	42,490			8.00
9.00	00900	HOUSEKEEPING	18,401	73,660	0	225,141		9.00
10.00	01000	DIETARY	13,388	98,551	57	13,977	323,449	10.00
11.00	01100	CAFETERIA	16,816	0	149	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,658	4,757	0	675	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,465	54,309	48	7,702	0	14.00
15.00	01500	PHARMACY	19,786	29,855	0	4,234	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,266	41,714	0	5,916	0	16.00
17.00	01700	SOCIAL SERVICE	5,775	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	97,330	423,136	10,707	60,008	308,615	30.00
43.00	04300	NURSERY	4,643	8,550	492	1,213	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,899	238,218	4,896	33,784	7,154	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,430	12,273	448	1,741	0	52.00
53.00	05300	ANESTHESIOLOGY	7,897	6,987	0	991	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,574	172,510	6,829	24,466	0	54.00
60.00	06000	LABORATORY	63,325	103,630	2	14,697	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,601	20,777	0	2,947	0	65.00
66.00	06600	PHYSICAL THERAPY	59,401	116,569	5,822	16,532	0	66.00
68.00	06800	SPEECH PATHOLOGY	3,076	2,482	0	352	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,911	4,114	903	583	0	69.00
69.01	06902	CARDIAC REHABILITATION	9,102	89,978	0	12,761	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,780	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,370	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,905	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	68,833	137,828	10,742	19,547	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	714,985	1,653,067	41,095	222,126	315,769	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	968	21,259	0	3,015	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,395	0	7,680	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	715,953	1,674,326	42,490	225,141	323,449	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	61,128					11.00
13.00	01300	NURSING ADMINISTRATION	1,216	24,986				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,808	34	174,435			14.00
15.00	01500	PHARMACY	1,935	0	589	115,532		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,982	0	5	0	148,340	16.00
17.00	01700	SOCIAL SERVICE	701	638	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,242	11,156	14,017	0	26,517	30.00
43.00	04300	NURSERY	520	473	238	0	1,868	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,306	4,835	27,626	0	17,380	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	471	431	217	0	1,096	52.00
53.00	05300	ANESTHESIOLOGY	1,395	1,271	1,897	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,885	0	11,456	0	7,309	54.00
60.00	06000	LABORATORY	6,208	0	71,968	0	13,319	60.00
65.00	06500	RESPIRATORY THERAPY	2,753	0	1,124	0	3,533	65.00
66.00	06600	PHYSICAL THERAPY	7,486	0	806	0	1,218	66.00
68.00	06800	SPEECH PATHOLOGY	332	0	0	0	487	68.00
69.00	06900	ELECTROCARDIOLOGY	475	0	345	0	2,436	69.00
69.01	06902	CARDIAC REHABILITATION	665	0	275	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,222	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,637	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	115,532	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,748	6,148	15,013	0	70,010	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,128	24,986	174,435	115,532	145,173	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,167	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	61,128	24,986	174,435	115,532	148,340	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	7,174					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,174	1,816,269	0	1,816,269		30.00
43.00	04300	NURSERY	0	38,198	0	38,198		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,083,539	0	1,083,539		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,595	0	47,595		52.00
53.00	05300	ANESTHESIOLOGY	0	56,528	0	56,528		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,043,835	0	1,043,835		54.00
60.00	06000	LABORATORY	0	509,786	0	509,786		60.00
65.00	06500	RESPIRATORY THERAPY	0	104,057	0	104,057		65.00
66.00	06600	PHYSICAL THERAPY	0	440,219	0	440,219		66.00
68.00	06800	SPEECH PATHOLOGY	0	11,240	0	11,240		68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,959	0	24,959		69.00
69.01	06902	CARDIAC REHABILITATION	0	275,222	0	275,222		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,002	0	14,002		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,007	0	22,007		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	146,437	0	146,437		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	620,691	0	620,691		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,174	6,254,584	0	6,254,584		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	63,611	0	63,611		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,242	0	12,242		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	7,174	6,330,437	0	6,330,437		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	118,414					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,311,310				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	13,596,440			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,360	349,996	1,764,969	-7,921,037	28,379,103	5.00
7.00	00700	OPERATION OF PLANT	37,086	49,922	427,018	0	2,886,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	35,416	0	219,616	8.00
9.00	00900	HOUSEKEEPING	3,205	0	384,234	0	729,379	9.00
10.00	01000	DIETARY	4,288	18,977	148,160	0	530,678	10.00
11.00	01100	CAFETERIA	0	42,718	389,091	0	666,555	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	263,196	0	382,848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	955	190,571	0	454,469	14.00
15.00	01500	PHARMACY	1,299	4,920	506,974	0	784,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	479,144	0	842,961	16.00
17.00	01700	SOCIAL SERVICE	0	0	167,408	0	228,930	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,411	74,002	1,902,328	0	3,857,772	30.00
43.00	04300	NURSERY	372	4,592	105,859	0	184,033	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	204,428	944,273	0	2,453,566	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	534	4,176	96,370	0	175,608	52.00
53.00	05300	ANESTHESIOLOGY	304	22,784	0	0	313,016	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	411,276	1,345,610	0	3,114,564	54.00
60.00	06000	LABORATORY	4,509	47,779	835,183	0	2,510,110	60.00
65.00	06500	RESPIRATORY THERAPY	904	14,968	476,104	0	737,305	65.00
66.00	06600	PHYSICAL THERAPY	5,072	20,676	1,528,498	0	2,354,580	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	85,812	0	121,918	68.00
69.00	06900	ELECTROCARDIOLOGY	179	3,619	103,518	0	194,645	69.00
69.01	06902	CARDIAC REHABILITATION	3,915	0	132,329	0	360,798	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	110,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	173,201	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,225,045	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	35,522	1,284,375	0	2,728,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,489	1,311,310	13,596,440	-7,921,037	28,340,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	38,369	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	4,911,802	1,351,391	4,996,653		7,921,037	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.479909	1.030566	0.367497		0.279115	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,853		715,953	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000357		0.025228	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	72,851					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	245,330				8.00
9.00	00900	HOUSEKEEPING	3,205	0	69,073			9.00
10.00	01000	DIETARY	4,288	328	4,288	17,858		10.00
11.00	01100	CAFETERIA	0	863	0	0	27,649	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	276	2,363	0	818	14.00
15.00	01500	PHARMACY	1,299	0	1,299	0	875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	1,801	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	317	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,411	61,822	18,411	17,039	5,538	30.00
43.00	04300	NURSERY	372	2,838	372	0	235	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	28,267	10,365	395	2,400	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	534	2,584	534	0	213	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	631	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	39,430	7,506	0	3,114	54.00
60.00	06000	LABORATORY	4,509	14	4,509	0	2,808	60.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	1,245	65.00
66.00	06600	PHYSICAL THERAPY	5,072	33,618	5,072	0	3,386	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	150	68.00
69.00	06900	ELECTROCARDIOLOGY	179	5,215	179	0	215	69.00
69.01	06902	CARDIAC REHABILITATION	3,915	0	3,915	0	301	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	62,021	5,997	0	3,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,926	237,276	68,148	17,434	27,649	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,054	0	424	0	192.00
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)	3,691,793	309,951	1,095,376	964,510	853,690	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	50.675941	1.263404	15.858237	54.009968	30.875981	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,674,326	42,490	225,141	323,449	61,128	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	22.982883	0.173195	3.259465	18.112275	2.210858	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/22/2017 11:53 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
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	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	166,857					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	226	1,712,996				14.00
15.00	01500	PHARMACY	0	5,789	1,225,045			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53	0	3,653		16.00
17.00	01700	SOCIAL SERVICE	4,259	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,499	137,652	0	653	100	30.00
43.00	04300	NURSERY	3,161	2,342	0	46	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,291	271,292	0	428	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,878	2,132	0	27	0	52.00
53.00	05300	ANESTHESIOLOGY	8,489	18,631	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	112,499	0	180	0	54.00
60.00	06000	LABORATORY	0	706,723	0	328	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,040	0	87	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,918	0	30	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	12	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,389	0	60	0	69.00
69.01	06902	CARDIAC REHABILITATION	0	2,704	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	110,200	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	173,201	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,225,045	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	41,054	147,431	0	1,724	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	166,857	1,712,996	1,225,045	3,575	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	78	0	192.00
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)	520,462	764,849	1,119,248	1,254,636	315,901	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.119210	0.446498	0.913638	343.453600	3,159.010000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,986	174,435	115,532	148,340	7,174	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.149745	0.101830	0.094308	40.607720	71.740000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,162,888		8,162,888	0	0	30.00
43.00	04300	NURSERY	297,696		297,696	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,328,020		4,328,020	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,196		289,196	0	0	52.00
53.00	05300	ANESTHESIOLOGY	474,890		474,890	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,741,309		4,741,309	0	0	54.00
60.00	06000	LABORATORY	4,025,643		4,025,643	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,076,495	0	1,076,495	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,510,098	0	3,510,098	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	171,885	0	171,885	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	296,230		296,230	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	732,484		732,484	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	190,162		190,162	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	298,878		298,878	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,686,221		2,686,221	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,847,559		4,847,559	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	457,298		457,298		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,586,952	0	36,586,952	0	0	200.00
201.00		Less Observation Beds	457,298		457,298		0	201.00
202.00		Total (see instructions)	36,129,654	0	36,129,654	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,866,403		3,866,403			30.00
43.00	04300	NURSERY	403,681		403,681			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,086,368	5,404,476	6,490,844	0.666788	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,130,026	454,453	1,584,479	0.182518	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	330,827	921,353	1,252,180	0.379251	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,057,712	34,655,455	35,713,167	0.132761	0.000000	54.00
60.00	06000	LABORATORY	2,268,450	14,321,523	16,589,973	0.242655	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	646,651	1,882,585	2,529,236	0.425621	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	423,087	5,108,118	5,531,205	0.634599	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	15,766	226,444	242,210	0.709653	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	249,585	1,700,802	1,950,387	0.151883	0.000000	69.00
69.01	06902	CARDIAC REHABILITATION	0	982,122	982,122	0.745818	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	878,850	978,054	1,856,904	0.102408	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	508,385	468,393	976,778	0.305984	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,342,712	9,712,060	12,054,772	0.222835	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	285,309	14,540,428	14,825,737	0.326969	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	57,655	571,858	629,513	0.726431	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,551,467	91,928,124	107,479,591			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,551,467	91,928,124	107,479,591			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06902	CARDIAC REHABILITATION	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,083,539	6,490,844	0.166933	148,358	24,766	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,595	1,584,479	0.030038	1,696	51	52.00
53.00	05300	ANESTHESIOLOGY	56,528	1,252,180	0.045144	38,937	1,758	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,043,835	35,713,167	0.029228	530,537	15,507	54.00
60.00	06000	LABORATORY	509,786	16,589,973	0.030729	913,839	28,081	60.00
65.00	06500	RESPIRATORY THERAPY	104,057	2,529,236	0.041142	314,008	12,919	65.00
66.00	06600	PHYSICAL THERAPY	440,219	5,531,205	0.079588	157,186	12,510	66.00
68.00	06800	SPEECH PATHOLOGY	11,240	242,210	0.046406	7,591	352	68.00
69.00	06900	ELECTROCARDIOLOGY	24,959	1,950,387	0.012797	128,780	1,648	69.00
69.01	06902	CARDIAC REHABILITATION	275,222	982,122	0.280232	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,002	1,856,904	0.007541	372,055	2,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,007	976,778	0.022530	190,574	4,294	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,437	12,054,772	0.012148	685,587	8,329	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	620,691	14,825,737	0.041866	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	101,750	629,513	0.161633	249	40	92.00
200.00		Total (lines 50-199)	4,501,867	103,209,507		3,489,397	113,061	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY 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	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,490,844	0.000000	0.000000	148,358	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,584,479	0.000000	0.000000	1,696	52.00
53.00	05300	ANESTHESIOLOGY	0	1,252,180	0.000000	0.000000	38,937	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,713,167	0.000000	0.000000	530,537	54.00
60.00	06000	LABORATORY	0	16,589,973	0.000000	0.000000	913,839	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,529,236	0.000000	0.000000	314,008	65.00
66.00	06600	PHYSICAL THERAPY	0	5,531,205	0.000000	0.000000	157,186	66.00
68.00	06800	SPEECH PATHOLOGY	0	242,210	0.000000	0.000000	7,591	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,950,387	0.000000	0.000000	128,780	69.00
69.01	06902	CARDIAC REHABILITATION	0	982,122	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,856,904	0.000000	0.000000	372,055	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	976,778	0.000000	0.000000	190,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,054,772	0.000000	0.000000	685,587	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,825,737	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	629,513	0.000000	0.000000	249	92.00
200.00		Total (lines 50-199)	0	103,209,507			3,489,397	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06902	CARDIAC REHABILITATION	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.666788	0	1,916,309	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.182518	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.379251	0	214,622	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132761	0	11,367,990	0	0	54.00
60.00	06000	LABORATORY	0.242655	0	4,415,527	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.425621	0	506,233	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.634599	0	1,498,253	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.709653	0	17,458	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151883	0	620,598	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	0.745818	0	459,746	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.102408	0	307,294	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305984	0	148,294	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222835	0	3,863,381	26,231	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.326969	0	4,063,272	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726431	0	228,586	0	0	92.00
200.00		Subtotal (see instructions)		0	29,627,563	26,231	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	29,627,563	26,231	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,277,772	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	81,396	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,509,226	0		54.00
60.00	06000	LABORATORY	1,071,450	0		60.00
65.00	06500	RESPIRATORY THERAPY	215,463	0		65.00
66.00	06600	PHYSICAL THERAPY	950,790	0		66.00
68.00	06800	SPEECH PATHOLOGY	12,389	0		68.00
69.00	06900	ELECTROCARDIOLOGY	94,258	0		69.00
69.01	06902	CARDIAC REHABILITATION	342,887	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,469	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,376	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	860,897	5,845		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,328,564	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	166,052	0		92.00
200.00		Subtotal (see instructions)	7,987,989	5,845		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,987,989	5,845		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.666788	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.182518	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.379251	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132761	0	0	0	0	54.00
60.00	06000	LABORATORY	0.242655	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.425621	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.634599	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.709653	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151883	0	0	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	0.745818	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.102408	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305984	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222835	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.326969	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726431	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06902	CARDIAC REHABILITATION	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,754	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,110	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,901	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	155	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	464	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	6	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	19	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,396	9.00
10.00	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)	122	10.00
11.00	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)	366	11.00
12.00	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	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	143.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	150.15	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,162,888	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	862	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,853	25.00
26.00	Total swing-bed cost (see instructions)	1,358,106	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,804,782	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	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	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	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 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,804,782	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,188.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,054,490	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,054,490	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	913,895	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,968,385	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	266,940	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	800,819	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,067,759	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	209	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,188.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	457,298	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	1,816,269	8,162,888	0.222503	457,298	101,750	90.00
91.00	Nursing School cost	0	8,162,888	0.000000	457,298	0	91.00
92.00	Allied health cost	0	8,162,888	0.000000	457,298	0	92.00
93.00	All other Medical Education	0	8,162,888	0.000000	457,298	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,860,785		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.666788	148,358	98,923	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.182518	1,696	310	52.00
53.00	05300	ANESTHESIOLOGY	0.379251	38,937	14,767	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132761	530,537	70,435	54.00
60.00	06000	LABORATORY	0.242655	913,839	221,748	60.00
65.00	06500	RESPIRATORY THERAPY	0.425621	314,008	133,648	65.00
66.00	06600	PHYSICAL THERAPY	0.634599	157,186	99,750	66.00
68.00	06800	SPEECH PATHOLOGY	0.709653	7,591	5,387	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151883	128,780	19,559	69.00
69.01	06902	CARDIAC REHABILITATION	0.745818	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.102408	372,055	38,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305984	190,574	58,313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222835	685,587	152,773	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.326969	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726431	249	181	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,489,397	913,895	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,489,397		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.666788	796	531	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.182518	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.379251	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132761	88,970	11,812	54.00
60.00	06000	LABORATORY	0.242655	196,727	47,737	60.00
65.00	06500	RESPIRATORY THERAPY	0.425621	84,733	36,064	65.00
66.00	06600	PHYSICAL THERAPY	0.634599	139,758	88,690	66.00
68.00	06800	SPEECH PATHOLOGY	0.709653	6,493	4,608	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151883	15,392	2,338	69.00
69.01	06902	CARDIAC REHABILITATION	0.745818	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.102408	93,988	9,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305984	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222835	141,486	31,528	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.326969	487	159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726431	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		768,830	233,092	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		768,830		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1322	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/22/2017 11:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,993,834	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,993,834	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	14.00
	Customary charges		
15.00	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 for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	8,073,772	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	42,052	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,073,096	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,958,624	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,958,624	30.00
31.00	Primary payer payments	84	31.00
32.00	Subtotal (line 30 minus line 31)	2,958,540	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	560,250	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	364,163	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	415,260	36.00
37.00	Subtotal (see instructions)	3,322,703	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,322,703	40.00
40.01	Sequestration adjustment (see instructions)	66,454	40.01
41.00	Interim payments	3,746,259	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-490,010	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part 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		3,019,709		3,746,259	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	09/22/2016	141,252		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		141,252		0	3.99
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)		3,160,961		3,746,259	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	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					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		436,888		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		490,010	6.02
7.00	Total Medicare program liability (see instructions)		3,597,849		3,256,249	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/22/2017 11:53 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part 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		1,263,785		0	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	09/22/2016	150,486		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		150,486		0	3.99
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)		1,414,271		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	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					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		131,360		0	6.02
7.00	Total Medicare program liability (see instructions)		1,282,911		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1322	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/22/2017 11:53 am
	Title XVIII	Hospital	Cost

		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 14	915	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,396	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	399	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,901	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	107,479,591	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,163,039	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1322 Component CCN: 14-Z322	Period: From 10/01/2015 To 09/30/2016	Worksheet E-2 Date/Time Prepared: 2/22/2017 11:53 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,078,437	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	235,423	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	488	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,313,860	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,313,860	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,313,860	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,767	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,309,093	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,309,093	0	19.00
19.01	Sequestration adjustment (see instructions)	26,182	0	19.01
20.00	Interim payments	1,414,271	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-131,360	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1322	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 2/22/2017 11:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,968,385	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,968,385	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,008,069	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,008,069	19.00
20.00	Deductibles (exclude professional component)	372,986	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,635,083	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,635,083	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	55,679	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	36,191	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,933	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,671,274	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,671,274	30.00
30.01	Sequestration adjustment (see instructions)	73,425	30.01
31.00	Interim payments	3,160,961	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	436,888	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/22/2017 11:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	24,258,138	0	0	0	1.00
2.00	Temporary investments	11,890,134	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,507,223	0	0	0	4.00
5.00	Other receivable	1,485,688	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,283,508	0	0	0	6.00
7.00	Inventory	611,603	0	0	0	7.00
8.00	Prepaid expenses	255,427	0	0	0	8.00
9.00	Other current assets	1,128,581	0	0	0	9.00
10.00	Due from other funds	345,647	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	48,198,933	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,302,988	0	0	0	12.00
13.00	Land improvements	6,012,382	0	0	0	13.00
14.00	Accumulated depreciation	-2,806,631	0	0	0	14.00
15.00	Buildings	42,453,836	0	0	0	15.00
16.00	Accumulated depreciation	-14,787,837	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	15,958,695	0	0	0	23.00
24.00	Accumulated depreciation	-10,714,593	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	37,418,840	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	32,357,377	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	487,850	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,845,227	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	118,463,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,252,772	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,171,713	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	1,128,581	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,389,212	0	0	0	43.00
44.00	Other current liabilities	380,071	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,322,349	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	41,890,467	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,890,467	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,212,816	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	71,250,184				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	71,250,184	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	118,463,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/22/2017 11:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		57,657,272		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,592,479				2.00
3.00	Total (sum of line 1 and line 2)		71,249,751		0		3.00
4.00	ROUNDING	433		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		433		0		10.00
11.00	Subtotal (line 3 plus line 10)		71,250,184		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		71,250,184		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			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			0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/22/2017 11:53 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,464,160		3,464,160	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	391,667		391,667	5.00
6.00	Swing bed - NF	15,819		15,819	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,871,646		3,871,646	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,871,646		3,871,646	17.00
18.00	Ancillary services	11,037,189	78,435,996	89,473,185	18.00
19.00	Outpatient services	346,907	15,250,297	15,597,204	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	403,681	0	403,681	27.00
27.01	PROFEES	655,182	9,565,147	10,220,329	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,314,605	103,251,440	119,566,045	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,369,552		29.00
30.00	PROVISION FOR BAD DEBTS	1,168,621			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,168,621		36.00
37.00		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)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		41,538,173		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/22/2017 11:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	119,566,045	1.00
2.00	Less contractual allowances and discounts on patients' accounts	71,649,057	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,916,988	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,538,173	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,378,815	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	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	148,016	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,056	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	2,810	22.00
23.00	Governmental appropriations	3,880,808	23.00
24.00	OTHER MISCELLANEOUS INCOME	149,610	24.00
24.01	MANAGEMENT SUPPORT	16,200	24.01
24.02	SALE OF REFUSE	87,373	24.02
25.00	Total other income (sum of lines 6-24)	4,285,873	25.00
26.00	Total (line 5 plus line 25)	10,664,688	26.00
27.00	NONOPERATING INCOME/EXPENSE	-2,927,791	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2,927,791	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,592,479	29.00