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 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/21/2018 2:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/21/2018 Time: 2:02 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (14-1322) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)_____
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	230,764	119,292	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	55,953	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	286,717	119,292	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2018 1:59 pm

	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	02/03/2003	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		02/03/2003	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)	10/01/2016	09/30/2017	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

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		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)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
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(b) 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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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
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. Enter in column 4, the 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. Enter in column 4, the 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 through 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2018 1:59 pm

		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

		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 is 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 is 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

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		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
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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a 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 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		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:	42,869	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 healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2018 1:59 pm

	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.			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

		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)	10/01/2016	09/30/2017	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/21/2018 1:59 pm

		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	01/10/2018	Y	01/10/2018	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/21/2018 1:59 pm

		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:	PRORATIONS		Y	Y	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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1322	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/21/2018 1:59 pm

		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 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/21/2018 1:59 pm

	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	9,125	81,761.00	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	9,125	81,761.00	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	9,125	81,761.00	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
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/21/2018 1:59 pm

	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)	1,270	348	2,766			1.00
2.00	HMO and other (see instructions)	515	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	396	0	566			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	45			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,666	348	3,377			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		220	367			13.00
14.00	Total (see instructions)	1,666	568	3,744	0.00	266.70	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	266.70	27.00
28.00	Observation Bed Days		24	166			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			39			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	65			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/21/2018 1:59 pm

	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	372	131	896	1.00
2.00	HMO and other (see instructions)			141	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	372	131	896	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/21/2018 1:59 pm

		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)	0.334046	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,423,452	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 and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	3,187,151	5.00
6.00	Medicaid charges	23,316,996	6.00
7.00	Medicaid cost (line 1 times line 6)	7,788,949	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)	1,178,346	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	33,795	9.00
10.00	Stand-alone CHIP charges	234,802	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	78,435	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	44,640	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
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (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)	1,222,986	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,217,054	321,517	3,538,571	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,074,644	321,517	1,396,161	21.00
22.00	Payments received from patients for amounts previously written off as charity care	760,397	0	760,397	22.00
23.00	Cost of charity care (line 21 minus line 22)	314,247	321,517	635,764	23.00

		1.00	
24.00	Does the amount on 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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	988,515	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	438,626	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	674,808	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	313,707	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	340,975	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	976,739	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,199,725	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/21/2018 1:59 pm

		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		3,041,748	3,041,748	2,360,808	5,402,556	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,231,686	1,231,686	88,374	1,320,060	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	410,703	4,892,993	5,303,696	-82,427	5,221,269	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,967,225	5,266,960	7,234,185	-57,950	7,176,235	5.00
7.00	00700	OPERATION OF PLANT	494,336	800,533	1,294,869	0	1,294,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	207,379	207,379	8.00
9.00	00900	HOUSEKEEPING	433,175	254,845	688,020	-207,379	480,641	9.00
10.00	01000	DIETARY	592,326	386,081	978,407	-642,709	335,698	10.00
11.00	01100	CAFETERIA	0	0	0	640,946	640,946	11.00
13.00	01300	NURSING ADMINISTRATION	448,748	23,450	472,198	-183,374	288,824	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	255,312	332,865	588,177	-330,512	257,665	14.00
15.00	01500	PHARMACY	586,025	1,344,173	1,930,198	-1,299,766	630,432	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	515,246	103,865	619,111	0	619,111	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	174,725	174,725	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	913,667	0	913,667	82,427	996,094	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,396,415	927,559	2,323,974	702,940	3,026,914	30.00
43.00	04300	NURSERY	0	0	0	115,660	115,660	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	870,859	734,674	1,605,533	-41,293	1,564,240	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	760,400	199,723	960,123	-818,600	141,523	52.00
53.00	05300	ANESTHESIOLOGY	0	278,103	278,103	-276	277,827	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,381,336	602,336	1,983,672	-48,165	1,935,507	54.00
60.00	06000	LABORATORY	864,497	1,177,964	2,042,461	0	2,042,461	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	463,973	34,728	498,701	0	498,701	65.00
66.00	06600	PHYSICAL THERAPY	1,521,163	90,383	1,611,546	0	1,611,546	66.00
68.00	06800	SPEECH PATHOLOGY	76,390	0	76,390	0	76,390	68.00
69.00	06900	ELECTROCARDIOLOGY	106,312	27,045	133,357	0	133,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	163,703	163,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	208,404	208,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,358,497	1,358,497	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	138,951	19,943	158,894	0	158,894	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,360,824	3,112,723	4,473,547	-180	4,473,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,391,232	2,391,232	-2,391,232	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,557,883	27,275,612	42,833,495	0	42,833,495	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 through 199)	15,557,883	27,275,612	42,833,495	0	42,833,495	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/21/2018 1:59 pm

		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	-458,860	4,943,696		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,569	1,331,629		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,372	5,211,897		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,161,943	6,014,292		5.00
7.00	00700	OPERATION OF PLANT	0	1,294,869		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	207,379		8.00
9.00	00900	HOUSEKEEPING	0	480,641		9.00
10.00	01000	DIETARY	0	335,698		10.00
11.00	01100	CAFETERIA	-165,891	475,055		11.00
13.00	01300	NURSING ADMINISTRATION	0	288,824		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	257,665		14.00
15.00	01500	PHARMACY	0	630,432		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,194	617,917		16.00
17.00	01700	SOCIAL SERVICE	0	174,725		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-996,094	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-571,011	2,455,903		30.00
43.00	04300	NURSERY	0	115,660		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,564,240		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-23	141,500		52.00
53.00	05300	ANESTHESIOLOGY	0	277,827		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,935,507		54.00
60.00	06000	LABORATORY	-1,996	2,040,465		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	498,701		65.00
66.00	06600	PHYSICAL THERAPY	-64,168	1,547,378		66.00
68.00	06800	SPEECH PATHOLOGY	0	76,390		68.00
69.00	06900	ELECTROCARDIOLOGY	0	133,357		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	163,703		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	208,404		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,358,497		73.00
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	158,894		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,441,922	2,031,445		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 through 117)	-5,860,905	36,972,590		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 through 199)	-5,860,905	36,972,590		200.00

RECLASSIFICATIONS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/21/2018 1:59 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - STERILE PROCESSING				
1.00	OPERATING ROOM	50.00	51,888	61,520	1.00
	0		51,888	61,520	
	B - LABOR & DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	556,716	146,224	1.00
2.00	NURSERY	43.00	91,601	24,059	2.00
	0		648,317	170,283	
	C - CASE MANAGEMENT				
1.00	SOCIAL SERVICE	17.00	174,725	0	1.00
	0		174,725	0	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	57,950	1.00
	0		0	57,950	
	E - DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,358,497	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
6.00		0.00	0	0	6.00
	0		0	1,358,497	
	F - LAUNDRY EXPENSE				
1.00	LAUNDRY & LINEN SERVICE	8.00	34,644	172,735	1.00
	0		34,644	172,735	
	G - IMPLANTS & MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	163,703	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	208,404	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	372,107	
	H - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	388,728	252,218	1.00
	0		388,728	252,218	
	I - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,187,507	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	69,655	2.00
	0		0	2,257,162	
	J - BOND AMORTIZATION EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,933	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,137	2.00
	0		0	134,070	
	K - CRNA BENEFITS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	82,427	1.00
	TOTALS		0	82,427	
500.00	Grand Total: Increases		1,298,302	4,918,969	500.00

RECLASSIFICATIONS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/21/2018 1:59 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - STERILE PROCESSING						
1.00	CENTRAL SERVICES & SUPPLY	14.00	51,888	61,520	0		1.00
	0		51,888	61,520			
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	648,317	170,283	0		1.00
2.00		0.00	0	0	0		2.00
	0		648,317	170,283			
	C - CASE MANAGEMENT						
1.00	NURSING ADMINISTRATION	13.00	174,725	0	0		1.00
	0		174,725	0			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,950	0		1.00
	0		0	57,950			
	E - DRUG EXPENSE						
1.00	DIETARY	10.00	0	1,763	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	8,649	0		2.00
3.00	PHARMACY	15.00	0	1,299,631	0		3.00
4.00	OPERATING ROOM	50.00	0	13	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	276	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,165	0		6.00
	0		0	1,358,497			
	F - LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	34,644	172,735	0		1.00
	0		34,644	172,735			
	G - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	217,104	0		1.00
2.00	PHARMACY	15.00	0	135	0		2.00
3.00	OPERATING ROOM	50.00	0	154,688	0		3.00
4.00	EMERGENCY	91.00	0	180	0		4.00
	0		0	372,107			
	H - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	388,728	252,218	0		1.00
	0		388,728	252,218			
	I - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,257,162	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	2,257,162			
	J - 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			
	K - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	82,427	0		1.00
	TOTALS		0	82,427			
500.00	Grand Total: Decreases		1,298,302	4,918,969			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/21/2018 1:59 pm

		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	1,302,988	40,172	0	40,172	2,205	1.00
2.00	Land Improvements	6,012,383	36,175	0	36,175	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	42,434,984	36,747	0	36,747	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,432,619	1,288,086	0	1,288,086	481,581	6.00
7.00	HIT designated Assets	2,526,077	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,709,051	1,401,180	0	1,401,180	483,786	8.00
9.00	Reconciling Items	-18,850	-83,032	0	-83,032	0	9.00
10.00	Total (line 8 minus line 9)	65,727,901	1,484,212	0	1,484,212	483,786	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,340,955	0	1.00
2.00	Land Improvements	6,048,558	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	42,471,731	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	14,239,124	0	6.00
7.00	HIT designated Assets	2,526,077	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,626,445	0	8.00
9.00	Reconciling Items	-101,882	0	9.00
10.00	Total (line 8 minus line 9)	66,728,327	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/21/2018 1:59 pm

	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	3,041,748	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,231,686	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,273,434	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	3,041,748	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,231,686	2.00
3.00	Total (sum of lines 1-2)	0	4,273,434	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/21/2018 1:59 pm

	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	49,861,244	0	49,861,244	0.748370	43,368	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,765,201	0	16,765,201	0.251630	14,582	2.00
3.00	Total (sum of lines 1-2)	66,626,445	0	66,626,445	1.000000	57,950	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	43,368	3,083,955	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	14,582	1,259,210	0	2.00
3.00	Total (sum of lines 1-2)	0	0	57,950	4,343,165	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	1,686,440	43,368	0	129,933	4,943,696	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	53,700	14,582	0	4,137	1,331,629	2.00
3.00	Total (sum of lines 1-2)	1,740,140	57,950	0	134,070	6,275,325	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/21/2018 1:59 pm

	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	-501,067	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-15,955	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-4,116	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	-3,542	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-10,305	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	-3,012,933			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-16,780	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	255,261			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-165,891	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	-1,194	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (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	A	-996,094	NONPHYSICIAN ANESTHETISTS	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
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-157,344	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INCOME - A&G	B	-4,210	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/21/2018 1:59 pm

	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	
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.02	MISC INCOME - L&D	B	-23	DELIVERY ROOM & LABOR ROOM	52.00	0	33.02
33.03	MISC INCOME - LAB	B	-1,996	LABORATORY	60.00	0	33.03
33.04	MISC INCOME - PT	B	-64,168	PHYSICAL THERAPY	66.00	0	33.04
34.00	PROVIDER TAX	A	-970,901	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	PROVIDER TAX ASSISTANCE	A	-16,806	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADVERTISING EXPENSE	A	-90,341	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	MARKETING - SALARIES	A	-39,622	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	MARKETING - BENEFITS	A	-9,372	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.02
35.03	MARKETING - OTHER	A	-25,145	ADMINISTRATIVE & GENERAL	5.00	0	35.03
36.00	FUNDED DEPRECIATION TRUSTEE FEES	A	68,598	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	ALMH FOUNDATION MGMT/ACCT SVCS	B	-16,320	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	LOBBYING EXPENSE	A	-21,023	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	PHYSICIAN LOAN FORGIVENESS	A	-36,717	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	RENTAL INCOME	B	-2,899	ADMINISTRATIVE & GENERAL	5.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,860,905				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 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/21/2018 1:59 pm

	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 POOLED CAPITAL - BLDG	42,101	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO POOLED CAPITAL - MME	17,550	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO DIRECT CAPITAL - BLDG	106	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO DIRECT CAPITAL - MME	167,318	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	17,970	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,412,171	2,011,760	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	2,136,542	2,526,737	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	60,546	60,546	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,854,304	4,599,043	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:					
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

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.

(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 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/21/2018 1:59 pm

	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	42,101	9		1.00
2.00	17,550	9		2.00
3.00	106	9		3.00
4.00	167,318	9		4.00
4.01	17,970	0		4.01
4.02	400,411	0		4.02
4.03	-390,195	0		4.03
4.04	0	0		4.04
5.00	255,261			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 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/21/2018 1:59 pm

	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	8,507	0	8,507	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	2,599	0	2,599	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	571,011	571,011	0	0	0	3.00
4.00	50.00	OPERATING ROOM	46,980	0	46,980	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	238,353	0	238,353	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	2,250	0	2,250	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	2,030	0	2,030	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	5,265	0	5,265	0	0	8.00
9.00	91.00	EMERGENCY	63,378	0	63,378	0	0	9.00
10.00	91.00	EMERGENCY	2,608,453	2,441,922	166,531	0	0	10.00
200.00			3,548,826	3,012,933	535,893		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	571,011		3.00
4.00	50.00	OPERATING ROOM	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	0		9.00
10.00	91.00	EMERGENCY	0	0	0	2,441,922		10.00
200.00			0	0	0	3,012,933		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/21/2018 1:59 pm

		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	4,943,696	4,943,696				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,331,629		1,331,629			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,211,897	4,885	0	5,216,782		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,014,292	349,024	291,153	708,465	7,362,934	5.00
7.00	00700	OPERATION OF PLANT	1,294,869	1,548,314	39,863	181,687	3,064,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	207,379	23,922	0	12,733	244,034	8.00
9.00	00900	HOUSEKEEPING	480,641	133,806	0	146,475	760,922	9.00
10.00	01000	DIETARY	335,698	179,021	21,547	74,830	611,096	10.00
11.00	01100	CAFETERIA	475,055	0	41,141	142,872	659,068	11.00
13.00	01300	NURSING ADMINISTRATION	288,824	8,642	0	100,714	398,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	257,665	98,653	940	74,766	432,024	14.00
15.00	01500	PHARMACY	630,432	54,232	4,664	215,386	904,714	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	617,917	75,775	0	189,372	883,064	16.00
17.00	01700	SOCIAL SERVICE	174,725	0	0	64,218	238,943	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,455,903	765,598	51,087	717,847	3,990,435	30.00
43.00	04300	NURSERY	115,660	15,531	3,103	33,667	167,961	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,564,240	432,731	266,669	339,144	2,602,784	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	141,500	25,342	3,798	41,195	211,835	52.00
53.00	05300	ANESTHESIOLOGY	277,827	12,692	17,104	0	307,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,935,507	313,370	450,197	507,692	3,206,766	54.00
60.00	06000	LABORATORY	2,040,465	188,247	58,902	317,735	2,605,349	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	498,701	37,741	13,502	170,527	720,471	65.00
66.00	06600	PHYSICAL THERAPY	1,547,378	211,752	20,273	559,084	2,338,487	66.00
68.00	06800	SPEECH PATHOLOGY	76,390	4,509	0	28,076	108,975	68.00
69.00	06900	ELECTROCARDIOLOGY	133,357	7,473	3,659	39,074	183,563	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	163,703	0	0	0	163,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,404	0	0	0	208,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,358,497	0	0	0	1,358,497	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	158,894	163,448	0	51,070	373,412	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,031,445	250,370	44,027	500,153	2,825,995	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 through 117)	36,972,590	4,905,078	1,331,629	5,216,782	36,933,972	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,618	0	0	38,618	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 through 201)	36,972,590	4,943,696	1,331,629	5,216,782	36,972,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/21/2018 1:59 pm

		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	7,362,934					5.00
7.00	00700	OPERATION OF PLANT	762,098	3,826,831				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,683	30,099	334,816			8.00
9.00	00900	HOUSEKEEPING	189,216	168,357	0	1,118,495		9.00
10.00	01000	DIETARY	151,959	225,247	464	69,435	1,058,201	10.00
11.00	01100	CAFETERIA	163,888	0	885	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	99,014	10,874	0	3,352	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,430	124,127	344	38,264	0	14.00
15.00	01500	PHARMACY	224,973	68,236	0	21,035	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,589	95,341	0	29,390	0	16.00
17.00	01700	SOCIAL SERVICE	59,417	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	992,282	963,287	88,807	296,946	999,543	30.00
43.00	04300	NURSERY	41,766	19,541	2,968	6,024	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	647,226	544,469	42,513	167,840	30,707	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,676	31,885	3,632	9,829	0	52.00
53.00	05300	ANESTHESIOLOGY	76,496	15,969	0	4,923	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	797,417	394,287	44,721	121,544	0	54.00
60.00	06000	LABORATORY	647,864	236,856	28	73,014	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	179,157	47,487	0	14,638	0	65.00
66.00	06600	PHYSICAL THERAPY	581,505	266,430	53,965	82,131	0	66.00
68.00	06800	SPEECH PATHOLOGY	27,098	5,673	0	1,749	0	68.00
69.00	06900	ELECTROCARDIOLOGY	45,646	9,403	7,692	2,899	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,708	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,823	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,813	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	92,855	205,653	0	63,395	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	702,732	315,020	80,048	97,109	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 through 117)	7,353,331	3,778,241	326,067	1,103,517	1,030,250	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,603	48,590	0	14,978	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8,749	0	27,951	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 through 201)	7,362,934	3,826,831	334,816	1,118,495	1,058,201	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/21/2018 1:59 pm

		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	823,841					11.00
13.00	01300	NURSING ADMINISTRATION	15,971	527,391				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,151	1,939	728,279			14.00
15.00	01500	PHARMACY	28,686	0	1,944	1,249,588		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,900	0	25	0	1,283,309	16.00
17.00	01700	SOCIAL SERVICE	10,157	12,402	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	170,994	233,636	51,757	0	210,664	30.00
43.00	04300	NURSERY	6,396	8,768	657	0	20,591	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,870	110,104	106,874	0	167,581	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,831	10,728	804	0	6,969	52.00
53.00	05300	ANESTHESIOLOGY	15,739	21,541	6,749	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,626	0	46,264	0	18,374	54.00
60.00	06000	LABORATORY	81,562	0	294,879	0	65,575	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,121	0	4,029	0	33,263	65.00
66.00	06600	PHYSICAL THERAPY	97,185	0	8,029	0	2,218	66.00
68.00	06800	SPEECH PATHOLOGY	3,993	0	0	0	634	68.00
69.00	06900	ELECTROCARDIOLOGY	5,699	0	1,838	0	18,374	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	61,959	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	78,878	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,249,588	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,342	0	874	0	1,901	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	93,618	128,273	62,719	0	730,829	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 through 117)	823,841	527,391	728,279	1,249,588	1,276,973	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	6,336	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 through 201)	823,841	527,391	728,279	1,249,588	1,283,309	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/21/2018 1:59 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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	320,919					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	320,919	0	8,319,270	-250,771	8,068,499	30.00
43.00	04300	NURSERY	0	0	274,672	0	274,672	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,486,968	48	4,487,016	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	336,189	0	336,189	52.00
53.00	05300	ANESTHESIOLOGY	0	0	449,040	0	449,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,723,999	0	4,723,999	54.00
60.00	06000	LABORATORY	0	0	4,005,127	0	4,005,127	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	164,153	164,153	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,034,166	0	1,034,166	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,429,950	0	3,429,950	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	148,122	0	148,122	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	275,114	0	275,114	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	266,370	0	266,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	339,105	0	339,105	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,945,898	0	2,945,898	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	71,072	71,072	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	747,432	0	747,432	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	5,036,343	15,498	5,051,841	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 through 117)	320,919	0	36,817,765	0	36,817,765	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	111,789	0	111,789	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	43,036	0	43,036	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	320,919	0	36,972,590	0	36,972,590	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/21/2018 1:59 pm

		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	4,885	0	4,885	4,885	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,480	349,024	291,153	667,657	663	5.00
7.00	00700	OPERATION OF PLANT	11,986	1,548,314	39,863	1,600,163	170	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,922	0	23,922	12	8.00
9.00	00900	HOUSEKEEPING	0	133,806	0	133,806	137	9.00
10.00	01000	DIETARY	0	179,021	21,547	200,568	70	10.00
11.00	01100	CAFETERIA	0	0	41,141	41,141	134	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,642	0	8,642	94	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	98,653	940	99,593	70	14.00
15.00	01500	PHARMACY	0	54,232	4,664	58,896	202	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,775	0	75,775	177	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	60	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,707	765,598	51,087	828,392	674	30.00
43.00	04300	NURSERY	0	15,531	3,103	18,634	32	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,985	432,731	266,669	736,385	317	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,342	3,798	29,140	39	52.00
53.00	05300	ANESTHESIOLOGY	0	12,692	17,104	29,796	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130	313,370	450,197	763,697	475	54.00
60.00	06000	LABORATORY	65	188,247	58,902	247,214	297	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,228	37,741	13,502	52,471	160	65.00
66.00	06600	PHYSICAL THERAPY	384	211,752	20,273	232,409	523	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,509	0	4,509	26	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,473	3,659	11,132	37	69.00
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	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	163,448	0	163,448	48	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	250,370	44,027	294,397	468	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 through 117)	89,965	4,905,078	1,331,629	6,326,672	4,885	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,618	0	38,618	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 through 201)	89,965	4,943,696	1,331,629	6,365,290	4,885	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/21/2018 1:59 pm

		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	668,320					5.00
7.00	00700	OPERATION OF PLANT	69,174	1,669,507				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,508	13,131	42,573			8.00
9.00	00900	HOUSEKEEPING	17,175	73,448	0	224,566		9.00
10.00	01000	DIETARY	13,793	98,267	59	13,941	326,698	10.00
11.00	01100	CAFETERIA	14,876	0	113	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,987	4,744	0	673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,751	54,152	44	7,682	0	14.00
15.00	01500	PHARMACY	20,420	29,769	0	4,223	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,932	41,594	0	5,901	0	16.00
17.00	01700	SOCIAL SERVICE	5,393	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,069	420,246	11,292	59,622	308,589	30.00
43.00	04300	NURSERY	3,791	8,525	377	1,209	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,747	237,532	5,406	33,698	9,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,781	13,910	462	1,973	0	52.00
53.00	05300	ANESTHESIOLOGY	6,943	6,967	0	988	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,380	172,013	5,686	24,403	0	54.00
60.00	06000	LABORATORY	58,805	103,332	4	14,659	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,262	20,717	0	2,939	0	65.00
66.00	06600	PHYSICAL THERAPY	52,782	116,234	6,862	16,490	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,460	2,475	0	351	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,143	4,102	978	582	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,695	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,704	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,663	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,428	89,719	0	12,728	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	63,786	137,432	10,178	19,497	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 through 117)	667,448	1,648,309	41,461	221,559	318,069	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	872	21,198	0	3,007	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,112	0	8,629	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 through 201)	668,320	1,669,507	42,573	224,566	326,698	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/21/2018 1:59 pm

		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	56,264					11.00
13.00	01300	NURSING ADMINISTRATION	1,091	24,231				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,649	89	173,030			14.00
15.00	01500	PHARMACY	1,959	0	462	115,931		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,818	0	6	0	147,203	16.00
17.00	01700	SOCIAL SERVICE	694	570	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,677	10,733	12,297	0	24,164	30.00
43.00	04300	NURSERY	437	403	156	0	2,362	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,567	5,059	25,392	0	19,223	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	535	493	191	0	799	52.00
53.00	05300	ANESTHESIOLOGY	1,075	990	1,603	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,462	0	10,992	0	2,108	54.00
60.00	06000	LABORATORY	5,570	0	70,059	0	7,522	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,399	0	957	0	3,815	65.00
66.00	06600	PHYSICAL THERAPY	6,637	0	1,908	0	254	66.00
68.00	06800	SPEECH PATHOLOGY	273	0	0	0	73	68.00
69.00	06900	ELECTROCARDIOLOGY	389	0	437	0	2,108	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14,721	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,740	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	115,931	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	638	0	208	0	218	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,394	5,894	14,901	0	83,830	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 through 117)	56,264	24,231	173,030	115,931	146,476	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	727	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 through 201)	56,264	24,231	173,030	115,931	147,203	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/21/2018 1:59 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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	6,717					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,717		1,784,472	0	1,784,472	30.00
43.00	04300	NURSERY	0		35,926	0	35,926	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		1,135,806	0	1,135,806	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52,323	0	52,323	52.00
53.00	05300	ANESTHESIOLOGY	0		48,362	0	48,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		1,058,216	0	1,058,216	54.00
60.00	06000	LABORATORY	0		507,462	0	507,462	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		99,720	0	99,720	65.00
66.00	06600	PHYSICAL THERAPY	0		434,099	0	434,099	66.00
68.00	06800	SPEECH PATHOLOGY	0		10,167	0	10,167	68.00
69.00	06900	ELECTROCARDIOLOGY	0		23,908	0	23,908	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		18,416	0	18,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		23,444	0	23,444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		146,594	0	146,594	73.00
76.00	03950	DIABETIC EDUCATION	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0		275,435	0	275,435	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		636,777	0	636,777	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 through 117)	6,717	0	6,291,127	0	6,291,127	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		63,695	0	63,695	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		10,468	0	10,468	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,717	0	6,365,290	0	6,365,290	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/21/2018 1:59 pm

		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		1,317,047				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	14,193,891			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,360	287,965	1,927,603	-7,362,934	29,609,656	5.00
7.00	00700	OPERATION OF PLANT	37,086	39,426	494,336	0	3,064,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	34,644	0	244,034	8.00
9.00	00900	HOUSEKEEPING	3,205	0	398,531	0	760,922	9.00
10.00	01000	DIETARY	4,288	21,311	203,598	0	611,096	10.00
11.00	01100	CAFETERIA	0	40,690	388,728	0	659,068	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	274,023	0	398,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	930	203,424	0	432,024	14.00
15.00	01500	PHARMACY	1,299	4,613	586,025	0	904,714	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	515,246	0	883,064	16.00
17.00	01700	SOCIAL SERVICE	0	0	174,725	0	238,943	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,338	50,528	1,953,131	0	3,990,435	30.00
43.00	04300	NURSERY	372	3,069	91,601	0	167,961	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	263,749	922,747	0	2,602,784	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	607	3,756	112,083	0	211,835	52.00
53.00	05300	ANESTHESIOLOGY	304	16,917	0	0	307,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	445,267	1,381,336	0	3,206,766	54.00
60.00	06000	LABORATORY	4,509	58,257	864,497	0	2,605,349	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	13,354	463,973	0	720,471	65.00
66.00	06600	PHYSICAL THERAPY	5,072	20,051	1,521,163	0	2,338,487	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	76,390	0	108,975	68.00
69.00	06900	ELECTROCARDIOLOGY	179	3,619	106,312	0	183,563	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	163,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	208,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,358,497	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	138,951	0	373,412	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	43,545	1,360,824	0	2,825,995	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 through 117)	117,489	1,317,047	14,193,891	-7,362,934	29,571,038	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	38,618	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)	4,943,696	1,331,629	5,216,782		7,362,934	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.749253	1.011072	0.367537		0.248667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,885		668,320	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000344		0.022571	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/21/2018 1:59 pm

		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	237,459				8.00
9.00	00900	HOUSEKEEPING	3,205	0	69,073			9.00
10.00	01000	DIETARY	4,288	329	4,288	16,128		10.00
11.00	01100	CAFETERIA	0	628	0	0	21,252	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	412	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	244	2,363	0	623	14.00
15.00	01500	PHARMACY	1,299	0	1,299	0	740	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	1,442	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	262	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,338	62,984	18,338	15,234	4,411	30.00
43.00	04300	NURSERY	372	2,105	372	0	165	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	30,151	10,365	468	1,725	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	607	2,576	607	0	202	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	406	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	31,717	7,506	0	2,441	54.00
60.00	06000	LABORATORY	4,509	20	4,509	0	2,104	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	906	65.00
66.00	06600	PHYSICAL THERAPY	5,072	38,273	5,072	0	2,507	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	103	68.00
69.00	06900	ELECTROCARDIOLOGY	179	5,455	179	0	147	69.00
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	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	241	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	56,772	5,997	0	2,415	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 through 117)	71,926	231,254	68,148	15,702	21,252	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	6,205	0	426	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)	3,826,831	334,816	1,118,495	1,058,201	823,841	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	52.529560	1.409995	16.192941	65.612661	38.765340	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,669,507	42,573	224,566	326,698	56,264	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	22.916734	0.179286	3.251140	20.256572	2.647468	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/21/2018 1:59 pm

		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	179,239					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	659	1,924,203				14.00
15.00	01500	PHARMACY	0	5,135	1,358,497			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65	0	4,051		16.00
17.00	01700	SOCIAL SERVICE	4,215	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,403	136,748	0	665	100	30.00
43.00	04300	NURSERY	2,980	1,736	0	65	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,420	282,374	0	529	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,646	2,124	0	22	0	52.00
53.00	05300	ANESTHESIOLOGY	7,321	17,831	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	122,236	0	58	0	54.00
60.00	06000	LABORATORY	0	779,109	0	207	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,646	0	105	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,214	0	7	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,856	0	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	163,703	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	208,405	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,358,497	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,309	0	6	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	43,595	165,712	0	2,307	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 through 117)	179,239	1,924,203	1,358,497	4,031	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	20	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)	527,391	728,279	1,249,588	1,283,309	320,919	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.942390	0.378483	0.919831	316.788200	3,209.190000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,231	173,030	115,931	147,203	6,717	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.135188	0.089923	0.085338	36.337448	67.170000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/21/2018 1:59 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			19.00		
		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			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03950	DIABETIC EDUCATION	0		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	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 through 117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	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)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-2 | Date/Time Prepared: 2/21/2018 1:59 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY & ANCILLARY	1	30.00	-179,699	7.00
8.00		IV THERAPY	1	50.00	48	8.00
9.00		ANCILLARY	1	64.00	164,153	9.00
10.00		IV THERAPY	1	91.00	15,498	10.00
11.00		DIABETIC EDUCATION	1	30.00	-71,072	11.00
12.00		DIABETIC EDUCATION	1	76.00	71,072	12.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/21/2018 1:59 pm

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	8,068,499		8,068,499	0	0	30.00
43.00	04300	NURSERY	274,672		274,672	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,487,016		4,487,016	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	336,189		336,189	0	0	52.00
53.00	05300	ANESTHESIOLOGY	449,040		449,040	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,723,999		4,723,999	0	0	54.00
60.00	06000	LABORATORY	4,005,127		4,005,127	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	164,153		164,153	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,034,166	0	1,034,166	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,429,950	0	3,429,950	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	148,122	0	148,122	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	275,114		275,114	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	266,370		266,370	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	339,105		339,105	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,945,898		2,945,898	0	0	73.00
76.00	03950	DIABETIC EDUCATION	71,072		71,072	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	747,432		747,432	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,051,841		5,051,841	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	382,564		382,564		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,200,329	0	37,200,329	0	0	200.00
201.00		Less Observation Beds	382,564		382,564		0	201.00
202.00		Total (see instructions)	36,817,765	0	36,817,765	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/21/2018 1:59 pm

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	4,331,720		4,331,720			30.00
43.00	04300	NURSERY	347,966		347,966			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,062,340	6,214,511	7,276,851	0.616615	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	618,423	450,283	1,068,706	0.314576	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	324,651	963,421	1,288,072	0.348614	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	813,177	38,591,648	39,404,825	0.119884	0.000000	54.00
60.00	06000	LABORATORY	2,137,579	14,636,881	16,774,460	0.238763	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	785	432,109	432,894	0.379199	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	614,088	2,077,102	2,691,190	0.384278	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	528,585	5,444,485	5,973,070	0.574236	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	25,143	204,314	229,457	0.645533	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	309,461	1,893,549	2,203,010	0.124881	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	902,324	1,051,652	1,953,976	0.136322	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	723,157	539,177	1,262,334	0.268633	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,955,815	5,532,792	7,488,607	0.393384	0.000000	73.00
76.00	03950	DIABETIC EDUCATION	0	121,758	121,758	0.583715	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1,063	846,268	847,331	0.882102	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	459,187	15,532,323	15,991,510	0.315908	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,369	461,547	529,916	0.721933	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,223,833	94,993,820	110,217,653			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,223,833	94,993,820	110,217,653			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/21/2018 1:59 pm

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
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
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	DIABETIC EDUCATION	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		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 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/21/2018 1:59 pm

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	1,135,806	7,276,851	0.156085	169,891	26,517	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,323	1,068,706	0.048959	3,274	160	52.00
53.00	05300	ANESTHESIOLOGY	48,362	1,288,072	0.037546	55,665	2,090	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,058,216	39,404,825	0.026855	382,472	10,271	54.00
60.00	06000	LABORATORY	507,462	16,774,460	0.030252	794,674	24,040	60.00
64.00	06400	INTRAVENOUS THERAPY	0	432,894	0.000000	785	0	64.00
65.00	06500	RESPIRATORY THERAPY	99,720	2,691,190	0.037054	280,949	10,410	65.00
66.00	06600	PHYSICAL THERAPY	434,099	5,973,070	0.072676	181,827	13,214	66.00
68.00	06800	SPEECH PATHOLOGY	10,167	229,457	0.044309	14,880	659	68.00
69.00	06900	ELECTROCARDIOLOGY	23,908	2,203,010	0.010852	181,590	1,971	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,416	1,953,976	0.009425	346,310	3,264	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,444	1,262,334	0.018572	229,783	4,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,594	7,488,607	0.019576	549,787	10,763	73.00
76.00	03950	DIABETIC EDUCATION	0	121,758	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	275,435	847,331	0.325062	482	157	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	636,777	15,991,510	0.039820	2,915	116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	84,610	529,916	0.159667	2,006	320	92.00
200.00		Total (lines 50 through 199)	4,555,339	105,537,967		3,197,290	108,220	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/21/2018 1:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
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	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/21/2018 1:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,276,851	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,068,706	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,288,072	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,404,825	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,774,460	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	432,894	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,691,190	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,973,070	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	229,457	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,203,010	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,953,976	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,262,334	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,488,607	0.000000	73.00
76.00	03950	DIABETIC EDUCATION	0	0	0	121,758	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	847,331	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	15,991,510	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	529,916	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	105,537,967		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/21/2018 1:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	169,891	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,274	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	55,665	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	382,472	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	794,674	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	785	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	280,949	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	181,827	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	14,880	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	181,590	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	346,310	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	229,783	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	549,787	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	482	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	2,915	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,006	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,197,290	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/21/2018 1:59 pm

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	0.616615	0	1,820,454	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314576	0	3,652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.348614	0	220,288	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119884	0	13,174,285	0	0	54.00
60.00	06000	LABORATORY	0.238763	0	4,590,020	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.379199	0	177,077	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.384278	0	661,846	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.574236	0	1,651,382	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.645533	0	24,888	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124881	0	686,787	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.136322	0	270,647	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.268633	0	161,870	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.393384	0	2,937,407	37,855	0	73.00
76.00	03950	DIABETIC EDUCATION	0.583715	0	23,210	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.882102	0	478,482	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.315908	0	4,484,872	7,377	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.721933	0	235,923	0	0	92.00
200.00		Subtotal (see instructions)		0	31,603,090	45,232	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	31,603,090	45,232	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/21/2018 1:59 pm

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	1,122,519	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,149	0		52.00
53.00	05300	ANESTHESIOLOGY	76,795	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,579,386	0		54.00
60.00	06000	LABORATORY	1,095,927	0		60.00
64.00	06400	INTRAVENOUS THERAPY	67,147	0		64.00
65.00	06500	RESPIRATORY THERAPY	254,333	0		65.00
66.00	06600	PHYSICAL THERAPY	948,283	0		66.00
68.00	06800	SPEECH PATHOLOGY	16,066	0		68.00
69.00	06900	ELECTROCARDIOLOGY	85,767	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,895	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,484	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,155,529	14,892		73.00
76.00	03950	DIABETIC EDUCATION	13,548	0		76.00
76.97	07697	CARDIAC REHABILITATION	422,070	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,416,807	2,330		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	170,321	0		92.00
200.00		Subtotal (see instructions)	8,506,026	17,222		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,506,026	17,222		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/21/2018 1:59 pm

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	0.616615	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314576	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.348614	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119884	0	0	0	0	54.00
60.00	06000	LABORATORY	0.238763	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.379199	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.384278	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.574236	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.645533	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124881	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.136322	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.268633	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.393384	0	0	0	0	73.00
76.00	03950	DIABETIC EDUCATION	0.583715	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.882102	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.315908	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.721933	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 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/21/2018 1:59 pm

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
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
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	DIABETIC EDUCATION	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/21/2018 1:59 pm

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)	3,543	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,932	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)	2,766	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	141	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)	425	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	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)	34	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,270	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)	99	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)	297	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	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,068,499	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)	1,710	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)	5,284	25.00
26.00	Total swing-bed cost (see instructions)	1,311,398	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,757,101	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)	6,757,101	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)	2,304.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,926,842	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)	2,926,842	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/21/2018 1:59 pm

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)	933,748	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,860,590	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)	228,155	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	684,466	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	912,621	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)	166	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,304.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	382,564	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/21/2018 1:59 pm

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	1,784,472	8,068,499	0.221165	382,564	84,610	90.00
91.00	Nursing School cost	0	8,068,499	0.000000	382,564	0	91.00
92.00	Allied health cost	0	8,068,499	0.000000	382,564	0	92.00
93.00	All other Medical Education	0	8,068,499	0.000000	382,564	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/21/2018 1:59 pm

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		1,819,826		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.616615	169,891	104,757	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314576	3,274	1,030	52.00
53.00	05300	ANESTHESIOLOGY	0.348614	55,665	19,406	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119884	382,472	45,852	54.00
60.00	06000	LABORATORY	0.238763	794,674	189,739	60.00
64.00	06400	INTRAVENOUS THERAPY	0.379199	785	298	64.00
65.00	06500	RESPIRATORY THERAPY	0.384278	280,949	107,963	65.00
66.00	06600	PHYSICAL THERAPY	0.574236	181,827	104,412	66.00
68.00	06800	SPEECH PATHOLOGY	0.645533	14,880	9,606	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124881	181,590	22,677	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.136322	346,310	47,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.268633	229,783	61,727	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.393384	549,787	216,277	73.00
76.00	03950	DIABETIC EDUCATION	0.583715	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.882102	482	425	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.315908	2,915	921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.721933	2,006	1,448	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,197,290	933,748	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)		3,197,290		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/21/2018 1:59 pm

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	0.616615	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.314576	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.348614	1,174	409	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119884	35,688	4,278	54.00
60.00	06000	LABORATORY	0.238763	134,507	32,115	60.00
64.00	06400	INTRAVENOUS THERAPY	0.379199	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.384278	70,083	26,931	65.00
66.00	06600	PHYSICAL THERAPY	0.574236	143,470	82,386	66.00
68.00	06800	SPEECH PATHOLOGY	0.645533	2,364	1,526	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124881	6,854	856	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.136322	120,434	16,418	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.268633	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.393384	81,854	32,200	73.00
76.00	03950	DIABETIC EDUCATION	0.583715	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.882102	31	27	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.315908	52	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.721933	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		596,511	197,162	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)		596,511		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1322	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/21/2018 1:59 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,523,248	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
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 lines 3, 4, and 4.01, 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)	8,523,248	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) (see instructions)	8,608,480	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, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	51,739	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,369,895	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)	3,186,846	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)	3,186,846	30.00
31.00	Primary payer payments	774	31.00
32.00	Subtotal (line 30 minus line 31)	3,186,072	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)	638,621	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	415,104	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	543,594	36.00
37.00	Subtotal (see instructions)	3,601,176	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
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
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)	3,601,176	40.00
40.01	Sequestration adjustment (see instructions)	72,024	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,409,860	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	119,292	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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/21/2018 1:59 pm

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		2,955,378		3,774,520	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	05/11/2017	244,773		0	3.01
3.02		09/28/2017	52,154		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	05/11/2017	279,536	3.50
3.51			0	09/28/2017	85,124	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)		296,927		-364,660	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)		3,252,305		3,409,860	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		230,764		119,292	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,483,069		3,529,152	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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/21/2018 1:59 pm

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		1,120,333		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		0		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	05/11/2017	87,653		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)		-87,653		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)		1,032,680		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		55,953		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,088,633		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 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/21/2018 1:59 pm
	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		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1322 | Component CCN: 14-Z322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/21/2018 1:59 pm

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)	921,747	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)	199,134	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	396	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)	1,120,881	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,120,881	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)	1,120,881	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,031	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)	1,110,850	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	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
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)	1,110,850	0	19.00
19.01	Sequestration adjustment (see instructions)	22,217	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,032,680	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)	55,953	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1322	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/21/2018 1:59 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,860,590	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)	3,860,590	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,899,196	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)	3,899,196	19.00
20.00	Deductibles (exclude professional component)	366,634	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,532,562	22.00
23.00	Coinsurance	1,932	23.00
24.00	Subtotal (line 22 minus line 23)	3,530,630	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	36,187	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	23,522	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,969	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,554,152	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	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,554,152	30.00
30.01	Sequestration adjustment (see instructions)	71,083	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,252,305	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, 30.02, 31, and 32)	230,764	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 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/21/2018 1:59 pm

		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	27,385,651	0	0	0	1.00
2.00	Temporary investments	18,111,350	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,715,082	0	0	0	4.00
5.00	Other receivable	206,446	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,954,306	0	0	0	6.00
7.00	Inventory	620,058	0	0	0	7.00
8.00	Prepaid expenses	276,855	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	298,639	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	54,659,775	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,340,955	0	0	0	12.00
13.00	Land improvements	6,048,557	0	0	0	13.00
14.00	Accumulated depreciation	-3,323,037	0	0	0	14.00
15.00	Buildings	42,471,731	0	0	0	15.00
16.00	Accumulated depreciation	-17,313,179	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	16,765,200	0	0	0	23.00
24.00	Accumulated depreciation	-11,558,792	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	101,884	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	34,533,319	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	41,197,038	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	135,791	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,332,829	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	130,525,923	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,121,034	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,533,182	0	0	0	38.00
39.00	Payroll taxes payable	176,813	0	0	0	39.00
40.00	Notes and loans payable (short term)	360,562	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	147,455	0	0	0	43.00
44.00	Other current liabilities	70,108	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,537,735	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	41,328,803	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	426,201	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,755,004	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	46,292,739	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	84,233,184				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)	84,233,184	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	130,525,923	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/21/2018 1:59 pm

		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		71,250,273		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,982,911				2.00
3.00	Total (sum of line 1 and line 2)		84,233,184		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		84,233,184		0		11.00
12.00	Deductions (debit adjustments) (specify)	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)		84,233,184		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	Additions (credit adjustments) (specify)		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	Deductions (debit adjustments) (specify)		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 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/21/2018 1:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,955,505		3,955,505	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	387,710		387,710	5.00
6.00	Swing bed - NF	30,825		30,825	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)	4,374,040		4,374,040	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)	4,374,040		4,374,040	17.00
18.00	Ancillary services	10,112,412	80,940,461	91,052,873	18.00
19.00	Outpatient services	527,556	16,196,095	16,723,651	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	347,966	0	347,966	27.00
27.01	PRO FEES	708,863	11,984,481	12,693,344	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,070,837	109,121,037	125,191,874	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,833,495		29.00
30.00	ADD (SPECIFY)	0			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)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,833,495		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1322 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/21/2018 1:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	125,191,874	1.00
2.00	Less contractual allowances and discounts on patients' accounts	79,731,275	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,460,599	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,833,495	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,627,104	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	87,306	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	165,891	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	1,194	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	2,899	22.00
23.00	Governmental appropriations	4,241,380	23.00
24.00	MANAGEMENT SUPPORT	16,320	24.00
24.01	SALE OF REFUSE	16,780	24.01
24.02	OTHER MISCELLANEOUS INCOME	70,308	24.02
24.03	NET INVESTMENT INCOME	6,292,651	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
25.00	Total other income (sum of lines 6-24)	10,894,729	25.00
26.00	Total (line 5 plus line 25)	13,521,833	26.00
27.00	LOSS ON DISPOSAL OF FIXED ASSETS	38,922	27.00
27.01	CONTRIBUTION EXPENSE	500,000	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	538,922	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,982,911	29.00