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: 14-1339	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/22/2018 9:05 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/22/2018 Time: 9:05 am
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 TAYLORVILLE MEMORIAL HOSPITAL (14-1339) 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	277,612	-430,203	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	12,243	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	289,855	-430,203	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2018 9:04 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 EAST PLEASANT STREET	PO Box:			1.00
2.00	City: TAYLORVILLE	State: IL	Zip Code: 62568	County: CHRISTIAN	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	TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	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	TAYLORVILLE MEMORIAL-SWB	14Z339	99914		09/01/2004	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: 1.00	To: 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.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 9:04 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 9:04 am

		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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 9:04 am

		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)	N	N	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)	N	N	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	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 9:04 am

		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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	26,768	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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 9:04 am

	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 HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2018 9:04 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/10/2018	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

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1339	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/22/2018 9:04 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2018 9:04 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	65,051.00	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	65,051.00	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						13.00
14.00	Total (see instructions)		25	9,125	65,051.00	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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2018 9:04 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,912	157	2,704			1.00
2.00	HMO and other (see instructions)	0	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	2,278	0	2,854			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	154			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,190	157	5,712			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)	4,190	157	5,712	0.00	267.68	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	267.68	27.00
28.00	Observation Bed Days		31	285			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			31			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2018 9:04 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	525	52	780	1.00
2.00	HMO and other (see instructions)			0	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	525	52	780	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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/22/2018 9:04 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.351385	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,326,849	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	2,618,561	5.00
6.00	Medicaid charges	18,760,983	6.00
7.00	Medicaid cost (line 1 times line 6)	6,592,328	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)	646,918	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	25,115	9.00
10.00	Stand-alone CHIP charges	151,305	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	53,166	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	28,051	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)	674,969	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)	1,672,039	312,199	1,984,238	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	587,529	312,199	899,728	21.00
22.00	Payments received from patients for amounts previously written off as charity care	344,887	0	344,887	22.00
23.00	Cost of charity care (line 21 minus line 22)	242,642	312,199	554,841	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)	906,563	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	571,905	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	879,854	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	26,709	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	317,334	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	872,175	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,547,144	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,407,394	1,407,394	953,655	2,361,049	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,061,881	1,061,881	101,923	1,163,804	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	413,503	4,156,172	4,569,675	-44,173	4,525,502	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,985,053	4,350,047	6,335,100	-30,598	6,304,502	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	795,194	2,239,604	3,034,798	0	3,034,798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,895	151,568	169,463	0	169,463	8.00
9.00	00900	HOUSEKEEPING	379,876	84,698	464,574	0	464,574	9.00
10.00	01000	DIETARY	416,882	360,071	776,953	-549,564	227,389	10.00
11.00	01100	CAFETERIA	0	0	0	549,564	549,564	11.00
13.00	01300	NURSING ADMINISTRATION	788,233	64,828	853,061	0	853,061	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	144,990	249,614	394,604	-5,516	389,088	14.00
15.00	01500	PHARMACY	428,986	1,220,108	1,649,094	-1,161,432	487,662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	484,160	44,745	528,905	0	528,905	16.00
17.00	01700	SOCIAL SERVICE	61,293	4,803	66,096	0	66,096	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	619,398	25,633	645,031	44,173	689,204	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,225,269	427,484	2,652,753	0	2,652,753	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	517,637	743,509	1,261,146	-363,654	897,492	50.00
53.00	05300	ANESTHESIOLOGY	0	282,819	282,819	-7,060	275,759	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,140,251	771,353	1,911,604	-1,458	1,910,146	54.00
60.00	06000	LABORATORY	908,196	1,072,639	1,980,835	0	1,980,835	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	445,344	107,150	552,494	-53,773	498,721	65.00
66.00	06600	PHYSICAL THERAPY	1,056,904	442,482	1,499,386	0	1,499,386	66.00
68.00	06800	SPEECH PATHOLOGY	115,615	59,189	174,804	0	174,804	68.00
69.00	06900	ELECTROCARDIOLOGY	154,295	25,187	179,482	0	179,482	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	130,954	130,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	321,471	321,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,159,666	1,159,666	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	155,152	172,496	327,648	0	327,648	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,709,386	2,758,217	4,467,603	-19,198	4,448,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,024,980	1,024,980	-1,024,980	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,963,512	23,308,671	38,272,183	0	38,272,183	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	1,428	1,428	0	1,428	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	14,963,512	23,310,099	38,273,611	0	38,273,611	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-150,485	2,210,564		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	142,937	1,306,741		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-219,359	4,306,143		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-529,799	5,774,703		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-8,798	3,026,000		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	169,463		8.00
9.00	00900	HOUSEKEEPING	-6	464,568		9.00
10.00	01000	DIETARY	0	227,389		10.00
11.00	01100	CAFETERIA	-187,081	362,483		11.00
13.00	01300	NURSING ADMINISTRATION	0	853,061		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	389,088		14.00
15.00	01500	PHARMACY	0	487,662		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,145	517,760		16.00
17.00	01700	SOCIAL SERVICE	0	66,096		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-689,204	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-156,550	2,496,203		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-48,311	849,181		50.00
53.00	05300	ANESTHESIOLOGY	-90,837	184,922		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-220	1,909,926		54.00
60.00	06000	LABORATORY	0	1,980,835		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	498,721		65.00
66.00	06600	PHYSICAL THERAPY	-324	1,499,062		66.00
68.00	06800	SPEECH PATHOLOGY	0	174,804		68.00
69.00	06900	ELECTROCARDIOLOGY	0	179,482		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	130,954		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	321,471		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-67	1,159,599		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	327,648		76.00
76.01	03950	DIABETIC EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,174,208	2,274,197		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)	-4,123,457	34,148,726		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,428		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,123,457	34,150,154		200.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/22/2018 9:04 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	294,874	254,690		1.00
	0		294,874	254,690		
	B - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,159,666		1.00
	0		0	1,159,666		
	C - IMPLANTS & MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	130,954		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	321,471		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
7.00		0.00	0	0		7.00
	0		0	452,425		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	30,598		1.00
	0		0	30,598		
	E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	878,716		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	88,415		2.00
	0		0	967,131		
	F - BOND AMORTIZATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,849		1.00
	TOTALS		0	57,849		
	G - CRNA BENEFITS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	44,173		1.00
	0		0	44,173		
500.00	Grand Total: Increases		294,874	2,966,532		500.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/22/2018 9:04 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	294,874	254,690	0		1.00
	0		294,874	254,690			
	B - DRUG EXPENSE						
1.00	PHARMACY	15.00	0	1,159,666	0		1.00
	0		0	1,159,666			
	C - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,516	0		1.00
2.00	PHARMACY	15.00	0	1,766	0		2.00
3.00	OPERATING ROOM	50.00	0	363,654	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	7,060	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,458	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	53,773	0		6.00
7.00	EMERGENCY	91.00	0	19,198	0		7.00
	0		0	452,425			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,598	0		1.00
	0		0	30,598			
	E - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	967,131	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	967,131			
	F - BOND AMORTIZATION EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	57,849	14		1.00
	TOTALS		0	57,849			
	G - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44,173	0		1.00
	0		0	44,173			
500.00	Grand Total: Decreases		294,874	2,966,532			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/22/2018 9:04 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	743,070	0	0	0	0	1.00
2.00	Land Improvements	3,013,819	17,205	0	17,205	0	2.00
3.00	Buildings and Fixtures	25,182,159	397,428	0	397,428	35,166	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	22,358,101	944,058	0	944,058	127,754	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	51,297,149	1,358,691	0	1,358,691	162,920	8.00
9.00	Reconciling Items	-250,094	0	0	0	-231,968	9.00
10.00	Total (line 8 minus line 9)	51,547,243	1,358,691	0	1,358,691	394,888	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	743,070	0	1.00
2.00	Land Improvements	3,031,024	0	2.00
3.00	Buildings and Fixtures	25,544,421	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	23,174,405	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,492,920	0	8.00
9.00	Reconciling Items	-18,126	0	9.00
10.00	Total (line 8 minus line 9)	52,511,046	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/22/2018 9:04 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,407,394	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,061,881	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,469,275	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	1,407,394	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,061,881	2.00
3.00	Total (sum of lines 1-2)	0	2,469,275	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/22/2018 9:04 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	29,318,515	0	29,318,515	0.558523	17,090	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,174,405	0	23,174,405	0.441477	13,508	2.00
3.00	Total (sum of lines 1-2)	52,492,920	0	52,492,920	1.000000	30,598	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	17,090	1,445,190	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,508	1,223,762	0	2.00
3.00	Total (sum of lines 1-2)	0	0	30,598	2,668,952	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	690,435	17,090	0	57,849	2,210,564	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	69,471	13,508	0	0	1,306,741	2.00
3.00	Total (sum of lines 1-2)	759,906	30,598	0	57,849	3,517,305	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/22/2018 9:04 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-188,281	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-18,944	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-3,448	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,937	ADMINISTRATIVE & GENERAL	5.00	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	-4,848	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-8,798	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,469,906			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	382,728			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-187,081	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	B	-67	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-11,145	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	-689,204	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		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-5,567	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/22/2018 9:04 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - HOUSEKEEPING	B	-6	HOUSEKEEPING	9.00	0	33.01
33.02	MISC INCOME - RADIOLOGY	B	-220	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	MISC INCOME - PT	B	-324	PHYSICAL THERAPY	66.00	0	33.03
34.00	PROVIDER TAX	A	-796,041	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	PROVIDER TAX ASSISTANCE	A	-11,000	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADVERTISING EXPENSE	A	-59,279	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXPENSE	A	-21,253	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PHYSICIAN LOAN FORGIVENESS	A	-28,836	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,123,457				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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/22/2018 9:04 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO NEW CAPITAL - BLDG	37,704	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	15,718	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	92	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	146,163	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	16,093	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,138,393	1,752,076	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	2,592,853	2,812,212	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	11,850	11,850	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,958,866	4,576,138	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 HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	0.00	9.00
10.00	B		0.00	PASSAVANT	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: 14-1339	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/22/2018 9:04 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	37,704	9		1.00
2.00	15,718	9		2.00
3.00	92	9		3.00
4.00	146,163	9		4.00
4.01	16,093	0		4.01
4.02	386,317	0		4.02
4.03	-219,359	0		4.03
4.04	0	0		4.04
5.00	382,728			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	HOSPITAL		8.00
9.00	HOME HEALTH		9.00
10.00	HOSPITAL		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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/22/2018 9:04 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	156,550	156,550	0	0	0	1.00
2.00	50.00	OPERATING ROOM	48,311	48,311	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	147,819	0	147,819	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	9,376	0	9,376	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	500	0	500	0	0	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	29,362	0	29,362	0	0	6.00
7.00	91.00	EMERGENCY	2,457,565	2,174,208	283,357	0	0	7.00
8.00	91.00	EMERGENCY	60,000	0	60,000	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	90,837	90,837	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,000,320	2,469,906	530,414		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	156,550		1.00
2.00	50.00	OPERATING ROOM	0	0	0	48,311		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0		3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0		5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		6.00
7.00	91.00	EMERGENCY	0	0	0	2,174,208		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	90,837		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,469,906		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,210,564	2,210,564				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,306,741		1,306,741			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,306,143	5,579	0	4,311,722		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,774,703	402,748	557,170	614,402	7,349,023	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	104,528	0	0	104,528	6.00
7.00	00700	OPERATION OF PLANT	3,026,000	598,377	52,254	246,124	3,922,755	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	169,463	12,112	0	5,539	187,114	8.00
9.00	00900	HOUSEKEEPING	464,568	44,199	338	117,577	626,682	9.00
10.00	01000	DIETARY	227,389	84,512	1,663	37,763	351,327	10.00
11.00	01100	CAFETERIA	362,483	32,477	4,019	91,268	490,247	11.00
13.00	01300	NURSING ADMINISTRATION	853,061	57,130	5,158	243,969	1,159,318	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	389,088	24,062	34,575	44,876	492,601	14.00
15.00	01500	PHARMACY	487,662	15,835	9,913	132,777	646,187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	517,760	54,280	1,255	149,854	723,149	16.00
17.00	01700	SOCIAL SERVICE	66,096	4,019	0	18,971	89,086	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,496,203	196,461	35,044	688,755	3,416,463	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	849,181	120,605	192,033	160,216	1,322,035	50.00
53.00	05300	ANESTHESIOLOGY	184,922	11,520	19,521	0	215,963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,909,926	90,817	275,919	352,924	2,629,586	54.00
60.00	06000	LABORATORY	1,980,835	46,228	59,147	281,099	2,367,309	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	498,721	54,805	19,889	137,840	711,255	65.00
66.00	06600	PHYSICAL THERAPY	1,499,062	61,365	6,316	327,127	1,893,870	66.00
68.00	06800	SPEECH PATHOLOGY	174,804	4,207	0	35,784	214,795	68.00
69.00	06900	ELECTROCARDIOLOGY	179,482	16,884	5,479	47,756	249,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	130,954	0	0	0	130,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	321,471	0	0	0	321,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,159,599	0	0	0	1,159,599	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	327,648	21,064	0	48,022	396,734	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,274,197	111,464	26,941	529,079	2,941,681	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)	34,148,726	2,175,278	1,306,634	4,311,722	34,113,333	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,482	0	0	8,482	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	26,804	107	0	28,339	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)	34,150,154	2,210,564	1,306,741	4,311,722	34,150,154	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	7,349,023					5.00
6.00	00600	MAINTENANCE & REPAIRS	28,662	133,190				6.00
7.00	00700	OPERATION OF PLANT	1,075,635	95,875	5,094,265			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,308	899	56,125	295,446		8.00
9.00	00900	HOUSEKEEPING	171,840	629	204,815	15,359	1,019,325	9.00
10.00	01000	DIETARY	96,336	1,214	391,627	2,563	0	10.00
11.00	01100	CAFETERIA	134,429	2,937	150,496	2,702	0	11.00
13.00	01300	NURSING ADMINISTRATION	317,892	132	264,739	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135,074	2,384	111,502	551	6,079	14.00
15.00	01500	PHARMACY	177,188	774	73,379	0	11,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198,292	226	251,533	0	17,132	16.00
17.00	01700	SOCIAL SERVICE	24,428	0	18,625	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	936,815	7,157	910,390	133,969	382,143	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	362,510	2,516	558,880	24,748	121,855	50.00
53.00	05300	ANESTHESIOLOGY	59,218	346	53,384	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	721,048	862	420,842	18,985	69,631	54.00
60.00	06000	LABORATORY	649,130	1,516	214,221	663	71,289	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	195,030	553	253,963	8,046	14,645	65.00
66.00	06600	PHYSICAL THERAPY	519,311	1,270	284,361	21,406	49,184	66.00
68.00	06800	SPEECH PATHOLOGY	58,898	145	19,497	0	5,803	68.00
69.00	06900	ELECTROCARDIOLOGY	68,442	491	78,238	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,908	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,149	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,969	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	108,787	50	97,611	0	18,237	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	806,627	3,686	516,522	60,099	239,012	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)	7,338,926	123,662	4,930,750	289,091	1,006,615	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,326	88	39,306	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,771	9,440	124,209	6,355	12,710	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)	7,349,023	133,190	5,094,265	295,446	1,019,325	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	843,067					10.00
11.00	01100	CAFETERIA	0	780,811				11.00
13.00	01300	NURSING ADMINISTRATION	0	44,150	1,786,231			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,321	14,519	779,031		14.00
15.00	01500	PHARMACY	0	21,535	94,103	2,087	1,026,858	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53,579	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,695	20,514	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	808,802	190,143	830,871	28,934	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,061	148,813	112,956	0	50.00
53.00	05300	ANESTHESIOLOGY	0	9,110	67,742	5,095	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	82,546	0	43,276	0	54.00
60.00	06000	LABORATORY	0	68,222	0	309,373	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	33,981	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66,844	0	4,216	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	5,654	0	367	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,488	0	1,525	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	70,080	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	172,035	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,026,858	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34,265	10,089	44,179	230	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	129,393	565,490	28,445	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)	843,067	780,811	1,786,231	778,619	1,026,858	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	412	0	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)	843,067	780,811	1,786,231	779,031	1,026,858	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,243,911					16.00
17.00	01700	SOCIAL SERVICE	0	157,348				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	345,716	157,348	0	8,148,751	-347,968	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,498	0	0	2,767,872	1,196	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	410,858	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,168	0	0	4,067,944	0	54.00
60.00	06000	LABORATORY	78,830	0	0	3,760,553	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	332,671	64.00
65.00	06500	RESPIRATORY THERAPY	16,367	0	0	1,233,840	0	65.00
66.00	06600	PHYSICAL THERAPY	3,340	0	0	2,843,802	0	66.00
68.00	06800	SPEECH PATHOLOGY	334	0	0	305,493	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,691	0	0	420,476	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	236,942	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	581,655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,504,426	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	668	0	0	710,850	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	10,013	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	624,295	0	0	5,915,250	4,089	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)	1,241,907	157,348	0	33,908,712	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	50,202	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,004	0	0	191,240	0	192.00
200.00		Cross Foot Adjustments			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)	1,243,911	157,348	0	34,150,154	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
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			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,800,783		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,769,068		50.00
53.00	05300	ANESTHESIOLOGY	410,858		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,067,944		54.00
60.00	06000	LABORATORY	3,760,553		60.00
64.00	06400	INTRAVENOUS THERAPY	332,671		64.00
65.00	06500	RESPIRATORY THERAPY	1,233,840		65.00
66.00	06600	PHYSICAL THERAPY	2,843,802		66.00
68.00	06800	SPEECH PATHOLOGY	305,493		68.00
69.00	06900	ELECTROCARDIOLOGY	420,476		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	236,942		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	581,655		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,504,426		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	710,850		76.00
76.01	03950	DIABETIC EDUCATION	10,013		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	5,919,339		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)	33,908,713		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,202		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	191,240		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	34,150,155		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,579	0	5,579	5,579	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	61,807	402,748	557,170	1,021,725	794	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	104,528	0	104,528	0	6.00
7.00	00700	OPERATION OF PLANT	385	598,377	52,254	651,016	318	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,112	0	12,112	7	8.00
9.00	00900	HOUSEKEEPING	0	44,199	338	44,537	152	9.00
10.00	01000	DIETARY	0	84,512	1,663	86,175	49	10.00
11.00	01100	CAFETERIA	0	32,477	4,019	36,496	118	11.00
13.00	01300	NURSING ADMINISTRATION	0	57,130	5,158	62,288	315	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,078	24,062	34,575	60,715	58	14.00
15.00	01500	PHARMACY	0	15,835	9,913	25,748	172	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,280	1,255	55,535	194	16.00
17.00	01700	SOCIAL SERVICE	0	4,019	0	4,019	25	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,917	196,461	35,044	240,422	896	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88	120,605	192,033	312,726	207	50.00
53.00	05300	ANESTHESIOLOGY	0	11,520	19,521	31,041	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	90,817	275,919	366,736	456	54.00
60.00	06000	LABORATORY	0	46,228	59,147	105,375	363	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,340	54,805	19,889	78,034	178	65.00
66.00	06600	PHYSICAL THERAPY	0	61,365	6,316	67,681	423	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,207	0	4,207	46	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,884	5,479	22,363	62	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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	21,064	0	21,064	62	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	111,464	26,941	138,405	684	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)	76,615	2,175,278	1,306,634	3,558,527	5,579	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,482	0	8,482	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,804	107	26,911	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)	76,615	2,210,564	1,306,741	3,593,920	5,579	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	1,022,519					5.00
6.00	00600	MAINTENANCE & REPAIRS	3,988	108,516				6.00
7.00	00700	OPERATION OF PLANT	149,662	78,114	879,110			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,139	733	9,685	29,676		8.00
9.00	00900	HOUSEKEEPING	23,909	512	35,345	1,543	105,998	9.00
10.00	01000	DIETARY	13,404	989	67,583	257	0	10.00
11.00	01100	CAFETERIA	18,704	2,393	25,971	271	0	11.00
13.00	01300	NURSING ADMINISTRATION	44,230	108	45,686	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,794	1,942	19,242	55	632	14.00
15.00	01500	PHARMACY	24,653	630	12,663	0	1,207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,590	184	43,407	0	1,781	16.00
17.00	01700	SOCIAL SERVICE	3,399	0	3,214	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	130,345	5,831	157,103	13,457	39,739	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,438	2,050	96,445	2,486	12,671	50.00
53.00	05300	ANESTHESIOLOGY	8,239	282	9,212	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,324	702	72,624	1,907	7,241	54.00
60.00	06000	LABORATORY	90,318	1,235	36,968	67	7,413	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	27,136	451	43,826	808	1,523	65.00
66.00	06600	PHYSICAL THERAPY	72,255	1,035	49,072	2,150	5,115	66.00
68.00	06800	SPEECH PATHOLOGY	8,195	118	3,365	0	603	68.00
69.00	06900	ELECTROCARDIOLOGY	9,523	400	13,501	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,996	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,265	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,241	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	15,136	41	16,845	0	1,896	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	112,231	3,003	89,135	6,037	24,855	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)	1,021,114	100,753	850,892	29,038	104,676	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	324	72	6,783	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,081	7,691	21,435	638	1,322	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)	1,022,519	108,516	879,110	29,676	105,998	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	168,457					10.00
11.00	01100	CAFETERIA	0	83,953				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,747	157,374			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,755	1,279	104,472		14.00
15.00	01500	PHARMACY	0	2,316	8,291	280	75,960	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,761	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	505	1,807	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	161,610	20,444	73,204	3,880	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,662	13,111	15,148	0	50.00
53.00	05300	ANESTHESIOLOGY	0	979	5,968	683	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,875	0	5,804	0	54.00
60.00	06000	LABORATORY	0	7,335	0	41,489	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,654	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,187	0	565	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	608	0	49	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,128	0	204	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,398	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,071	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	75,960	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,847	1,085	3,892	31	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,912	49,822	3,815	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)	168,457	83,953	157,374	104,417	75,960	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	55	0	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)	168,457	83,953	157,374	104,472	75,960	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	134,452					16.00
17.00	01700	SOCIAL SERVICE	0	12,969				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,368	12,969		897,268	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,593	0		517,537	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		56,404	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,773	0		573,442	0	54.00
60.00	06000	LABORATORY	8,521	0		299,084	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,769	0		157,379	0	65.00
66.00	06600	PHYSICAL THERAPY	361	0		205,844	0	66.00
68.00	06800	SPEECH PATHOLOGY	36	0		17,227	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,264	0		48,445	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		14,394	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		35,336	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		120,201	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72	0		66,971	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0		0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	67,478	0		509,377	0	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)	134,235	12,969	0	3,518,909	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		15,661	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	217	0		59,350	0	192.00
200.00		Cross Foot Adjustments			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)	134,452	12,969	0	3,593,920	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
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			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	897,268		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	517,537		50.00
53.00	05300	ANESTHESIOLOGY	56,404		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,442		54.00
60.00	06000	LABORATORY	299,084		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	157,379		65.00
66.00	06600	PHYSICAL THERAPY	205,844		66.00
68.00	06800	SPEECH PATHOLOGY	17,227		68.00
69.00	06900	ELECTROCARDIOLOGY	48,445		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,394		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,336		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,201		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	66,971		76.00
76.01	03950	DIABETIC EDUCATION	0		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	509,377		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)	3,518,909		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,661		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,350		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,593,920		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	164,447					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,293,232				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	415	0	13,930,611			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,961	551,408	1,985,053	-7,349,023	26,801,131	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,776	0	0	0	104,528	6.00
7.00	00700	OPERATION OF PLANT	44,514	51,714	795,194	0	3,922,755	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	901	0	17,895	0	187,114	8.00
9.00	00900	HOUSEKEEPING	3,288	335	379,876	0	626,682	9.00
10.00	01000	DIETARY	6,287	1,646	122,008	0	351,327	10.00
11.00	01100	CAFETERIA	2,416	3,977	294,874	0	490,247	11.00
13.00	01300	NURSING ADMINISTRATION	4,250	5,105	788,233	0	1,159,318	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,790	34,218	144,990	0	492,601	14.00
15.00	01500	PHARMACY	1,178	9,811	428,986	0	646,187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038	1,242	484,160	0	723,149	16.00
17.00	01700	SOCIAL SERVICE	299	0	61,293	0	89,086	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,615	34,682	2,225,269	0	3,416,463	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,972	190,048	517,637	0	1,322,035	50.00
53.00	05300	ANESTHESIOLOGY	857	19,319	0	0	215,963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,756	273,067	1,140,251	0	2,629,586	54.00
60.00	06000	LABORATORY	3,439	58,536	908,196	0	2,367,309	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,077	19,683	445,344	0	711,255	65.00
66.00	06600	PHYSICAL THERAPY	4,565	6,251	1,056,904	0	1,893,870	66.00
68.00	06800	SPEECH PATHOLOGY	313	0	115,615	0	214,795	68.00
69.00	06900	ELECTROCARDIOLOGY	1,256	5,422	154,295	0	249,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	130,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	321,471	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,159,599	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,567	0	155,152	0	396,734	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,292	26,662	1,709,386	0	2,941,681	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)	161,822	1,293,126	13,930,611	-7,349,023	26,764,310	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	631	0	0	0	8,482	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	106	0	0	28,339	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)	2,210,564	1,306,741	4,311,722		7,349,023	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.442410	1.010446	0.309514		0.274206	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,579		1,022,519	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000400		0.038152	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	21,177					6.00
7.00	00700	OPERATION OF PLANT	15,244	81,781				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	143	901	252,148			8.00
9.00	00900	HOUSEKEEPING	100	3,288	13,108	3,689		9.00
10.00	01000	DIETARY	193	6,287	2,187	0	25,564	10.00
11.00	01100	CAFETERIA	467	2,416	2,306	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	21	4,250	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	379	1,790	470	22	0	14.00
15.00	01500	PHARMACY	123	1,178	0	42	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36	4,038	0	62	0	16.00
17.00	01700	SOCIAL SERVICE	0	299	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	1,138	14,615	114,336	1,383	24,525	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	400	8,972	21,121	441	0	50.00
53.00	05300	ANESTHESIOLOGY	55	857	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	137	6,756	16,203	252	0	54.00
60.00	06000	LABORATORY	241	3,439	566	258	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	88	4,077	6,867	53	0	65.00
66.00	06600	PHYSICAL THERAPY	202	4,565	18,269	178	0	66.00
68.00	06800	SPEECH PATHOLOGY	23	313	0	21	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78	1,256	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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8	1,567	0	66	1,039	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	586	8,292	51,291	865	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)	19,662	79,156	246,724	3,643	25,564	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14	631	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,501	1,994	5,424	46	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)	133,190	5,094,265	295,446	1,019,325	843,067	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.289371	62.291547	1.171717	276.314719	32.978681	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	108,516	879,110	29,676	105,998	168,457	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.124239	10.749563	0.117693	28.733532	6.589618	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	39,085					11.00
13.00	01300	NURSING ADMINISTRATION	2,210	192,171				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	817	1,562	1,455,730			14.00
15.00	01500	PHARMACY	1,078	10,124	3,899	1,159,666		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,682	0	0	0	3,724	16.00
17.00	01700	SOCIAL SERVICE	235	2,207	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	9,518	89,389	54,067	0	1,035	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,705	16,010	211,075	0	238	50.00
53.00	05300	ANESTHESIOLOGY	456	7,288	9,520	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,132	0	80,868	0	243	54.00
60.00	06000	LABORATORY	3,415	0	578,110	0	236	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,701	0	0	0	49	65.00
66.00	06600	PHYSICAL THERAPY	3,346	0	7,879	0	10	66.00
68.00	06800	SPEECH PATHOLOGY	283	0	685	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	525	0	2,849	0	35	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	130,954	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	321,471	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,159,666	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	505	4,753	430	0	2	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,477	60,838	53,153	0	1,869	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)	39,085	192,171	1,454,960	1,159,666	3,718	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	770	0	6	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)	780,811	1,786,231	779,031	1,026,858	1,243,911	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.977255	9.295008	0.535148	0.885477	334.025510	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	83,953	157,374	104,472	75,960	134,452	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.147960	0.818927	0.071766	0.065502	36.104189	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/22/2018 9:04 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	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
6.00	00600	MAINTENANCE & REPAIRS				6.00
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	2,207			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,207	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03950	DIABETIC EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	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)	2,207	0		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		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	157,348	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	71.294971	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,969	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.876303	0.000000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-2 | Date/Time Prepared: 2/22/2018 9:04 am

		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 & ANCILLARIES	1	30.00	-337,955	7.00
8.00		ANCILLARIES	1	50.00	1,196	8.00
9.00		IV THERAPY	1	64.00	332,671	9.00
10.00		ANCILLARIES	1	91.00	4,089	10.00
11.00		DIABETIC EDUCATION	1	30.00	-10,013	11.00
12.00		DIABETIC EDUCATION	1	76.01	10,013	12.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,800,783		7,800,783	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,769,068		2,769,068	0	0	50.00
53.00	05300	ANESTHESIOLOGY	410,858		410,858	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,067,944		4,067,944	0	0	54.00
60.00	06000	LABORATORY	3,760,553		3,760,553	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	332,671		332,671	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,233,840	0	1,233,840	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,843,802	0	2,843,802	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	305,493	0	305,493	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	420,476		420,476	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	236,942		236,942	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	581,655		581,655	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,504,426		2,504,426	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	710,850		710,850	0	0	76.00
76.01	03950	DIABETIC EDUCATION	10,013		10,013	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,919,339		5,919,339	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	379,326		379,326		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,288,039	0	34,288,039	0	0	200.00
201.00		Less Observation Beds	379,326		379,326		0	201.00
202.00		Total (see instructions)	33,908,713	0	33,908,713	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,366,545		6,366,545			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	393,820	3,578,782	3,972,602	0.697041	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	88,991	557,290	646,281	0.635727	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,145,404	33,548,306	35,693,710	0.113968	0.000000	54.00
60.00	06000	LABORATORY	2,315,266	10,719,542	13,034,808	0.288501	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	4,169	1,689,366	1,693,535	0.196436	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,055,478	1,896,029	2,951,507	0.418037	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,583,444	3,690,529	5,273,973	0.539214	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	235,632	487,378	723,010	0.422529	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	193,475	1,738,726	1,932,201	0.217615	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	573,467	479,083	1,052,550	0.225112	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	835,114	737,369	1,572,483	0.369896	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,607,951	4,788,605	6,396,556	0.391527	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	228	547,458	547,686	1.297915	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	5,550	21,846	27,396	0.365491	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	213,731	13,417,033	13,630,764	0.434263	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	984,680	984,680	0.385228	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,618,265	78,882,022	96,500,287			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,618,265	78,882,022	96,500,287			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03950	DIABETIC EDUCATION	0.000000		76.01
		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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	517,537	3,972,602	0.130277	232,393	30,275	50.00
53.00	05300	ANESTHESIOLOGY	56,404	646,281	0.087275	53,490	4,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,442	35,693,710	0.016066	1,175,404	18,884	54.00
60.00	06000	LABORATORY	299,084	13,034,808	0.022945	1,125,219	25,818	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,693,535	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	157,379	2,951,507	0.053322	524,283	27,956	65.00
66.00	06600	PHYSICAL THERAPY	205,844	5,273,973	0.039030	178,780	6,978	66.00
68.00	06800	SPEECH PATHOLOGY	17,227	723,010	0.023827	50,116	1,194	68.00
69.00	06900	ELECTROCARDIOLOGY	48,445	1,932,201	0.025072	117,600	2,948	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,394	1,052,550	0.013675	287,981	3,938	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,336	1,572,483	0.022471	480,299	10,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,201	6,396,556	0.018792	731,280	13,742	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	66,971	547,686	0.122280	228	28	76.00
76.01	03950	DIABETIC EDUCATION	0	27,396	0.000000	1,404	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	509,377	13,630,764	0.037370	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,631	984,680	0.044310	0	0	92.00
200.00		Total (lines 50 through 199)	2,665,272	90,133,742		4,958,477	147,222	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/22/2018 9:04 am

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
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/22/2018 9:04 am

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	3,972,602	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	646,281	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,693,710	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,034,808	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,693,535	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,951,507	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,273,973	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	723,010	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,932,201	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,052,550	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,572,483	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,396,556	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	547,686	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	27,396	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	13,630,764	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	984,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	90,133,742		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/22/2018 9:04 am

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	232,393	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53,490	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,175,404	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,125,219	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	524,283	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	178,780	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	50,116	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	117,600	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	287,981	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	480,299	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	731,280	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	228	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.000000	1,404	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,958,477	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.697041	0	1,646,005	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.635727	0	207,093	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113968	0	12,736,096	0	0	54.00
60.00	06000	LABORATORY	0.288501	0	4,297,840	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196436	0	963,075	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.418037	0	617,318	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.539214	0	1,212,011	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.422529	0	28,361	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.217615	0	837,249	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225112	0	142,775	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369896	0	296,402	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391527	0	2,850,533	6,203	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.297915	0	474,915	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.365491	0	12,879	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.434263	0	4,071,406	2,071	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.385228	0	574,007	0	0	92.00
200.00		Subtotal (see instructions)		0	30,967,965	8,274	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	30,967,965	8,274	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,147,333	0		50.00
53.00	05300	ANESTHESIOLOGY	131,655	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,507	0		54.00
60.00	06000	LABORATORY	1,239,931	0		60.00
64.00	06400	INTRAVENOUS THERAPY	189,183	0		64.00
65.00	06500	RESPIRATORY THERAPY	258,062	0		65.00
66.00	06600	PHYSICAL THERAPY	653,533	0		66.00
68.00	06800	SPEECH PATHOLOGY	11,983	0		68.00
69.00	06900	ELECTROCARDIOLOGY	182,198	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,140	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	109,638	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,116,061	2,429		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	616,399	0		76.00
76.01	03950	DIABETIC EDUCATION	4,707	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,768,061	899		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	221,124	0		92.00
200.00		Subtotal (see instructions)	9,133,515	3,328		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,133,515	3,328		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.697041	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.635727	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113968	0	0	0	0	54.00
60.00	06000	LABORATORY	0.288501	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196436	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.418037	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.539214	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.422529	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.217615	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225112	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369896	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391527	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.297915	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.365491	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.434263	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.385228	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: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03950	DIABETIC EDUCATION	0	0		76.01
		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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,997	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,989	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)	2,704	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	951	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)	1,903	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	51	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)	103	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,912	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)	759	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)	1,519	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)	7,800,783	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)	7,926	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)	16,007	25.00
26.00	Total swing-bed cost (see instructions)	3,822,521	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,978,262	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)	3,978,262	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)	1,330.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,544,815	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)	2,544,815	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	1,546,529	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,091,344	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)	1,010,206	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	2,021,743	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	3,031,949	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)	285	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,330.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	379,326	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	897,268	7,800,783	0.115023	379,326	43,631	90.00
91.00	Nursing School cost	0	7,800,783	0.000000	379,326	0	91.00
92.00	Allied health cost	0	7,800,783	0.000000	379,326	0	92.00
93.00	All other Medical Education	0	7,800,783	0.000000	379,326	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,750,894		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.697041	232,393	161,987	50.00
53.00	05300	ANESTHESIOLOGY	0.635727	53,490	34,005	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113968	1,175,404	133,958	54.00
60.00	06000	LABORATORY	0.288501	1,125,219	324,627	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196436	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.418037	524,283	219,170	65.00
66.00	06600	PHYSICAL THERAPY	0.539214	178,780	96,401	66.00
68.00	06800	SPEECH PATHOLOGY	0.422529	50,116	21,175	68.00
69.00	06900	ELECTROCARDIOLOGY	0.217615	117,600	25,592	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225112	287,981	64,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369896	480,299	177,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391527	731,280	286,316	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.297915	228	296	76.00
76.01	03950	DIABETIC EDUCATION	0.365491	1,404	513	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.434263	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.385228	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,958,477	1,546,529	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)		4,958,477		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.697041	12,109	8,440	50.00
53.00	05300	ANESTHESIOLOGY	0.635727	422	268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.113968	246,381	28,080	54.00
60.00	06000	LABORATORY	0.288501	471,543	136,041	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196436	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.418037	247,262	103,365	65.00
66.00	06600	PHYSICAL THERAPY	0.539214	997,973	538,121	66.00
68.00	06800	SPEECH PATHOLOGY	0.422529	136,080	57,498	68.00
69.00	06900	ELECTROCARDIOLOGY	0.217615	10,789	2,348	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225112	112,239	25,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369896	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391527	424,219	166,093	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.297915	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.365491	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.434263	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.385228	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,659,017	1,065,520	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)		2,659,017		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/22/2018 9:04 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,136,843	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)	9,136,843	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)	9,228,211	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)	46,914	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,342,688	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)	3,838,609	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)	3,838,609	30.00
31.00	Primary payer payments	460	31.00
32.00	Subtotal (line 30 minus line 31)	3,838,149	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)	766,945	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	498,514	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	714,184	36.00
37.00	Subtotal (see instructions)	4,336,663	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)	4,336,663	40.00
40.01	Sequestration adjustment (see instructions)	86,733	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,680,133	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-430,203	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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,375,810		4,680,133	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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,375,810		4,680,133	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		277,612		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		430,203	6.02
7.00	Total Medicare program liability (see instructions)		3,653,422		4,249,930	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: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,976,546		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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,976,546		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		12,243		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,988,789		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: 14-1339	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/22/2018 9:04 am
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		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: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/22/2018 9:04 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	3,062,268	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)	1,076,175	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	2,278	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)	4,138,443	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	4,138,443	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)	4,138,443	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	68,250	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)	4,070,193	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)	4,070,193	0	19.00
19.01	Sequestration adjustment (see instructions)	81,404	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	3,976,546	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)	12,243	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: 14-1339	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/22/2018 9:04 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,091,344	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)	4,091,344	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,132,257	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,132,257	19.00
20.00	Deductibles (exclude professional component)	477,344	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,654,913	22.00
23.00	Coinsurance	322	23.00
24.00	Subtotal (line 22 minus line 23)	3,654,591	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	112,909	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	73,391	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	107,746	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,727,982	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)	3,727,982	30.00
30.01	Sequestration adjustment (see instructions)	74,560	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,375,810	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)	277,612	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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/22/2018 9:04 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	38,331,983	0	0	0	1.00
2.00	Temporary investments	1,679,626	0	0	0	2.00
3.00	Notes receivable	9,130,390	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	841,383	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,682,492	0	0	0	6.00
7.00	Inventory	520,557	0	0	0	7.00
8.00	Prepaid expenses	254,047	0	0	0	8.00
9.00	Other current assets	326,299	0	0	0	9.00
10.00	Due from other funds	81,359	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	49,483,152	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	743,070	0	0	0	12.00
13.00	Land improvements	3,031,024	0	0	0	13.00
14.00	Accumulated depreciation	-1,403,432	0	0	0	14.00
15.00	Buildings	25,562,547	0	0	0	15.00
16.00	Accumulated depreciation	-12,025,809	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	23,174,405	0	0	0	23.00
24.00	Accumulated depreciation	-19,076,339	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,005,466	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,694,822	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	116,679	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,811,501	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,300,119	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,348,737	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,084,337	0	0	0	38.00
39.00	Payroll taxes payable	163,094	0	0	0	39.00
40.00	Notes and loans payable (short term)	154,491	0	0	0	40.00
41.00	Deferred income	483,565	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	22,701	0	0	0	43.00
44.00	Other current liabilities	2,327,182	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,584,107	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,797,259	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	590,394	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,387,653	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,971,760	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	48,328,359				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)	48,328,359	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,300,119	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/22/2018 9:04 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,451,311		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,877,045				2.00
3.00	Total (sum of line 1 and line 2)		48,328,356		0		3.00
4.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		48,328,359		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)		48,328,359		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	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: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/22/2018 9:04 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,173,187		3,173,187	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	3,029,868		3,029,868	5.00
6.00	Swing bed - NF	163,490		163,490	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)	6,366,545		6,366,545	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)	6,366,545		6,366,545	17.00
18.00	Ancillary services	11,226,006	66,099,005	77,325,011	18.00
19.00	Outpatient services	220,767	14,754,485	14,975,252	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	PROFESSIONAL SERVICES	236,804	9,092,327	9,329,131	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,050,122	89,945,817	107,995,939	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,273,611		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)		38,273,611		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/22/2018 9:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	107,995,939	1.00
2.00	Less contractual allowances and discounts on patients' accounts	66,442,694	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,553,245	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,273,611	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,279,634	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	24,002	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	1,937	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	187,081	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	11,145	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	298,405	23.00
24.00	GAIN/LOSS ON DISPOSAL	8,669	24.00
24.01	REALIZED GAIN/LOSS ON INVESTMENTS	48,272	24.01
24.02	UNREALIZED GAIN/LOSS ON INVESTMENTS	376,543	24.02
24.03	INTEREST & DIVIDENDS	215,667	24.03
24.04	HOSPITAL ACCESS IMPROVEMENT	3,414,602	24.04
24.05	MISCELLANEOUS INCOME	11,088	24.05
25.00	Total other income (sum of lines 6-24)	4,597,411	25.00
26.00	Total (line 5 plus line 25)	7,877,045	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,877,045	29.00