Heal th	Financial Systems	ADAMS MEMORI A	- HOSPI TAL		In Lie	eu of Form CMS-	2552-10
This r	eport is required by law (42 USC 1395g; 42	CFR 413.20(b)). Fa	ailure to repo	ort can result	in all interim	FORM APPROVED)
paymen	ts made since the beginning of the cost rep	orting period bein	ng deemed over	payments (42	USC 1395g).	OMB NO. 0938-	
						EXPIRES 05-31	-2019
	AL AND HOSPITAL HEALTH CARE COMPLEX COST RE	PORT CERTIFICATION	N Provider CC		Period:	Worksheet S	
AND SE	TTLEMENT SUMMARY				From 01/01/2016 To 12/31/2016		nared.
					10 12/01/2010	5/26/2017 12:	
PART I	- COST REPORT STATUS						
Provi d	er 1.[X]Electronically filed cost r	report			Date: 5/26/20	D17 Time: 1	2:27 pm
use on	j <u>r</u> j j						
	3. [0] If this is an amended report			e provider res	submitted this c	ost report	
0.1	4. [F] Medicare Utilization. Enter		L TOF TOW.	10 NF			
Contra		e Received: tractor No.			PR Date: ontractor's Vend	or Code:	1
use on	(2) Settled without Audit 8. [N]Initial Report	for this Provi	der CCN 12. [0]If line 5, co	olumn 1 is 4: !	Enter
	(3) Settled with Audit 9. [N]Final Report fo	r this Provide	er CCN		mes reopened =	
	(4) Reopened						
	(5) Amended						
	I - CERTIFICATION RESENTATION OR FALSIFICATION OF ANY INFORMA		THIS COST DED				
	STRATIVE ACTION, FINE AND/OR IMPRISONMENT U						
	ED OR PROCURED THROUGH THE PAYMENT DI RECTLY						
	STRATIVE ACTION, FINES AND/OR IMPRISONMENT						
	CERTIFICATION BY OFFICER OR ADMI	NISTRATOR OF PROVI	DER(S)				
	I HEREBY CERTIFY that I have read the abo					1 5 5	
	electronically filed or manually submitte						
	Expenses prepared by ADAMS MEMORIAL HOSPI						
	ending 12/31/2016 and to the best of my k						
	complete and prepared from the books and except as noted. I further certify that						
	heal th care services, and that the servic						
	laws and regulations.		1113 0031 1 opt		ded in compilian	de mitili suom	
		(Si gne	ed)				
				er or Adminis	trator of Provid	der(s)	
			Title				
			Date				
			Date				
			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	ніт	Title XIX	
	'	1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	363, 785	189, 47		-	
2.00	Subprovider - IPF	0	13, 130		0	C	
3.00	Subprovider - IRF	0	0		0	C	
5.00	Swing bed - SNF	0	-49, 234		0	C	
6.00	Swing bed - NF	0			~	C	
7.00	SKILLED NURSING FACILITY	0	0		0	C C	
9.00 200.00	HOME HEALTH AGENCY I	0	0 327, 681	189, 47	-		9.00
-	ove amounts represent "due to" or "due from	the applicable i					1200.00
	ing to the Paperwork Reduction Act of 1995,						it
	ys a valid OMB control number. The valid O	•		•			11
	ed to complete and review the information c						ew
	ctions, search existing resources, gather t						
	ny comments concerning the accuracy of the						CMS,
	ecurity Boulevard, Attn: PRA Report Clearan				5		
	do not send applications, claims, payments						
	s Clearance Office. Please note that any c the associated OMB control number listed on						
anaci	the desserated one control number risted on	Child Form WELL HU		, ioimaraca,	S. Forannou, II	, Ju nuve ques	

or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

00	1.00						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	
	1.00								5/26/20		
00	1.00	2.00	0	3	8. 00		1	4.00	3720720	17 12.	
00	Hospital and Hospital Health Care Co										
~~	Street: 1100 MERCER AVENEUE	PO Box:			4/700						1
00	City: DECATUR	State: IN Component Name		ip Code: CCN	46733 CBSA	Provi de	nty: ADAMS er Date	Daymor	nt Syst	om (D	2
					Number	Type	Certified		0, or		
						51		V	XVIII		1
		1.00	2	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen					1					L .
00		ADAMS MEMORIAL HOS		51330	99915	1	11/01/2005		0	P	3
00 00	Subprovider - IPF Subprovider - IRF	ADAMS MEMORIAL HOS	PTTAL 15	5M330	99915	4	11/01/2005	N	P	Р	4
00	Subprovider - (Other)										6
00		ADAMS MEMORIAL HOS	PI TAL 15	5Z330	99915		11/01/2005	N	0	Р	7
00	Swing Beds - NF										8
00	Hospital-Based SNF										9
0.00	Hospital-Based NF										10
. 00	Hospital-Based OLTC Hospital-Based HHA										11
3. 00	Separately Certified ASC										12
. 00	Hospi tal -Based Hospi ce										14
5.00	Hospital-Based Health Clinic - RHC										15
. 00	Hospital-Based Health Clinic - FQHC										16
. 00	Hospital-Based (CMHC) I										17
8.00 9.00	Renal Dialysis Other										18
. 00	other						From:		То	:	17
							1.00		2.0		
. 00	Cost Reporting Period (mm/dd/yyyy)						01/01/2	016	12/31/	2016	20
. 00	Type of Control (see instructions)						9				21
. 00	Inpatient PPS Information Does this facility qualify and is it	ourrontly, receivin		te for	dicaraa	ortionat	e N				22
. 00	share hospital adjustment, in accord										22
	for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en										
2. 01	Did this hospital receive interim un						N		N		22
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)	opor tring porrou oot	ourring o		001	0001 1.					
. 02	Is this a newly merged hospital that								N		22
	determined at cost report settlement										
	or "N" for no, for the portion of the in column 2, "Y" for yes or "N" for the interval of the										
	or after October 1.	no, foi the portroi	i ui the	CUSTIE	portrig	perrou					
2. 03	Did this hospital receive a geograph	ic reclassificatior	n from ur	ban to	rural a	s a resu	It N		Ν		22
	of the OMB standards for delineating						r				
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column :						ha				
	cost reporting period occurring on o						ne				
	hospital contain at least 100 but no						th				
	42 CFR 412.105)? Enter in column 3,										
8.00	Which method is used to determine Me						n	2	N		23
	1, enter 1 if date of admission, 2 i method of identifying the days in th	J .			5		d				
	used in the prior cost reporting per										
			n-State	In-Sta		ut-of		edi cai	d 01	ther	
			Medicaid	Medi ca		State		MO day		i cai d	
		p	aid days	eligit		di cai d	Medicaid		d	ays	
				unpai days	·	d days	el i gi bl e unpai d				
			1.00	2.00		3.00	4.00	5.00	6	. 00	1
. 00	If this provider is an IPPS hospital	, enter the	0		0	0	0		0		24
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
. 00	If this provider is an IRF, enter the	e in-state	0)	0	0	о		0		25
	Medicaid paid days in column 1, the										
	Medicaid eligible unpaid days in col	umn 2,		1							1
						1	1				1
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col										

SPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		Period: From 01/01/	2016	Workshee Part I	et S-2	
					Fo 12/31/		Date/Tin	ne Pre	pared
					Urban/Rur	al S	5/26/201 Date of		
					1.00		2.00		
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			inning of the		I			26.
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) sta	tus at the end	of the cost		1			27.
	enter the effective date of the geographic reclassifi			pri Cabre,					
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number	of periods SC	H status in		0			35.
	errect fill the cost reporting perrou.				Begi nni i	ng:	Endi n	g:	
00	Enter applicable beginning and ending dates of SCH st	atus S	Subscript Lipo	26 for number	1.00		2.00)	36.
	of periods in excess of one and enter subsequent date	S.	·						
00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the nu	umber of period	s MDH status		0			37.
01	Is this hospital a former MDH that is eligible for th				N				37.
	accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	r yes o	or "N" for no.	(see					
00	If line 37 is 1, enter the beginning and ending dates								38.
	greater than 1, subscript this line for the number of enter subsequent dates.	period	is in excess of	one and					
					Y/N		Y/N		
00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	or low volume	1.00		2.00 N	J	39.
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage reg								
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes								
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob				N		N		40
	no in column 2, for discharges on or after October 1.								
						V 1.00	XVIII 2.00	XI X 3.00	-
	Prospective Payment System (PPS)-Capital					1.00	, 2.00	0.00	
00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for c	li sproporti onat	e share in ac	cordance	N	N	Ν	45
00	Is this facility eligible for additional payment exce					N	N	Ν	46
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, Pt	. III and Wkst	. L-1, Pt. I	through				
00	Is this a new hospital under 42 CFR §412.300 PPS capi					N	N	Ν	47.
00	Is the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for no		N	N	N	48
00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56
00	or "N" for no. If line 56 is yes, is this the first cost reporting p	eriod c	luring which re	sidents in ap	proved				57.
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont								
	for yes or "N" for no in column 2. If column 2 is "Y	", comp	olete Worksheet						
00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb			ns' services	25	N			58
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	e Wkst. D-5.		45				
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N N			59
	provider-operated criteria under §413.85? Enter "Y"	for yes	s or "N" for no	. (see instru	ctions)			0.115	
		Y/N	IME	Direct GME	IME		Di rect	GME	
00	Did your beenital receive FTF clate water ACA	1.00	2.00	3.00	4.00		5.00		111
00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in					0.00		0.00	1 01.
01	column 1. (see instructions) Enter the average number of unweighted primary care		0.00	0.0	0				61.
01	FTEs from the hospital's 3 most recent cost reports		0.00	0.0					01.
	ending and submitted before March 23, 2010. (see instructions)								
02	Enter the current year total unweighted primary care		0.00	0.0	o				61.
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								
	ACA). (see instructions)								
03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.0	U				61.
	determining compliance with the 75% test. (see								
	instructions) Enter the number of unweighted primary care/or		0.00	0.0	o				61.
04	surgery allopathic and/or osteopathic FTEs in the		3.00	5.0					
04					1				1
	current cost reporting period.(see instructions). Enter the difference between the baseline primary		0 00	0.0	o				61
	current cost reporting period. (see instructions). 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		0.00	0.0	0				61.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DA	ΛTΑ	Provider CC		eriod: com 01/01/2016 12/31/2016	Worksheet S-2 Part I Date/Time Pre	
		Y/N	IME	Direct GME	I ME	5/26/2017 12: Direct GME	
		1.00	0.00	0.00	4.00	F 00	-
1.06 Enter the amount of ACA §5503 award th	at is being	1.00	2.00	3.00	4.00	5.00	61. (
used for cap relief and/or FTEs that a care or general surgery. (see instruct	ire nonprimary						
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
1.10 Of the FTEs in line 61.05, specify each special ty, if any, and the number of F for each new program. (see instruction column 1, the program name, enter in column 3, the l unweighted count and enter in column 4 FTE unweighted count.	TE residents s) Enter in column 2, the ME FTE				0.00	0.00	61.
1. 20 Of the FTEs in line 61.05, specify eac program specialty, if any, and the num residents for each expanded program. (instructions) Enter in column 1, the p enter in column 2, the program code, e 3, the IME FTE unweighted count and en 4, direct GME FTE unweighted count.	ber of FTE see program name, enter in column				0.00	0. 00	61. :
						1.00	_
ACA Provisions Affecting the Health Re 2.00 Enter the number of FTE residents that					od for which	0.00	62.
your hospital received HRSA PCRE fundi 2.01 Enter the number of FTE residents that during in this cost reporting period c	ng (see instructions in the second seco	ctions) a Teachi	ng Health Cent	er (THC) into			62.
Teaching Hospitals that Claim Resident 3.00 Has your facility trained residents in	s in Nonprovid	er Setti	ngs		eriod? Enter	N	63.
"Y" for yes or "N" for no in column 1.	If yes, comple	ete line	<u>s 64-67. (see</u>	instructions) Unweighted	Unweighted	Ratio (col. 1/	
				FTĔs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te 1. 00	2.00	3.00	-
Section 5504 of the ACA Base Year FTE				his base year	is your cost r	eporti ng	
 period that begins on or after July 1, 4.00 Enter in column 1, if line 63 is yes, in the base year period, the number of resident FTEs attributable to rotation settings. Enter in column 2 the number resident FTEs that trained in your hos of (column 1 divided by (column 1 + column 2) 	or your facilia ounweighted nor s occurring in of unweighted pital. Enter in	ty train n-primar all non d non-pr n column	ed residents y care provider imary care 3 the ratio	0.00	0.00	0. 000000	64.
Pr	ogram Name	Pro	ogram 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	
5.00 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				0.00	0.00	0. 000000	65. (

Heal th	Financial Systems	ADAMS	MEMORIAL H	OSPI TAL		In	Lieu of Fo	rm CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	ATA	Provider CC	F	Period: From 01/01/20 To 12/31/20)16 Part I)16 Date/T	eet S-2 ime Prep 017 12:	oared:
					Unweighted	Unweighte	d Ratio (col. 1/	
					FTEs Nonprovi der	FTEs in Hospital	(col. 1 2)	+ COL.	
				-	Si te				
	Section 5504 of the ACA Current	Year FTF Residents i	n Nonprovia	ler Settings	1.00 Effective f	2.00 Or cost repo		00 ods	
	<u>beginning on or after July 1, 20</u>	10	•						
	Enter in column 1 the number of FTEs attributable to rotations o				0.0	0	. 00 C	. 000000	66.00
	Enter in column 2 the number of	unweighted non-prima	ry care res	i dent					
	FTEs that trained in your hospit (column 1 divided by (column 1 +								
		Program Name		am Code	Unweighted	Unweighte		col. 3/	
					FTEs Nonprovider	FTEs in Hospital	(col. 3))	
					Si te				
67 00	Enter in column 1, the program	1.00	2.	00	3.00	4.00		00	67 00
	name associated with each of				0.0			. 000000	07.00
	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)								
						1	. 00 2. 00	3.00	
	Inpatient Psychiatric Facility P								70.00
	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or do	es it conta	IN AN IPF SUD	provi der?	Y		70.00
71.00	If line 70 yes. Column 1: Did th	e facility have an a					N	0	71.00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF Column 3: If column 2 is Y, indi	R 412.424 (d)(1)(iii))(D)? Enter	"Y" for ye	s or "N" for	no.			
	(see instructions)	cate which program ye	ear beyarr c	iui i ng thi s	cost reportin	g periou.			
	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re			doos it co	ntain an IDE		N	1	75.00
	subprovider? Enter "Y" for yes	and "N" for no.							75.00
	If line 75 yes: Column 1: Did th recent cost reporting period end							0	76.00
	no. Column 2: Did this facility	train residents in a	new teachi	ng program	in accordance	with 42			
	CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega					i			
	····· ····			(1		00	
_	Long Term Care Hospital PPS						I.	00	
80.00	Is this a long term care hospita					nori ad? Fr+	•	N	80. 00 81. 00
81.00	ls this a LTCH co-located within "Y" for yes and "N" for no.	another nospital rol	r part or a	III OF THE C	ost reporting	period? Ento	er	N	81.00
	TEFRA Providers	CED Cooti on 6412 40/1	E) (1) (;) T	CDA2 Enter	"\/" far \	an "N" fan n		N	0E 00
	ls this a new hospital under 42 Did this facility establish a ne						J.	N	85.00 86.00
	§413.40(f)(1)(ii)? Enter "Y" fo			an 100((d)(1) (D) (:) (!)	O Enter "V"		N	07 00
	Is this hospital a "subclause (I for yes or "N" for no.	T) LICH CLASSIFIED (under secti	011 1886(u)(Г) (В) (ГV) (ГГ)	enter r		N	87.00
						V 1.00		I X 00	
	Title V and XIX Services					1			
	Does this facility have title V yes or "N" for no in the applica		hospital s	ervi ces? En	ter "Y" for	N		Y	90.00
91.00	Is this hospital reimbursed for	title V and/or XIX th			either in	N	1	N	91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy				on)? (see		1	N	92.00
	instructions) Enter "Y" for yes	or "N" for no in the	appl i cabl e	e column.	, ,	N		N	93.00
	Does this facility operate an IC "Y" for yes or "N" for no in the	applicable column.				IN		N	
	Does title V or XIX reduce capit applicable column.		or yes, and	l "N" for no	in the	N		N	94.00

	AL HOSPITAL Provider CO	NI 1E 1220	Ir Period:	n Lieu	of Form Workshee	CMS-25	52-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	F	From 01/01/ 0 12/31/		Part I Date/Tir	ne Prepa	
			V		5726720 XI X	17 12:15	pm
			1.00		2.0		
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			0.00 N		0.0 N		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	pplicable colum	n	0.00		0.0	9	97.00
105.00 Does this hospital qualify as a critical access hospital (0 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	Y N)5.00)6.00
107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	mn 1. (see inst I. 25 and the p	ructions) lf rogram is cost					07.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physical	Occupational	N Speech		Respi ra		08.00
	1.00	2.00	3.00	<u> </u>	4.0		
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.	e N	N	N		N	10	9.00
				-	1.0	2	
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for	-	N		10.00
Wiegellongous Cast Departing Information				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided	2. If column 2 i ent for long te	is "E", enter rm care (inclu	in column des	N		0 11	15.00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu no.			"N" for	N Y			16.00 17.00
118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1	if the policy	is	1		11	8.00
		Premi ums	Losses	6	Insura	ince	
		1.00	2.00				
118.01 List amounts of malpractice premiums and paid losses:		1.00 128,08	2.00	0	3.0		
		120,00	•			011	18 01
110 00 Are malarastics premiums and paid lesses reported in a sect				0		011	8.01
118.02 Are malpractice premiums and paid losses reported in a cost	t contor other	than the	1.00		2.0	2	
Administrative and General? If yes, submit supporting sche and amounts contained therein.			1.00 N			D 11	18. 02
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA \$3121 and applicable amendments	edule listing co Id Harmless prov in column 1, "Y qualifies for th	ost centers vision in ACA " for yes or he Outpatient				D 11 11	
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that co	edule listing co ld Harmless prov in column 1, "Y qualifies for t ents? (see inst	ost centers vision in ACA " for yes or he Outpatient ructions)	N		2.0	D 11 11 12	18. 02
and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impli- patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.	edule listing co Id Harmless prov in column 1, "Y qualifies for th ents? (see inst I antable devices ? Enter "Y" for	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	N		2.0	D 11 11 12 12	18. 02 19. 00 20. 00
and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impline patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	edule listing co ld Harmless prov in column 1, "Y qualifies for t ents? (see inst lantable device: ? Enter "Y" for the Worksheet A	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	NN		2. 00 N	D 11 11 12 12 0 12	18. 02 19. 00 20. 00 21. 00
 and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in center. 	edule listing co Id Harmless prov in column 1, "Y qualifies for th ents? (see inst lantable devices ? Enter "Y" for the Worksheet A for yes and "N" enter the certi	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	N N N Y		2. 00 N	D 11 11 12 12 0 12 12	18. 02 19. 00 20. 00 21. 00 22. 00
and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impling patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column	edule listing co ld Harmless province column 1, "Y qualifies for the ents? (see insti- lantable device: ? Enter "Y" for the Worksheet A for yes and "N" enter the certifient 2. nter the certifient 2.	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	N N N Y		2. 00 N	D 11 11 12 12 0 12 12 12 12 12 12 12	18.02 19.00 20.00 21.00 22.00 25.00 26.00 27.00
and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impli- patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column	edule listing control listing	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	N N Y N		2. 00 N	D 11 11 12 12 0 12 12 12 12 12 12 12	18.02 19.00 20.00 21.00 22.00 25.00 26.00 27.00 28.00
 and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, ent column 1 and termination date, if applicable, in column 	edule listing co Id Harmless province in column 1, "Y qualifies for the ents? (see insti- lantable devices? ? Enter "Y" for the Worksheet A for yes and "N" enter the certifies nter the certifies ter the certifies	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date in	N N Y N		2. 00 N	D 11 11 12 12 0 12 12 12 12 12 12 12 12 12 12	18.02 19.00 20.00 21.00 22.00 25.00 26.00 27.00 28.00 29.00
 and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, enter 	edule listing control light and ligh	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date in tification	N N Y N		2. 00 N	D 11 11 12 12 12 12 12 12 12 12 12 12 12 1	18.02 19.00 20.00 21.00 22.00 25.00 26.00 27.00 28.00

Health Financial Systems	ADAMS MEMORIA	L HOSPI TAL			In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	(IDENTIFICATION DATA	Provider CC	CN: 15-1330			Worksheet S-2	
					01/01/2016	Part I Date/Time Pre	pared
					2/01/2010	5/26/2017 12:	15 pm
					1 00	2.00	
133.00 If this is a Medicare certified ot	her transplant center, ent	er the certifi	cation da	te	1.00	2.00	133.00
in column 1 and termination date,	if applicable, in column 2						
134.00 If this is an organ procurement or		e OPO number i	n column	1			134.00
and termination date, if applicable All Providers	e, in column 2.						
140.00 Are there any related organization	or home office costs as d	lefined in CMS	Pub. 15-1	,	Y	15H060	140.00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office co				
are claimed, enter in column 2 the			tions)		0.00		
<u> </u>	2.00		uah 1/3 th	o namo an	3.00	of the	
home office and enter the home off					la adul ess	of the	
141.00 Name: ADAMS HEALTH NETWORK	Contractor's Name: WPS			actor's Nu	umber: 0810	1	141.00
142.00 Street: 1100 MERCER AVE	PO Box:						142.00
143.00 City: DECATUR	State: IN		Zip C	ode:	4673	3	143.00
						1.00	
144.00 Are provider based physicians' cos	ts included in Worksheet A	?				Y	144.00
			. 6		1.00 N	2.00 N	145.00
145.00 If costs for renal services are cl inpatient services only? Enter "Y"				< l	IN	IN IN	145.00
no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"							
146.00 Has the cost allocation methodolog				1.6	N		146. 00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d		5-2, chapter 4	10, 94020)				
						1.00	1
147.00 Was there a change in the statisti						N	147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				for no		N N	148.00 149.00
147. oojwas there a change to the shipi in	ed cost finding method: En	Part A	Part		Title V	Title XIX	149.00
		1.00	2.00		3.00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or " 155.00Hospital	N TOP NO FOR EACH COMPONE	N	and Part	B. (See 4	N	N	155.00
156.00 Subprovi der – IPF		N	N		N	N	156.00
157.00 Subprovider - IRF		Ν	N		N	N	157.00
158. 00 SUBPROVI DER							158.00
159.00 SNF 160.00 HOME_HEALTH_AGENCY		N N	N N		N N	N N	159.00 160.00
161. 00 CMHC		IN	N N		N	N	161.00
						1.00	
Multicampus 165.00Is this hospital part of a Multica	mous beenited that has one		icoc in di	fforont (DCAc2	N	165.00
Enter "Y" for yes or "N" for no.	iipus nospi tai that has one	or more campu			DOAS (IN	105.00
	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						0.00	166.00
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)							
						1.00	
Health Information Technology (HIT							
167.00 Is this provider a meaningful user						Y	167.00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			e 16/is "	Y"), ente	r the	C	168.00
168.01 If this provider is a CAH and is n			rgualif∨	for a har	dshi p		168. 01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or "N"	for no. (see i	nstructio	ns)			
169.00 If this provider is a meaningful u		is not a CAH ((line 105	is "N"), (enter the	0.00	169. 00
transition factor. (see instructio	1137					I	I

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Peri od:	Worksheet S-2	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre	
				5/26/2017 12:	<u>15 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR bec	inning date and ending dat	te for the reporting	10/01/2016	09/30/2017	170.00
period respectively (mm/dd/yyyy)					
			1.00	2.00	1
171.00 If line 167 is "Y", does this provid	ler have any days for indiv	/iduals enrolled in	N	0	171.00
section 1876 Medicare cost plans rep	orted 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, er	nter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet S- Part II Date/Time Pr 5/26/2017 12	epared:
				Y/N	Date	_
	Compared Instructions Enter V for all VES recompases. Enter N	for all NO re	ononono Ent	<u> </u>	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	FOR ALL NU FE	esponses. Ento	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					-
	Provi der Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	beai nni na of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c)		
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe	ffices, drug er or its f the board	Y			3. 0
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		1.00	2.00	0.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	N			4. C
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N	Legal Oper.	_
	Approved Educational Activitica			1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	he provider i	s N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing school and/or allied health programs approved a		d during the	N N		7.0
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Ν		9.0
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		the current	Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	YZN	11. (
					1.00	-
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. (13. (
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I	fyes, see in	structions.	N	14. (
5.00	Did total beds available change from the prior cost reporti	ng period? If	yes, see ins	tructions.	N	15. (
		Pai	rt A	Par	tВ	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	05/08/2017	Y	05/08/2017	16.0
7. 00	instructions) 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	Ν		N		17.0
3. 00	in columns 2 and 4. (see instructions) 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	Ν		N		18. (
9. 00	cost report? If yes, see instructions. 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.	Ν		Ν		19. (

JSPI TAL	inancial Systems ADAMS MEMORIA AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCI	N: 15-1330	Period: From 01/01/2016	Worksheet S Part II	S-2
				To 12/31/2016		
		Descri	otion	Y/N	Y/N	<u>12. 15 p</u>
		0		1.00	3.00	
	f line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.
	leport data for other? Describe the other aujustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	as the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
					1.00	
	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	SPI TALS)			
	apital Related Cost	1			N	
	lave assets been relifed for Medicare purposes? If yes, see lave changes occurred in the Medicare depreciation expense		ls made dur	ing the cost	N N	22.
	eporting period? If yes, see instructions. /ere new leases and/or amendments to existing leases entere	d into during t	his cost re	eporting period?	Ν	24.
	f yes, see instructions lave there been new capitalized leases entered into during	the cost report	ing period?	Plfyes, see	Ν	25.
. OO W	nstructions. /ere assets subject to Sec.2314 of DEFRA acquired during th	e cost reportin	ıg period? I	f yes, see	Ν	26.
	nstructions. las the provider's capitalization policy changed during the	cost reporting	period? If	⁼yes, submit	Ν	27.
	opy. nterest Expense					
	lere new Loans, mortgage agreements or Letters of credit en beriod? If yes, see instructions.	tered into duri	ng the cost	reporting	Ν	28
	Nid the provider have a funded depreciation account and/or reated as a funded depreciation account? If yes, see instr		t Service R	Reserve Fund)	Ν	29
	las existing debt been replaced prior to its scheduled matu nstructions.	rity with new d	ebt? If yes	s, see	Ν	30
i	las debt been recalled before scheduled maturity without is: nstructions.	suance of new d	ebt? If yes	s, see	Ν	31
. 00 H	urchased Services lave changes or new agreements occurred in patient care ser		i through co	ontractual	N	32
. 00 1	irrangements with suppliers of services? If yes, see instru- fline 32 is yes, were the requirements of Sec. 2135.2 app 10, see instructions.		to competi	tive bidding? If	Ν	33
	rovi der-Based Physi ci ans					
	re services furnished at the provider facility under an ar f yes, see instructions.	rangement with	provi der-ba	ased physi ci ans?	Y	34.
. 00 1	f line 34 is yes, were there new agreements or amended exi- hysicians during the cost reporting period? If yes, see in		s with the	provi der-based	Y	35.
10	ing for any daring the cost reporting period. In yes, see the			Y/N	Date	
				1.00	2.00	
	ome Office Costs					
. 00 1	lere home office costs claimed on the cost report? fline 36 is yes, has a home office cost statement been pro	epared by the h	ome office?	P Y Y		36. 37.
. 00 1	f yes, see instructions. f line 36 is yes , was the fiscal year end of the home off			= N		38
. 00 1	he provider? If yes, enter in column 2 the fiscal year end f line 36 is yes, did the provider render services to othe			s, Y		39
. 00 1	see instructions. f line 36 is yes, did the provider render services to the l	home office? I	f yes, see	Ν		40
<u> i</u>	nstructions.					
		1.0	0	2.	00	
. 00 E		SKANDER		NASSER		41.
	eld by the cost report preparer in columns 1, 2, and 3, espectively.	BRADLEY ASSOCIA	TES			42.
.00 E	preparer.	317-237-5500	ITES	SKANDERN@BRADLI		43

Heal th	Financial Systems ADAMS M	EMORI	AL HOSPI TAL	In Lieu	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	E	Provider CCN: 15-13	eriod: rom 01/01/2016	Worksheet S-2 Part II	
						pared: <u>15 pm</u>
				4		
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position		PARTNER			41.00
	held by the cost report preparer in columns 1, 2, and	3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the co	ost				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	ADAMS MEMORIA	Provi der CO	CN· 15-1330	Peri od:	worksheet S-3	
					From 01/01/2016 To 12/31/2016	Part I	pared:
						I/P Days / O/P	
						<u>Visits / Trips</u>	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e		5.00	
1 00		1.00	2.00	3.00	4.00	5.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	21	7,68	91, 008. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed SNI Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		21	7,6	91, 008. 00		
7.00	beds) (see instructions)		21	7,00	91,000.00	0	/.00
8.00	INTENSI VE CARE UNI T	31.00	4	1, 40	9, 552. 00	0	8.00
9.00	CORONARY CARE UNIT	01100		.,	,,002.00		9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	
14.00	Total (see instructions)	101 00	25	9, 1	50 100, 560. 00		
15.00	CAH visits		20		100,000,00	0	
16.00	SUBPROVIDER - IPF	40.00	10	3, 6	50	0	
17.00	SUBPROVIDER - IRF					-	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0		0	0	
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE	116.00	0		0		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)		35				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						32.01
	outpatient days (see instructions)						
33 00	LTCH non-covered days						33.00

		AL DATA	Provider CC	1	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/26/2017 12:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui val ents	
	Component	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, 594	171	3, 720			1.00
2.00	HMO and other (see instructions)	668	0				2.00
3.00	HMO I PF Subprovi der	107	0				3.00
4.00	HMO I RF Subprovider	0	0				4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF	265	0	26	5		5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	205	0	31			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 859	171	4, 308			7.00
8.00	INTENSIVE CARE UNIT	200	4	398	8		8.00
9.00	CORONARY CARE UNI T						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		59	380	D		13.00
14.00	Total (see instructions)	2, 059	234	5, 080	6 0.00	484.76	14.00
15.00	CAH visits	30, 239	6, 035	128, 51	5		15.00
16.00	SUBPROVIDER - IPF	357	106	1, 550	0.00	20.68	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	0	0	(0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	(0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0	0	(0.00	0.00	1
24.10	HOSPICE (non-distinct part)	0	0	(C		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	
27.00	Total (sum of lines 14-26)				0.00	505.44	
28.00	Observation Bed Days		0	1, 344	4		28.00
29.00	Ambul ance Trips	680					29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0	60			32.00
32. 01	Total ancillary labor & delivery room			(C		32.01
	outpatient days (see instructions) LTCH non-covered days	0					33.00

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/26/2017 12:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d 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	4	54 65	1, 597	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			1	56 0 0 0		2.00 3.00 4.00
5.00 5.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00
3.00 9.00 10.00 11.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T						8.00 9.00 10.00 11.00
2.00 3.00 4.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0. 00	0	4	54 65	1, 597	12.00 13.00 14.00
15.00 16.00 17.00	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF	0. 00	0		50 27	346	15.0 16.0 17.0
8.00 9.00 0.00	SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY	0. 00					18.0 19.0 20.0
1.00 2.00 3.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	0. 00					21. C 22. C 23. C
4.00 4.10 5.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00					24. 0 24. 1 25. 0
6. 00 6. 25 7. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0. 00 0. 00					26. 0 26. 2 27. 0
8.00 9.00 0.00 1.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF						28.0 29.0 30.0 31.0
2.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						32. 0 32. 0 33. 0

Heal th	Financial Systems ADAMS MEMORIAL F	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1330	Peri od:	Worksheet S-	10
				From 01/01/2016 To 12/31/2016	Date/Time Pre	narod
				10 12/31/2010	5/26/2017 12:	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lir	ne 202 columr	8)	0. 439316	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				1, 716, 993	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplementa		from Medicaic	?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments fro	∍m Medicaid			(
6.00	Medi cai d charges				9, 464, 322	
7.00	Medicaid cost (line 1 times line 6)				4, 157, 828	
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minu	us sum of lir	ies 2 and 5; if	2, 440, 835	8.00
	< zero then enter zero)		- \			
0.00	Children's Health Insurance Program (CHIP) (see instructions f	or each tine	=)		100.000	
9.00	Net revenue from stand-al one CHIP				100, 000	
10.00	Stand-alone CHIP charges				200, 000	
11.00	Stand-alone CHIP cost (line 1 times line 10)	(line 11 mi)		f . Jong then	87, 863	
12.00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(The Think	nus i i ne 9; i	i < zero then	(12.00
	Other state or local government indigent care program (see ins	tructions fo	or each line)			
13.00	Net revenue from state or local indigent care program (See This				(13.00
14.00	Charges for patients covered under state or local indigent car				(10100
11.00	10)					
15.00	State or local indigent care program cost (line 1 times line 1	4)			(15.00
16.00	Difference between net revenue and costs for state or local in		program (lir	e 15 minus line	C	16.00
	13; if < zero then enter zero)	5				
	Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to f	unding chari	ity care		(1
18.00	Government grants, appropriations or transfers for support of	hospital ope	erations		(18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca	ul indigent o	care programs	(sum of lines	2, 440, 835	19.00
	8, 12 and 16)					L
			Uni nsured	Insured	Total (col. 1	
		-	patients	pati ents	+ col . 2)	
20.00	Charity care charges for the entire facility (see instructions		<u> </u>	2.00	3.00	20.00
20.00	Cost of patients approved for charity care (line 1 times line		78, 44		78, 440	
21.00	Partial payment by patients approved for charity care	20)	70, 44	0 0	/0, 440	
23.00	Cost of charity care (line 21 minus line 22)		78, 44	-		23.00
23.00			70, 4	0	70, 440	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patien	it days beyor	nd a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care		5	5		
25.00	If line 24 is "yes," charges for patient days beyond an indig	jent care pro	ogram's lengt	h of stay limit	(25.00
26.00	Total bad debt expense for the entire hospital complex (see in	structions)	0	÷	3, 920, 368	26.00
27.00	Medicare bad debts for the entire hospital complex (see instru				205, 508	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (I		s line 27)		3, 714, 860	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (line	1 times line	28)	1, 631, 997	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 710, 437	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus I	ine 30)			4, 151, 272	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ADAMS MEMORIAL F EXPENSES	Provi der CC		Period:	u of Form CMS-: Worksheet A	2002-10
					From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	OFNERAL OFRICAS OOOT OFNITERO	1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		2, 631, 300	2, 631, 30	52, 181	2, 683, 481	1.00
2.00	00200 NEW CAP REL COSTS-DEDG & TTXT		2,031,300		0 0	2,003,401	
3.00	00300 OTHER CAP REL COSTS		0		0 0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	18, 988	18, 98	в О	18, 988	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 217, 663	7, 240, 082	9, 457, 74		9, 240, 033	
7.00	00700 OPERATION OF PLANT	183,004	641, 987	824, 99		824, 991	
7.01		3, 518	130, 121	133, 63		133, 639	
7.02 7.03	00702 UTILITIES - HOSPITAL 00703 UTILITIES - OFFSITE BLDGS	0	702, 427 108, 745	702, 42 108, 74		707, 894 103, 278	
8.00	00800 LAUNDRY & LINEN SERVICE	43, 966	154, 629	198, 59		198, 595	
9.00	00900 HOUSEKEEPI NG	437, 869	293, 143	731, 01		731, 012	
10.00	01000 DI ETARY	691,086	734, 408	1, 425, 49		258, 824	
11.00	01100 CAFETERI A	0	0		1, 166, 670	1, 166, 670	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	843, 588	242, 065	1, 085, 65	3 0	1, 085, 653	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14.00
15.00	01500 PHARMACY	721, 117	493, 932	1, 215, 04		1, 215, 049	
16.00	01600 MEDICAL RECORDS & LIBRARY	395, 414	756, 564	1, 151, 97	8 0	1, 151, 978	16.00
30. 00	03000 ADULTS & PEDIATRICS	2, 172, 828	824, 389	2, 997, 21	7 472, 594	3, 469, 811	30.00
31.00	03100 I NTENSI VE CARE UNI T	590, 494	223, 275	813, 76		813, 769	
40.00	04000 SUBPROVI DER – I PF	795, 561	402, 036	1, 197, 59		1, 197, 597	
43.00	04300 NURSERY	0	0		253, 318	253, 318	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 516, 270	1, 440, 518	3, 956, 78		3, 956, 788	
52.00	05200 DELIVERY ROOM & LABOR ROOM	663, 089	276, 345	939, 43		213, 522	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 1, 018, 844	0 1, 209, 813	2, 228, 65	0 7 0	0 2, 228, 657	
60.00	06000 LABORATORY	1, 042, 939	2, 312, 023	3, 354, 96		3, 354, 962	
65.00	06500 RESPI RATORY THERAPY	647, 774	295, 454	943, 22		943, 228	
66.00	06600 PHYSI CAL THERAPY	789, 050	283, 637	1, 072, 68		1, 072, 687	
67.00	06700 OCCUPATI ONAL THERAPY	267, 444	99, 928	367, 37	2 0	367, 372	67.00
68.00	06800 SPEECH PATHOLOGY	178, 590	56, 487	235, 07		235, 077	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	1, 797, 446	1, 797, 44		1, 797, 446	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0 1, 569, 437	1, 569, 43	0 7 0	0 1, 569, 437	
76.00	03020 OP PSYCH	329, 248	1, 509, 437	448, 52		462, 599	
/0.00	OUTPATIENT SERVICE COST CENTERS	027,210	117,217	110, 02	11,072	102, 077	/ 0. 00
90.00	09000 CLI NI C	1, 039, 404	443, 607	1, 483, 01	1 0		
	09001 CLINIC - AMO	1, 098, 398	213, 237	1, 311, 63			
	09002 CLINIC - AMH NEURO	240, 764	42, 267	283, 03		283, 031	90.02
90.03	09003 CLINIC - NIGLIAZZO	1, 116, 147	227, 965	1, 344, 11		1, 344, 112	
90.04	04950 INTENSIVE OP BEHAVIORAL HEALTH	18, 192	34, 967	53, 15		53, 159	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 165, 406	457, 810	2, 623, 21	6 261, 747	2, 884, 963	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	1, 129, 980	550, 527	1, 680, 50	7 0	1, 680, 507	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0		97.00
	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	· · ·			-		
	11600 HOSPI CE	0	0		0 0		116.00
118.00		23, 357, 647	27, 028, 838	50, 386, 48	5 110, 288	50, 496, 773	1118.00
100 00	NONREIMBURSABLE COST CENTERS		0			0	100.00
	07950 TITLE XX	0	0				190.00 194.00
194 01	I 07951 OTHER NRCC	741, 842	411, 589	1, 153, 43	-	1, 153, 431	
	207952 OTHER MOBS	385, 197	398, 252	783, 44			
				893, 21			
194.03	3 07953 MONROE	551, 194	342, 021	073, 21	5 -55, 069	838, 146	194. Us

ECLASSIFICA	cial Systems TION AND ADJUSTMENTS OF TRIAL BALANCE C	ADAMS MEMORIA	Provi der C	CN: 15-1330	Peri od:	u of Form CMS-2 Worksheet A	
LOENSSTITON	THON AND ADJUSTMENTS OF TREAS DALANCE C			JN. 15 1550	From 01/01/2016 To 12/31/2016	Date/Time Pre	
	Cost Conton Decerintian	Adiustmente	Nat Experses			5/26/2017 12:	<u>15 pr</u>
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
GENERA	AL SERVICE COST CENTERS	0.00		<u> </u>			
	NEW CAP REL COSTS-BLDG & FIXT	-330, 184	2, 353, 297				1 1.
	NEW CAP REL COSTS-MVBLE EQUIP	0					2.
	OTHER CAP REL COSTS	0		•			3.
	EMPLOYEE BENEFITS DEPARTMENT	0					4.
	ADMINI STRATI VE & GENERAL	39, 305					5.
	OPERATION OF PLANT	-73, 619					7.
	BIO-MEDICAL	-125, 417					7.
	UTILITIES - HOSPITAL	-34, 852					7.
	UTILITIES - OFFSITE BLDGS	0					7.
	LAUNDRY & LINEN SERVICE	0					8.
	HOUSEKEEPING	0					9.
	DI ETARY	0					10.
	CAFETERIA	-448, 232					111.
	NURSI NG ADMI NI STRATI ON	-15, 944		1			13.
	CENTRAL SERVICES & SUPPLY	0					14
	PHARMACY	0					15
	MEDICAL RECORDS & LIBRARY	-25, 363	.,				16
	ENT ROUTI NE SERVI CE COST CENTERS	-23, 303	1, 120, 013				1 10
	ADULTS & PEDIATRICS	-851, 116	2, 618, 695				30
	INTENSIVE CARE UNIT	-584		1			31
	SUBPROVIDER - IPF	-244, 499					40
	NURSERY	-244, 499		1			40
1 1	SKILLED NURSING FACILITY	0		1			43
	ARY SERVICE COST CENTERS	0	0				44
	OPERATING ROOM	-1, 815, 433	2, 141, 355				50
	DELIVERY ROOM & LABOR ROOM			1			50
	ANESTHESI OLOGY	0		1			52
	RADI OLOGY – DI AGNOSTI C	0					54
	LABORATORY	-	_,,				60
	RESPIRATORY THERAPY	-48, 920					65
		-103, 804					
	PHYSI CAL THERAPY	0					66
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0					68
	ELECTROCARDI OLOGY	0					69
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71
	IMPL. DEV. CHARGED TO PATIENT	0					72
	DRUGS CHARGED TO PATIENTS	-606, 060					73
	OP PSYCH	0	462, 599				76
	TIENT SERVICE COST CENTERS	700 1/0	(04.040				1
		-788, 162		1			90
	CLINIC - AMO	-749, 033					90
	CLINIC - AMH NEURO	000.225					90
	CLINIC - NIGLIAZZO	-999, 235					90
1 1	INTENSIVE OP BEHAVIORAL HEALTH	0					90
	EMERGENCY	-1, 363, 646	1, 521, 317				91
	OBSERVATION BEDS (NON-DISTINCT PART)	I					92
	REI MBURSABLE COST CENTERS AMBULANCE SERVI CES		1 (00 507				95
1 1		0					
	DURABLE MEDICAL EQUIP-SOLD	0					97
	HOME HEALTH AGENCY	0	0				101
	AL PURPOSE COST CENTERS						111/
6.0011600		0 504 700					116
	SUBTOTALS (SUM OF LINES 1-117)	-8, 584, 798	41, 911, 975				118
	MBURSABLE COST CENTERS		-				1000
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
4.0007950		0					194
	OTHER NRCC	0	.,				194
	OTHER MOBS	0					194
4. 03 07953		0	838, 146				194
0.00	TOTAL (SUM OF LINES 118-199)	-8, 584, 798	44, 631, 782	1			200

Heal th	Financial Systems		ADAMS MEMORIAL	HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1330	Peri od:	Worksheet A-	6
						From 01/01/2016 To 12/31/2016	Date/Time Pr 5/26/2017 12	epared: :15 pm
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A – OB, NURSERY AND L&D							
1.00	ADULTS & PEDIATRICS	30.00	346, 005	126, 589				1.00
2.00	NURSERY	43.00	18 <u>5, 4</u> 64	6 <u>7, 8</u> 54				2.00
	0		531, 469	194, 443				
	B – I NSURANCE							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	52, 181				1.00
	FIXT							
	0		0	52, 181				
	C – CAFETERIA							
1.00	CAFETERI A		567, 452	<u>599, 2</u> 18				1.00
	0		567, 452	599, 218				
	D – ED RECLASS				1			_
1.00	EMERGENCY		23 <u>3, 7</u> 03	2 <u>8, 0</u> 44				1.00
	TOTALS		233, 703	28, 044				
	E - HOSPITAL USE OF SWISS CI							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	5, 936				1.00
2.00	OP PSYCH	76.00	0	14, 072				2.00
3.00	UTILITIES - HOSPITAL		0	<u>5, 4</u> 67				3.00
	0		0	25, 475				
	F - MANAGEMENT FEE							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	90, 280				1.00
2.00		0.00	0	0				2.00
	TOTALS		0	90, 280				
500.00	Grand Total: Increases		1, 332, 624	989, 641				500.00

Heal th	Financial Systems		ADAMS MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2552-1
RECLAS	SEFECATIONS			Provider (CCN: 15-1330	Period:	Worksheet A-6
						From 01/01/2016 To 12/31/2016	Date/Time Prepared: 5/26/2017 12:15 pm
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .	
	6. 00	7.00	8.00	9.00	10.00		
	A – OB, NURSERY AND L&D						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	531, 469	194, 443		0	1.00
2.00	L	0.00	0	0		0	2.00
	0		531, 469	194, 443			
	B – I NSURANCE				1	İ	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	5 <u>2, 1</u> 81	1	2	1.00
	0		0	52, 181			
	C – CAFETERIA				1		
1.00	DI ETARY	10.00	<u> </u>	<u> </u>		Q	1.00
	0		567, 452	599, 218			
	D - ED RECLASS	5.00	000 700		1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	233, 703	28,044		Ō	1.00
	TOTALS	->/	233, 703	28, 044			
1 00	E - HOSPITAL USE OF SWISS CIT OTHER MOBS		0	20.000	1	0	1.00
1.00	UTILITIES - OFFSITE BLDGS	194.02 7.03	0	20, 008		0	2.00
2.00 3.00	UTILITIES - OFFSTTE BLDGS	0.00	0	5, 467			2.00
3.00				25, 475		<u>u</u>	3.00
	G F - MANAGEMENT FEE		0	25,475			
1.00	OTHER MOBS	194.02	0	35, 211	1	0	1.00
2.00	MONROE	194.02	0	35, 211 55, 069			2.00
2.00	TOTALS	194.03	— — — 0	<u>55,089</u> 90,280			2.00
E00 00	Grand Total: Decreases		1, 332, 624	90, 280			500.00
500.00	GLANG TOTAL DECLEASES		1, 332, 024	707, 041	I	1	1 500. 00

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Li	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1330	Period: From 01/01/2016 To 12/31/2016		pared:
			Acqui si ti or	IS		
	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Land	367, 244	0		0 0	0 0	1.00
2.00 Land Improvements	1, 624, 680	0		0 (10, 819	2.00
3.00 Buildings and Fixtures	38, 317, 830	2, 048, 916		0 2, 048, 916	6 0	3.00
4.00 Building Improvements	0	0		0 (0 0	4.00
5.00 Fixed Equipment	4, 591, 700	23, 240		0 23, 240	0 0	5.00
6.00 Movable Equipment	23, 447, 242	797, 215		0 797, 215	5 0	6.00
7.00 HIT designated Assets	0	0		0 0	0 0	7.00
8.00 Subtotal (sum of lines 1-7)	68, 348, 696	2, 869, 371		0 2, 869, 371	10, 819	8.00
9.00 Reconciling Items	0	0		0 0	0 0	9.00
10.00 Total (line 8 minus line 9)	68, 348, 696	2, 869, 371		0 2, 869, 371	10, 819	10.00
	Endi ng Bal ance	Fully				
	Ũ	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00 Land	367, 244	0				1.00
2.00 Land Improvements	1, 613, 861	0				2.00
3.00 Buildings and Fixtures	40, 366, 746	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	4, 614, 940	0				5.00
6.00 Movable Equipment	24, 244, 457	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	71, 207, 248	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	71, 207, 248	0				10.00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		nared
					10 12/01/2010	5/26/2017 12:	<u>15 pm</u>
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2	-		
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 512, 027	0	1, 119, 27	3 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 512, 027	0	1, 119, 27	3 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 631, 300				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2, 631, 300				3.00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Prep 5/26/2017 12:	
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			(col. 1 - col 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI 1.00 NEW CAP REL COSTS-BLDG & FIXT	64, 611, 203	0	64, 611, 20	3 1.000000	0	1.00
2.00 NEW CAP REL COSTS-BEDG & TTXT	04,011,203		04,011,20	0 0.000000		2.00
3.00 Total (sum of lines 1-2)	64, 611, 203	0	64, 611, 20			3.00
		TION OF OTHER C		SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
	(00	d Costs 7.00	through 7) 8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6.00	7.00	8.00	9.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1, 452, 124	0	1.00
2.00 NEW CAP REL COSTS MVBLE EQUIP	0	0		0 1, 102, 121	0	2.00
3.00 Total (sum of lines 1-2)	0	0		0 1, 452, 124	0	3.00
		SL	IMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	848, 992	52, 181		0 0	2, 353, 297	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00 Total (sum of lines 1-2)	848, 992	52, 181		0 0	2, 353, 297	3.00

	Financial Systems MENTS TO EXPENSES		ADAMS MEMORI	Provider CCN: 15-1330	In Lie Period:	Worksheet A-8	
					From 01/01/2016 To 12/31/2016	Date/Time Prep 5/26/2017 12:	pared: 15 pm
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	В		NEW CAP REL COSTS-BLDG & FLXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	2) Investment income - other		C		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		C		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		C		0.00	0	
8.00	21) Television and radio service	А	-7,410	ADMI NI STRATI VE & GENERAL	5.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	
10.00 11.00	Provider-based physician adjustment Sale of scrap, waste, etc.	A-8-2	-6, 728, 316		0.00	0	
	(chapter 23)				0.00		
12.00	Related organization transactions (chapter 10)	A-8-1	-268, 510			0	
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	C -448, 232	CAFETERI A	0.00 11.00	0	
15.00	Rental of quarters to employee and others		C		0.00	0	15.00
16. 00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16. 00
17.00	Sale of drugs to other than patients	В	-606,060	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and	В	-25,363	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
19. 00	abstracts Nursing school (tuition, fees,		C		0.00	0	19.00
	books, etc.) Vending machines		C		0.00		
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		C		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		C	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		C	NEW CAP REL COSTS-MVBLE	2.00	0	27.00
28.00	Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C C	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		C		0.00	0	32.00

Heal th	Financial Systems		ADAMS MEMORIA	AL HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8 Date/Time Pre 5/26/2017 12:	pared:
				Expense Classification of To/From Which the Amount i		372072017 12.	
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	I HA DUES	A	-911	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
33.01	AHA DUES	A	-3, 382	ADMI NI STRATI VE & GENERAL	5.00	0	33. 01
33.02			0		0.00	0	00.02
33.03	JAY COUNTY MGMT REVENUE	В		SUBPROVIDER – IPF	40.00		33.03
33.04	WORTHMAN FITNESS CENTER	В		RESPI RATORY THERAPY	65.00	0	33.04
33.05	MI SC I NCOME	В	-213, 883	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ECU RUN-OFF EXPENSES	A	-584	INTENSIVE CARE UNIT	31.00	0	33.06
33. 07	HOSPITAL PROVIDER TAX SHORTFALL	A	455, 246	ADMI NI STRATI VE & GENERAL	5.00	0	33. 07
33.08			0		0.00	0	
33.09	MARKETING	A	-266, 120	ADMI NI STRATI VE & GENERAL	5.00	0	
33.10			0		0.00	0	
33.11			0		0.00	0	00111
33.12	HOSPI TALI ST OTHER	A	-8, 193	ADULTS & PEDIATRICS	30.00	0	33. 12
33.13			0		0.00	0	33.13
33.14			0		0.00	0	33.14
33.15			0		0.00	0	33. 15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33. 18			0		0.00	0	33. 18
33.19			0		0.00	0	33. 19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8, 584, 798				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.

Health Financial Syst	ems	ADAMS MEMORI	AL HOSPI TAL	In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1330	Peri od:	Worksheet A-8	8-1
OFFICE COSTS				From 01/01/2016		
				To 12/31/2016		
Ling	e No.	Cost Center	Expanse I toms	Amount of	5/26/2017 12: Amount	15 pili
LINE	e NO.	cost center	Expense Items	Allowable Cost		
					Wks. A, column	
					5 S NRS. A, COLUMIT	
1	00	2.00	3.00	4,00	5.00	
		MENTS REQUIRED AS A RESULT OF				
HOME OFFICE CC						
1.00		NEW CAP REL COSTS-BLDG & FIX		78, 913	74, 143	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX		0	59, 903	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL		3, 134, 250	0	3.00
3.01	7.02	UTILITIES - HOSPITAL		0	34, 852	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL		0	2, 968, 205	3.02
3.03	7.00	OPERATION OF PLANT		0	73, 619	3.03
3.04	7.01	BI O-MEDI CAL		0	125, 417	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL		0	35, 211	3.05
3.06	5. OC	ADMINISTRATIVE & GENERAL		0	55,069	3.06
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX		0	55, 254	4.00
5.00 0			0	3, 213, 163	3, 481, 673	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	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0.00 ADAMS HEALTH NETWORK 0.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form			
STATEMENT OF COSTS OF SERVICES FROM RELAT OFFICE COSTS	TED ORGANIZATIONS AND HOME Provider CCN	From 01/01/2016	Worksheet A-8-1
		To 12/31/2016	Date/Time Prepared:

					5	/26/2017 12:1	5 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRAI	NSACTIONS WITH RELATED C	RGANIZATIONS OR CLA	AIMED	
	HOME OFFICE CO	STS:					
1.00	4, 770	11					1.00
2.00	-59, 903	9					2.00
3.00	3, 134, 250	0					3.00
3.01	-34,852	0					3.01
3.02	-2, 968, 205	0					3. 02
3.03	-73, 619						3.03
3.04	-125, 417	0					3.04
3.05	-35, 211	0					3.05
3.06	-55,069	0					3.06
4.00	-55, 254						4.00
5.00	-268, 510						5.00
	2007010						

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.

nao no			
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	51		
	6,00		
	0.00		
	B. INTERRELATIONSHIP TO RELAT	FED 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	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
7.00 8.00 9.00 10.00 100.00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organizati on.

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.

	Financial Syste		ADAMS MEMOR	AL HOSPITAL		In Li	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 01/01/2016 To 12/31/2016	Worksheet A-8 5 5 Date/Time Pre	
							5/26/2017 12:	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		NURSING ADMINISTRATION	15, 944		C			1.00
2.00		ADULTS & PEDIATRICS	842, 923					2.00
3.00		SUBPROVIDER - IPF	105, 020			-		3.00
4.00		OPERATING ROOM	1, 815, 433			, second se	Ŭ,	4.00
5.00		LABORATORY	50, 000		1, 080			5.00
6.00		CLINIC	788, 162		C) C	Ű	6.00
7.00		CLINIC - AMO	749, 033) C	Ű	7.00
8.00		CLINIC – NIGLIAZZO	999, 235	999, 235) C	0 0	8.00
9.00	91.00	EMERGENCY	1, 753, 179	1, 363, 646	389, 533	C C	0	9.00
10.00	0.00		0	0	C	C	0	10.00
200.00			7, 118, 929	6, 728, 316	390, 613	8	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		NURSING ADMINISTRATION	0	, o				1.00
2.00		ADULTS & PEDIATRICS	0	-				2.00
3.00		SUBPROVIDER – IPF	0	°				3.00
4.00		OPERATING ROOM	0	0	C) C	0 0	4.00
5.00		LABORATORY	0	0	C) C		5.00
6.00	90.00	CLINIC	0	0	C	0 0	0	6.00
7.00	90. 01	CLINIC - AMO	0	0	C	0 0	0	7.00
8.00	90. 03	CLINIC – NIGLIAZZO	0	0	C	0 0	0 0	8.00
9.00	91.00	EMERGENCY	0	0	C	0 0	0 0	9.00
10.00	0.00		0	0	C) C	0	10.00
200.00			0	0	C	c c	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance	-		
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	NURSING ADMINISTRATION	0	0	C	15, 944		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	C	842, 923		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	C	105, 020		3.00
4.00	50.00	OPERATING ROOM	0	0	C	1, 815, 433		4.00
5.00	60.00	LABORATORY	0	0	C	48, 920		5.00
6.00	90.00	CLINIC	0	0	C	788, 162	2	6.00
7.00	90.01	CLINIC - AMO	0	0	C	749,033		7.00
8.00		CLINIC - NIGLIAZZO	0	0	C			8.00
9.00		EMERGENCY	0	0			1 1	9.00
10.00	0.00		0	0			1 1	10.00
200.00	51.00		0	-	-	-		200.00
	I	1		. 0		1, 2, 20, 510	1 I	

Health Financial Systems	ADAMS MEMORIA	L HOSPI TAL			In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1330		ri od:	Worksheet B	
				Fro	om 01/01/2016 12/31/2016	Part I	arad
				10	12/31/2010	Date/Time Pre 5/26/2017 12:	
		CAPI TAL REL	ATED COSTS				
Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	NEW MVBLE EQUI P		EMPLOYEE BENEFI TS	Subtotal	
	Allocation	1171	LUUIF		DEPARTMENT		
	(from Wkst A				DELYNCIMENT		
	col. 7)						
	0	1.00	2.00		4.00	4A	
1.00 GENERAL SERVICE COST CENTERS	2, 353, 297	2, 353, 297					1.00
2.00 00200 NEW CAP REL COSTS-BLDG & FIXT	2, 353, 297	2, 303, 291		0			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	18, 988	0		0	18, 988		4.00
5.00 00500 ADMINI STRATI VE & GENERAL	9, 279, 338	236, 805		0	1, 504	9, 517, 647	5.00
7.00 00700 OPERATION OF PLANT	751, 372	360, 811		0	139	1, 112, 322	7.00
7. 01 00701 BI 0-MEDI CAL	8, 222	6, 129		0	3	14, 354	7.01
7. 02 00702 UTILITIES - HOSPITAL	673, 042	0		0	0	673, 042	7.02
7. 03 00703 UTILITIES - OFFSITE BLDGS 8. 00 00800 LAUNDRY & LINEN SERVICE	103, 278 198, 595	0 34, 858		0	0 33	103, 278 233, 486	7.03 8.00
9. 00 00900 HOUSEKEEPING	731, 012	47,458		0	332	778, 802	9.00
10. 00 01000 DI ETARY	258, 824	25, 080		0	94	283, 998	10.00
11. 00 01100 CAFETERIA	718, 438	115, 117		0	430	833, 985	11.00
13.00 01300 NURSING ADMINISTRATION	1, 069, 709	11, 834		0	639	1, 082, 182	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	0	14.00
	1, 215, 049	33, 184		0	547	1, 248, 780	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 126, 615	51, 188		0	300	1, 178, 103	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 618, 695	339, 503		0	1, 917	2, 960, 115	30.00
31. 00 03100 I NTENSI VE CARE UNI T	813, 185	63, 526		0	448	877, 159	31.00
40.00 04000 SUBPROVIDER - IPF	953, 098	144, 128		0	603	1, 097, 829	40.00
43. 00 04300 NURSERY	253, 318	33, 749		0	141	287, 208	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0		0	0	0	44.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	2, 141, 355	221, 060		0	1, 907	2, 364, 322	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 141, 355	221,080		0	1, 907	2, 304, 322 237, 573	
53. 00 05300 ANESTHESI OLOGY	213, 322	23, 731		0	0	237, 373	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 228, 657	178, 521		0	772	2, 407, 950	
60. 00 06000 LABORATORY	3, 306, 042	64, 756		0	791	3, 371, 589	60.00
65. 00 06500 RESPI RATORY THERAPY	839, 424	82, 436		0	491	922, 351	65.00
66. 00 06600 PHYSI CAL THERAPY	1,072,687	70, 058		0	598	1, 143, 343	
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	367, 372 235, 077	2, 016 1, 008		0	203 135	369, 591 236, 220	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	233, 077	1,000		0	0	230, 220	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 797, 446	0		0	0	1, 797, 446	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	963, 377	0		0	0	963, 377	73.00
76.00 03020 OP PSYCH	462, 599	0		0	250	462, 849	76.00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	694, 849	0		0	788	40E 427	90.00
90. 01 09000 CLINIC - AMO	562, 602	0		0	833	695, 637 563, 435	90.00 90.01
90. 02 09002 CLINIC - AMH NEURO	283, 031	0		0	182	283, 213	
90. 03 09003 CLINIC - NIGLIAZZO	344, 877	0		0	846	345, 723	90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	53, 159	17, 399		0	14	70, 572	90.04
91.00 09100 EMERGENCY	1, 521, 317	112, 092		0	1, 819	1, 635, 228	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						0	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	1, 680, 507	0		0	857	1, 681, 364	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	1,000,007	0		0	037	1, 001, 304	97.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	-	101.00
SPECIAL PURPOSE COST CENTERS							
116. 00 11600 HOSPI CE	0	0		0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	41, 911, 975	2, 276, 667		0	17, 716	41, 834, 073	118.00
NONREI MBURSABLE COST CENTERS		10 105		0	0	13, 185	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194. 00 07950 TITLE XX	0	13, 185 0		0 0	0		190.00 194.00
194. 01 07951 OTHER NRCC	1, 153, 431	63, 445		0	562	1, 217, 438	
194. 02 07952 OTHER MOBS	728, 230	0		0	292	728, 522	
194.03 07953 MONROE	838, 146	0		0	418	838, 564	194. 03
200.00 Cross Foot Adjustments		_			_		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	11 421 702	0 2, 353, 297		0 0	10 000	0 44, 631, 782	201.00
202.00 TUTAL (SUILTINES TIS-201)	44, 631, 782	2, 353, 297		U	18, 988	44, 031, 782	202.00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016		pared: 15 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	BI O-MEDI CAL	UTI LI TI ES - HOSPI TAL	UTILITIES - OFFSITE BLDGS	
	GENERAL SERVICE COST CENTERS	5.00	7.00	7.01	7.02	7.03	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	9, 517, 647					5.00
7.00 7.01	00700 OPERATION OF PLANT 00701 BI 0-MEDI CAL	301, 494 3, 891	1, 413, 816 3, 911		6		7.00 7.01
7.01	00702 UTILITIES - HOSPITAL	182, 427	0		0 855, 469		7.02
7.03	00703 UTILITIES - OFFSITE BLDGS	27, 993			0 0	131, 271	7.03
8.00	00800 LAUNDRY & LINEN SERVICE	63, 286	22, 242		0 17, 044	0	8.00
9.00	00900 HOUSEKEEPI NG	211, 094	35, 402			0	9.00
10.00	01000 DI ETARY	76, 977	16,003		8 12, 263	0	10.00
11.00 13.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	226, 051 293, 324	73, 454 7, 551		5 56, 288 0 5, 787	0	11.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	293, 324			0 5,787	0	13.00
15.00	01500 PHARMACY	338, 481	21, 174			0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	319, 324	32, 662		0 25, 029	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00	03000 ADULTS & PEDIATRICS	802, 336				0	30.00
31.00		237, 753				0	31.00
40.00 43.00	04000 SUBPROVI DER – I PF 04300 NURSERY	297, 565 77, 847	91, 965 21, 535			0	40.00 43.00
43.00	04400 SKILLED NURSING FACILITY	0			0 0	0	43.00
111.00	ANCI LLARY SERVICE COST CENTERS				<u> </u>		
50.00	05000 OPERATI NG ROOM	640, 847	141, 055	5, 01	9 108, 091	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	64, 394				0	52.00
53.00	05300 ANESTHESI OLOGY	0	-		0 0	0	53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	652, 672 913, 864	113, 912 50, 504			0	54.00 60.00
65.00	06500 RESPI RATORY THERAPY	250, 002				0	65.00
66.00	06600 PHYSI CAL THERAPY	309, 902				0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	100, 177			986	0	67.00
68.00	06800 SPEECH PATHOLOGY	64, 027	643		0 493	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	487, 196	0		0 0 0 0	0	71.00 72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	261, 122			0 0	0	72.00
76.00	03020 OP PSYCH	125, 455			0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	188, 552			8 0		90.00
90.01	09001 CLINIC - AMO	152, 718			0 0		
90. 02 90. 03	09002 CLINIC - AMH NEURO 09003 CLINIC - NIGLIAZZO	76, 765 93, 708		-		0	90. 02 90. 03
	04950 I NTENSI VE OP BEHAVI ORAL HEALTH	19, 128			0 8, 507	0	
	09100 EMERGENCY	443, 227					
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD	455, 732					95.00
	010100 HOME HEALTH AGENCY	0			0 0 0 0		97.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
116.00	11600 HOSPI CE	0	0		0 0	0	116.00
118.00		8, 759, 331	1, 257, 917	22, 11	4 818, 000	17, 829	118.00
	NONREI MBURSABLE COST CENTERS	0.574		1			
) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN) 07950 TITLE XX	3, 574	8, 413		0 6,447 0 0		190. 00 194. 00
	I 07951 OTHER NRCC	329, 985	89, 418		-	16, 137	
	207952 OTHER MOBS	197, 465			0 0		194. 02
194.03	3 07953 MONROE	227, 292			0 0		194. 03
200.00							200.00
201.00		0 517 (47	0	00.45			201.00
202.00) TOTAL (sum lines 118-201)	9, 517, 647	1, 413, 816	22, 15	6 855, 469	131, 271	JZUZ. UU

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 01/01/2016	Worksheet B Part I	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1.00 2.00 4.00 5.00
7.00 7.01 7.02	00700 OPERATION OF PLANT 00701 BI 0-MEDI CAL 00702 UTI LI TI ES - HOSPI TAL						7.00 7.01 7.02
7.03 8.00	00703 UTILITIES - OFFSITE BLDGS 00800 LAUNDRY & LINEN SERVICE	336, 058					7.03 8.00
9.00	00900 HOUSEKEEPI NG	50, 263	1, 098, 829				9.00
10.00	01000 DI ETARY	2, 500					10.00
11.00	01100 CAFETERI A	11, 474			1, 260, 975		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0			52, 121	1, 447, 101	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0		-	0	0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0		0	31, 180	0	15.00 16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	20, 341	0	35, 167	0	10.00
30, 00	03000 ADULTS & PEDIATRICS	42, 986	176, 031	267, 391	176, 197	506, 887	30.00
31.00	03100 I NTENSI VE CARE UNI T	11, 273			60, 242	173, 310	
40.00	04000 SUBPROVIDER - IPF	7, 385			75, 103		
43.00	04300 NURSERY	19, 807			14, 859		
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCI LLARY SERVICE COST CENTERS	r					
50.00	05000 OPERATING ROOM	48, 865			99, 069	285, 009	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 024	12, 418		10, 545	30, 338	52.00
53.00	05300 ANESTHESI OLOGY	0	0	-	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 083			92, 689	0	54.00
60.00		139			104, 771	0	60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	9, 470 20, 441	42, 743 36, 325		61, 563 43, 683	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	20, 441			58, 784	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	523		6, 361	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0,001	0 0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	2, 765	4, 181	0	24, 040	0	76.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS	0.05/	15.040		10.705		
90.00	09000 CLINIC	2, 256			43, 725	0	90.00
90. 01 90. 02	09001 CLINIC - AMO 09002 CLINIC - AMH NEURO	36	20, 436	0	27, 305 6, 127	0	90. 01 90. 02
	09003 CLINIC - NIGLIAZZO	734	24, 304	-	18, 452		90.02
	04950 I NTENSI VE OP BEHAVI ORAL HEALTH	327			1, 638	0	
	09100 EMERGENCY	46, 064			67,000		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	14, 472	45, 189	0	98, 123	0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0		97.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
444 04	SPECIAL PURPOSE COST CENTERS						111 (00
		0			0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	333, 364	972, 147	404, 753	1, 208, 744	1, 447, 101	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 836	0	0	0	190.00
194 00	07950 TITLE XX	0		0	0		194.00
	07951 OTHER NRCC	1, 148		0	52, 231		194.00
	07952 OTHER MOBS	627	29, 269		0		194. 02
	07953 MONROE	919			0		194.03
200.00							200. 00
201.00	S S	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	336, 058	1, 098, 829	404, 753	1, 260, 975	1, 447, 101	202.00

	Financial Systems	ADAMS MEMORIA				u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016		pared: 15 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	1					
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 BIO-MEDICAL 00702 UTILITIES - HOSPITAL 00703 UTILITIES - OFFSITE BLDGS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0	1, 673, 089 0	1, 616, 82	26		1.00 2.00 4.00 5.00 7.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 11.00 13.00 14.00 15.00 16.00
30.00	03000 ADULTS & PEDIATRICS	0	0	531, 97	5, 849, 796	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	34, 14	1, 526, 592	0	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	105, 44		0	40.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0	3, 07	79 501, 353 0 0	0	43.00
44.00	ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	44.00
90. 02 90. 03 90. 04 91. 00 92. 00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05200 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07200 DRUGS CHARGED TO PATI ENTS 03020 OP PSYCH 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C - AMO 09002 CLI NI C - AMH NEURO 09003 CLI NI C - NI GLI AZZO 04950 I NTENSI VE OP BEHAVI ORAL HEALTH 09100 EMERGENCY		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	150, 84 2, 18 21, 14 14, 60 34, 8 4, 55 6, 17 80 2, 90 74 688, 05	35 392, 653 0 0 04 3, 512, 106 0 4, 514, 493 07 1, 394, 740 0 1, 633, 026 0 531, 869 0 308, 267 0 0 0 2, 284, 642 0 0 0 2, 897, 588 15 659, 251 35 1, 036, 983 78 803, 230 08 366, 948 515, 861 121, 041	0 0 0 0 0	52.00 53.00 54.00 60.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.00 90.01 90.02 90.03 90.04 91.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0 0	0	97.00 101.00
116.00 118.00	11600 HOSPI CE	000	0 1, 673, 089	1, 601, 57	0 0 74 40, 572, 046		116. 00 118. 00
194.00 194.01 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 TITLE XX 07951 OTHER NRCC 207952 OTHER MOBS	0 0 0 0	0 0 0 0	12, 00 1, 23	1, 082, 680	0 0 0	190. 00 194. 00 194. 01 194. 02
	07953 MONROE	0	0	2, 02		0	194.03
200.00			0		0		200.00
201.00							

Heal th	Financial Systems	ADAMS MEMORI AL	- HOSPI TAL	In Lieu	ı of Form CMS-2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1330	Peri od:	Worksheet B
				From 01/01/2016 To 12/31/2016	Part I Date/Time Prepared: 5/26/2017 12:15 pm
	Cost Center Description	Total			<u>372072017 12. 13 piii</u>
		26.00			
1 00	GENERAL SERVICE COST CENTERS				1.00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP				1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00	00700 OPERATI ON OF PLANT				7.00
7.01	00701 BI 0-MEDI CAL				7.00
7.02	00702 UTILITIES - HOSPITAL				7.02
7.03	00703 UTILITIES - OFFSITE BLDGS				7.03
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				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
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·			
30.00	03000 ADULTS & PEDIATRICS	5, 849, 796			30.00
31.00	03100 INTENSIVE CARE UNIT	1, 526, 592			31.00
40.00	04000 SUBPROVIDER - IPF	2, 145, 882			40.00
43.00	04300 NURSERY	501, 353			43.00
44.00	04400 SKILLED NURSING FACILITY	0			44.00
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	3, 957, 737			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	392, 653			52.00
53.00	05300 ANESTHESI OLOGY	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 512, 106			54.00
60.00	06000 LABORATORY	4, 514, 493			60.00
65.00	06500 RESPI RATORY THERAPY	1, 394, 740			65.00
66.00	06600 PHYSI CAL THERAPY	1, 633, 026			66.00
67.00	06700 OCCUPATI ONAL THERAPY	531, 869			67.00
68.00	06800 SPEECH PATHOLOGY	308, 267			68.00
69.00	06900 ELECTROCARDI OLOGY	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 284, 642			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 897, 588			73.00
76.00	03020 OP PSYCH	659, 251			76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1,036,983			90.00
90.01	09001 CLINIC - AMO	803, 230			90.01
90.02	09002 CLINIC - AMH NEURO	366, 948			90.02
90.03	09003 CLINIC - NIGLIAZZO	515, 861			90.03
90.04		121,041			90.04
	09100 EMERGENCY	3, 256, 946			91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				92.00
05 00	OTHER REIMBURSABLE COST CENTERS	2 2/1 0/2			05.00
95.00		2, 361, 042			95.00
	09700 DURABLE MEDICAL EQUIP-SOLD 10100 HOME HEALTH AGENCY	0			97.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	0			101.00
116 0	DI1600 HOSPICE	0			116.00
118.00		40, 572, 046			118.00
110.00	NONREIMBURSABLE COST CENTERS	40, 372, 040			118.00
190 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	38, 455			190.00
	07950 TITLE XX	38,433			190.00
	107951 OTHER NRCC	1, 822, 083			194.00
	207952 OTHER MOBS	1, 082, 680			194.01
	307953 MONROE	1, 116, 518			194. 02
200.00		1, 110, 518			200.00
200.00		0			200.00
201.00		44, 631, 782			201.00
202.00	1 101AE (3011 11103 110-201)	, , , , , , , , , , , , , , , , , , ,			1202.00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CAPI TAL RELATED COSTS		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared:	
						5/26/2017 12:	15 pm
			CAPITAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FI XT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	236, 805		0 236, 805	0	5.00
7.00	00700 OPERATION OF PLANT	0	360, 811		0 360, 811	0	7.00
7.01	00701 BI 0-MEDI CAL	0	6, 129		0 6, 129	0	7.01
7.02	00702 UTILITIES - HOSPITAL	0	0		0 0	0	7.02
7.03 8.00	00703 UTILITIES - OFFSITE BLDGS 00800 LAUNDRY & LINEN SERVICE	0	0 34, 858		0 0 0 34,858	0	7.03 8.00
8.00 9.00	00900 HOUSEKEEPING	0	47, 458		0 47,458	0	9.00
10.00	01000 DI ETARY	0	25, 080		0 25,080	0	10.00
11.00	01100 CAFETERI A	0	115, 117		0 115, 117	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	11, 834		0 11, 834	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	33, 184 51, 188		0 33, 184 0 51, 188	0	15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	51, 100		0 51,188	0	10.00
30.00	03000 ADULTS & PEDIATRICS	0	339, 503		0 339, 503	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	63, 526		0 63, 526	0	31.00
40.00	04000 SUBPROVIDER - IPF	0	144, 128		0 144, 128	0	40.00
43.00	04300 NURSERY	0	33, 749		0 33, 749	0	43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	<u> </u>	0		0 0	0	44.00
50.00	05000 OPERATI NG ROOM	0	221, 060		0 221,060	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	23, 951		0 23, 951	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	178, 521		0 178, 521	0	54.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	64, 756 82, 436		0 64, 756 0 82, 436	0	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	70, 058		0 70, 058	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 016		0 2,016	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 008		0 1,008	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03020 OP PSYCH	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS	1 1					
	09000 CLINIC	0	0		0 0		
90. 01 90. 02	09001 CLINIC - AMO 09002 CLINIC - AMH NEURO	0	0		0 0	0	90.01 90.02
	09003 CLINIC - NIGLIAZZO	0	0		0 0	0	90.02
	04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	17, 399		0 17, 399		90.04
	09100 EMERGENCY	0	112, 092		0 112, 092	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
	10100 HOME HEALTH AGENCY	0	0		0 0		101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0			0 0		116.00
118.00		0	2, 276, 667		0 2, 276, 667	0	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13 185		0 13, 185	0	190.00
	07950 TITLE XX	0	13, 185 0		0 13, 185 0 0		190.00
	07951 OTHER NRCC	0	63, 445		0 63, 445		194.00
194.02	07952 OTHER MOBS	0	0		0 0	0	194. 02
	07953 MONROE	0	0		0 0	0	194. 03
200.00					0	_	200.00
201.00 202.00		0	0 2, 353, 297		0 2, 353, 297		201.00 202.00
202.00		ı V	2, 333, 297		2, 303, 297	0	1202.00

ALLOCATION OF COPI TAL RELATED COSTS Provider CCL: 15:13:20 Pref dit To 10:000 PR CopI FAL RELATED COSTS Provider CCL: 15:13:20 Pref dit To 10:000 PR CopI FAL RELATED COSTS Provider CCL: 15:13:20 Pref dit To 10:000 PR CopI FAL RELATED COSTS Provider COL: 15:13:20 Provider COL: 15:13:20<	Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description AUMINISTRATIVE OPERATION OF A COMPARIANCE BIO-NEDICAL INFORMATION 7 00 UTILITES - PORTITE SLOS 7 00 UTILITES - PORTITE SLOS 7 00 100 OPENING AND CAR FEL COSTS - MORE EQUIP 4 000 00000 ADDERVITION IF INFITISE - BLOS F FILT 7 00 1.00 1.00 2.00 D0000 ADDERVITION OF E & DEPARIA IN ID 200 00000 ADDERVITION IF INFITISE - BLOS F FILT 7.00 1.00 1.00 7.01 7.02 7.03 7.03 7.03 7.00 0.0000 ADDERVITION IF INFITISE - BLOS F FILT 7.00 1.00 1.00 1.00 7.01 7.01 7.02 7.03 7.03 7.00 7.00 7.01 7.01 7.01 7.02 7.02 7.02 7.00 <td< td=""><td>ALLOCA</td><td>TION OF CAPITAL RELATED COSTS</td><td></td><td>Provider CO</td><td>F</td><td>rom 01/01/2016</td><td>Part II Date/Time Pre</td><td>pared: 15 pm</td></td<>	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	F	rom 01/01/2016	Part II Date/Time Pre	pared: 15 pm
DEREMAL SERVICE COST CONTENT 1.00 1.00 DODOON WA CAP REL COSTS-INDER E LOUIP 2.00 2.00 DODOON DEWICAP, MER CAPTER, BURNAT 236, 805 7.00 DOTOON OPERATION OF FLAAM 7.501 7.00 DOTOON OPERATION OF FLAAM 7.501 7.00 DOTOON OPERATION OF FLAAM 7.501 7.00 DOTOON UNTITIES - OFFSTE BLDGS 0.977 7.00 DOTOON UNTITIES - OFFSTE BLDGS 0.977 8.00 DDODON LAMARY A LI NEN SLEVICE 1.575 8.00 DDODON DESERF 5.525 4.229 2.246 8.00 DDODON LAMARY A LI NEN SLEVICE 1.575 0.793 0.1300 1.00 DITOON DESERF 5.525 4.9135 1.266 0.1300 1.00 DITOON DESERF 5.525 5.516 0.00		Cost Center Description	& GENERAL	PLANT		HOSPI TAL	UTILITIES - OFFSITE BLDGS	
2.00 002000 INFN CAP REL COSTS-IVVELE EQUIP 4.00 5.00 002000 AMINI IN SIRAI IV & 4 GEREARAL 236, 805 5.00 002000 AMINI IN SIRAI IV & 4 GEREARAL 236, 805 7.02 002000 AMINI IN SIRAI IV & 4 GEREARAL 4, 539 0 7.02 002000 LUTL IT ES - FORST TAL 4, 539 0 6, 530 7.02 002000 LUNNERY & LINEN SERVICE 1, 755 5, 794 0		GENERAL SERVICE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
11.00 01100 CARETERIA 5.624 19,135 11 299 0 11.00 13.00 01300 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 14.00 0 0 0 0 0 14.00 0	2.00 4.00 5.00 7.00 7.01 7.02 7.03 8.00 9.00	00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 BI O-MEDI CAL 00702 UTILITIES - HOSPITAL 00703 UTILITIES - OFFSITE BLDGS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	7, 501 97 4, 539 697 1, 575 5, 252	368, 312 1, 019 0 5, 794 9, 223	7, 245 0 0 0 21	4, 539 0 90 123	0	2.00 4.00 5.00 7.00 7.01 7.02 7.03 8.00 9.00
13. 00 01300 UNUESING CAMINI STRATION 7,298 1,967 0 31 0 13. 00 15. 00 01500 PHARMACY 8,422 5,516 14 66 0 15. 00 01500 14. 00 14. 00 15. 00 01500 PHARMACY 8,422 5,516 14 66 0 15. 00 00 00 00 00 00 00 01 15. 00 15. 00 0 15. 00 00							-	
30:00 03000 ADULTS & PEDIATRICS 19,963 56,435 1,060 879 0 00 03.00 00 0100 010700 INTENSIVE CARE UNIT 5,916 0,560 37 166 0 31.00 01:00 00000 NURSERY 1,937 5,610 89 98 0 43.00 04:00 044000 NURSERY 1,937 5,610 89 98 0 44.00 04:00 0000 NURSERY 1,937 5,610 89 88 0 44.00 04:00 05000 OPELVERY ROM & LABOR ROOM 1,602 3,981 59 62 0 52.00 05:00 05000 APESTIRX ING ROOM 1,602 3,981 59 62 0 52.00 00 0 0 0 0 0 0 53.00 66.00 6600 6600 CEST RATORY THERAPY 22.734 13,173 302 168 66.00 6600 6600 CEST RATORY THERAPY 2,741 13,703 358 214 65.00 66.00 6600 6600 CEST RATORY THERAPY 2,433 35 0	13.00 14.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	7, 298 0 8, 422	1, 967 0 5, 516	0 0 14	31 0 86	0 0 0	13.00 14.00 15.00
31.0.00 04000 INTENIVE CARE UNIT 5.916 10.500 37 165 0 31.00 43.00 04000 NURSING FACLITY 1,937 5,610 89 88 0 40.00 40.00 044000 PENTINES NG FACLITY 0 0 0 0 40.00 0.00 05000 PENTINE ROM 15,945 36,746 1,643 57.41 52.00 0.00 05000 DELIVERY ROM & LABOR ROM 1,602 3,975 3,186 463 54.00 0.00 05300 DES300 DELIVERY ROM & LABOR ROM 1,6239 29,675 3,186 463 54.00 0.00 06000 LABORATORY 22,734 13,1703 3358 214 65.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00			1		1			
40:00 Vertice 7,404 23,988 9 374 0 40.00 44:00 04400 SKILLED NURSING FACILITY 0								1
43.00 04300 NURSERY 1,937 5,610 89 88 0 43.00 44.00 04400 04400 0								1
44.00 04400_SKILLED_NURSING FACILITY 0 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000_OPEARTING ROOM 15,945 36,746 1,643 574 0 52.00 50.00 05300_DELIVERY ROOM & LABOR ROOM 1,602 3,981 59 62 0 53.00 54.00 05400_RADILOGY-DI AGNOSTIC 16,239 29,675 3,186 463 0 54.00 06500_RESPI RATORY THERAPY 22,734 13,157 302 168 0 60.00 06600_DEPHYSICAL THERAPY 7,711 11,645 122 182 0 66.00 06700_DCUPATIONAL THERAPY 7,711 11,645 122 182 0 67.00 06700_DCUPATIONAL THERAPY 7,711 1,445 0 0 0 0 0 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.0								1
50. 00 05000 (OPERATING ROOM 15,945 36,746 1,643 574 0 50. 00 52. 00 05200 (DELIVERY ROOM & LABOR ROOM 1,602 3,981 59 62 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 53. 00 54. 00 05400 (PROI OLCO-PLARONSTI C 16,239 29,675 3,186 46.3 0 54. 00 65. 00 06500 (RESPIRATORY THERAPY 6,220 13,703 358 214 0 65. 00 66. 00 06000 OPHYSI CAL THERAPY 7,711 11,645 122 182 0 66. 00 0. 06700 OCUPATI ONAL THERAPY 2,493 335 0 5 0 67. 00 69. 00 06000 CLECTROCARDI OLOCY 1,593 168 0 3 0 68. 00 72. 00 072.00 IMPL ES CHARGED TO PATI ENTS 6,497 0 0 0 72. 00 73. 00 07300 INUS CHARGED TO PATI ENTS 6,497 0 0 0 0 <td>44.00</td> <td>04400 SKILLED NURSING FACILITY</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>44.00</td>	44.00	04400 SKILLED NURSING FACILITY	0			0	0	44.00
52:00 052:00 DELUVERY ROOM & LABOR ROOM 1, 602 3,981 59 62 0 52.00 53:00 05300 NESTHESI OLOGY 0 0 0 0 53.00 54:00 05400 NASIDIESI OLOGY 16,239 29,675 3,186 463 0 60.00 60:00 RESH RATORY THERAPY 22,734 13,703 358 214 0 65.00 66:00 OCCOUPTIONAL THERAPY 2,493 335 0 5 0 67.00 67:00 OCOO CUCUPATIONAL THERAPY 2,493 335 0 5 0 67.00 68:00 DELECTROCANDAL THERAPY 2,493 335 0 5 0 67.00 71:00 OCLICAL SUPPLIES CHARGED TO PATIENTS 12,122 0 0 0 0 72.00 73:00 OT300 DRUGS CHARGED TO PATIENTS 6,497 0 0 0 72.00 73:00 OT300 DRUGS CHARGED TO PATIENTS 6,497 </td <td></td> <td></td> <td>1</td> <td></td> <td>r</td> <td>[</td> <td></td> <td></td>			1		r	[
53.00 Description 0 0 0 53.00 0 53.00 Description 53.00 0 53.00 0 53.00 0 53.00 0 54.00 56.00 54.00 56.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 71.00								
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60.00 06000 LABORATORY 22,734 13,157 302 168 0 60.00 66.00 66.00 65.00 66.00 RESPI RATORY THERAPY 6,220 13,703 358 214 0 66.00 66.00 06700 0COUPATI ONAL THERAPY 2,493 335 0 5 0 67.00 68.00 06800 SPECE TATAULOGY 1,593 168 0 3 0 68.00 69.00 MOD MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0			-			-	-	1
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67.00 0c700 0c2UPATI ONAL THERAPY 2.493 335 0 5 0 67.00 68.00 06800 SPECH PATHOLOGY 1.593 168 0 3 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0							0	1
68.00 06800 SPECH PATHOLOGY 1,593 168 0 3 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0								1
69:00 Cost of Cost Cost Cost Cost Cost Cost Cost Cost								1
71.00 INTO MEDI CAL SUPPLIES CHARGED TO PATIENTS 12,122 0 0 0 0 71.00 72.00 07300 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6.497 0 0 0 0 73.00 00 09000 CLINIC 3.121 1.340 0 0 90.00 90.00 09000 CLINIC 46.691 14.698 3 0 0 90.00 90.01 09000 CLINIC AMO 3.800 6.552 0 0 42 90.01 90.02 09003 CLINIC - NIN GLIAZZO 2.332 7.792 23 0 90.03 90.03 90.04 90.04 90.04 91.00 91.00 91.00 91.00 91.00 92.00 92.00 95.00 95.00 95.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00<						3		1
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73.00 07300 DRUGS CHARGED TO PATIENTS 6,497 0 0 0 0 73.00 00000 CLINIC 0				0	-	0		•
76.00 03220 [OP PSYCH 3, 121 1, 340 0 0 76.00 OUTPATIENT SERVICE COST CENTERS								
90.00 09000 CLINIC 4,691 14,698 3 0 0 90.00 90.01 09001 CLINIC - AMO 3,800 6,552 0 0 42 90.01 90.02 09003 CLINIC - AMH NEURO 1,910 0 11 0 0 90.02 90.04 04950 INTENSIVE OP BEHAVI ORAL HEALTH 476 2,832 7,792 23 0 0 90.04 90.00 DEMERGENCY 11,028 18,633 54 291 0 91.00 92.00 DBSCNATION BEDS (NON-DI STINCT PART) 11,028 18,633 54 291 0 92.00 97.00 DPSOR AMBULANCE SERVITOS 11,339 14,487 227 0 52 95.00 97.00 DVRABLE MEDI CAL EQUI P-SOLD 0				1, 340				
90.01 09001 CLINIC - AMO 3,800 6,552 0 0 42 90.01 90.02 09002 CLINIC - AMH NEURO 1,910 0 11 0 0 90.02 90.03 09003 CLINIC - NIGLIAZZO 2,332 7,792 23 0 0 90.03 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 476 2,892 0 45 0 90.04 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 11,028 18,633 54 291 0 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 11,028 18,633 54 291 0 91.00 92.00 09500 AMBULANCE SERVICES 11,339 14,487 227 0 52 95.00 9500 MBULANCE SERVICES 11,339 14,487 227 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
90.02 09002 CLINIC - AMH NEURO 1,910 0 11 0 0 90.02 90.03 09003 CLINIC - NIGLIAZZO 2,332 7,792 23 0 0 90.03 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 476 2,892 0 45 0 90.04 91.00 09000 EKERGENCY 11,028 18,633 54 291 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) - - 92.00 097.00 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 95.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 0 97.00 116.00 11600 HOSPI CE 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS - - 0 0 0 0 116.00 140.00 194.00 194.0								
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91.00 09100 EMERGENCY 11,028 18,633 54 291 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 11,028 18,633 54 291 0 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 11,339 14,487 227 0 0 97.00 00 0								
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 11, 339 14, 487 227 0 52 95.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 97.00 101.00 HOME HEALTH AGENCY 0<						291	0	
95.00 09500 AMBULANCE SERVICES 11, 339 14, 487 227 0 52 95.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 101.00 HOME HEALTH AGENCY 0 <td>92.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>	92.00							92.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97. 00 101. 00 HOME HEALTH AGENCY 0 <td>05 00</td> <td></td> <td>11.000</td> <td>44.407</td> <td>007</td> <td></td> <td>50</td> <td>05.00</td>	05 00		11.000	44.407	007		50	05.00
101.00 10100 HOME HEALTH AGENCY 0<								
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPICE 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 217,938 327,699 7,231 4,340 94 118.00 NONREI MBURSABLE COST CENTERS 190.00 1900.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 89 2,192 0 34 0 190.00 194.00 07950 TI TLE XX 0 0 0 0 194.00 194.01 07951 OTHER NRCC 8,210 23,294 14 165 86 194.01 194.02 07952 OTHER MOBS 4,913 9,383 0 0 476 194.02 194.03 07953 MONROE 5,655 5,744 0 0 41 194.03 194.03 Cross Foot Adjustments 0 0 0 0 200.00 0 0 0 200.00								
116.00 11600 HOSPI CE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 217,938 327,699 7,231 4,340 94 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 89 2,192 0 34 0 190.00 194.00 07950 TI TLE XX 0 0 0 0 194.00 194.01 07951 OTHER NRCC 8,210 23,294 14 165 86 194.01 194.02 07952 OTHER MOBS 4,913 9,383 0 0 476 194.02 194.03 07953 MONRE 5,655 5,744 0 0 41 194.03 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0201.00	101.00			0			0	101.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 89 2, 192 0 34 0 190. 00 194. 00 07950 TI TLE XX 0 0 0 0 194. 00 194. 01 07951 OTHER NRCC 8, 210 23, 294 14 165 86 194. 01 194. 02 07952 OTHER MOBS 4, 913 9, 383 0 0 476 194. 02 194. 03 07953 MONROE 5, 655 5, 744 0 0 41 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 200. 00 0 0 0 200. 00	116.00		0	0	0	0	0	116.00
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 89 2, 192 0 34 0 190.00 194.00 07950 TITLE XX 0 0 0 0 194.00 194.01 07951 OTHER NRCC 8, 210 23, 294 14 165 86 194.01 194.02 07952 OTHER MOBS 4, 913 9, 383 0 0 476 194.02 194.03 07953 MONROE 5, 655 5, 744 0 0 41 194.03 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201.00		SUBTOTALS (SUM OF LINES 1-117)	217, 938	327, 699	7, 231	4, 340	94	118.00
194. 00 07950 TITLE XX 0 0 0 0 194. 00 194. 01 07951 0THER NRCC 8, 210 23, 294 14 165 86 194. 01 194. 02 07952 0THER NRCC 8, 210 23, 294 14 165 86 194. 01 194. 02 07952 0THER MOBS 4, 913 9, 383 0 0 476 194. 02 194. 03 07953 MONROE 5, 655 5, 744 0 0 41 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0201. 00 201. 00 Negative Cost Centers 0 0 0 0 0201. 00	100.00			0.400			0	100.00
194. 01 07951 0THER NRCC 8, 210 23, 294 14 165 86 194. 01 194. 02 07952 0THER MOBS 4, 913 9, 383 0 0 476 194. 02 194. 03 07953 MONROE 5, 655 5, 744 0 0 41 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00								
194. 02 07952 0THER MOBS 4,913 9,383 0 0 476 194. 02 194. 03 07953 MONROE 5,655 5,744 0 0 41 194. 03 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00						-		
194. 03 07953 MONROE 5, 655 5, 744 0 0 41 194. 03 200. 00 Cross Foot Adjustments 200. 00 200. 00 200. 00 200. 00 200. 00 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00								
201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00	194.03	07953 MONROE				0	41	194.03
201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00 202. 00 TOTAL (sum lines 118-201) 236, 805 368, 312 7, 245 4, 539 697 202. 00								
202.00 101AL (sum lines 118-201) 236,805 368,312 7,245 4,539 697 202.00			-	0	0	0	0	201.00
	202.00	μ μιθιΑL (sum lines 118-201)	236, 805	368, 312	7, 245	4, 539	697	202.00

<u>Heal th</u>	Financial Systems	ADAMS MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO		eriod: com 01/01/2016 o 12/31/2016		pared: 15 pm
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00 4.00 5.00 7.00 7.01 7.02 7.03	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 BIO-MEDICAL 00702 UTILITIES - HOSPITAL 00703 UTILITIES - OFFSITE BLDGS						1.00 2.00 4.00 5.00 7.00 7.01 7.02 7.03
8.00 9.00 10.00 11.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	42, 317 6, 331 315 1, 445	68, 408 810 3, 716	32, 356 0	145, 347		8.00 9.00 10.00 11.00
13. 00 14. 00 15. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0	0 1, 071	0 0	6, 008 0 3, 594 4, 054	27, 520 0 0	13. 00 14. 00 15. 00 16. 00
30.00	03000 ADULTS & PEDIATRICS	5, 413	10, 960	21, 376	20, 309	9, 639	30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	1, 419 930			6, 944 8, 657	3, 296 4, 109	31.00 40.00
43.00	04300 NURSERY	2, 494	1, 089	0	1, 713	813	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	44.00
50.00	05000 OPERATI NG ROOM	6, 153			11, 419	5, 420	50.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 010 0			1, 216 0	577 0	52.00 53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	4, 292 18	5, 763 2, 555		10, 684 12, 076	0	54.00 60.00
65. 00	06500 RESPI RATORY THERAPY	1, 192		0	7, 096	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 574	2, 261 65	0	5, 035 6, 776	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	33	-	733	0	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00 71.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		-	0	0	73.00
76.00	03020 OP PSYCH OUTPATI ENT SERVICE COST CENTERS	348	260	0	2, 771	0	76.00
90.00	09000 CLINIC 09001 CLINIC - AMO	284	2,854		5, 040		90.00
90. 01 90. 02	09002 CLINIC - AMH NEURO	4	1, 272 0		3, 147 706	0	90. 01 90. 02
	09003 CLINIC - NIGLIAZZO	92	1, 513		2, 127	0	90.03
	04950 I NTENSI VE OP BEHAVI ORAL HEALTH 09100 EMERGENCY	41 5, 800	562 3, 618		189 7, 723	0 3, 666	90. 04 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				.,		92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1,822	2, 813	0	11, 310	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
116.00 118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 41, 977		0 32, 356	0 139, 327		116. 00 118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		190.00
	07950 TITLE XX 07951 OTHER NRCC	0		Ŭ	0 6, 020		194. 00 194. 01
194.02	07952 OTHER MOBS	79	1, 822	0	0	0	194. 02
194.03 200.00	07953 MONROE Cross Foot Adjustments	116	1, 115	0	0		194. 03 200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	42, 317	68, 408	32, 356	145, 347	27, 520	202.00

Heal th	Financial Systems	ADAMS MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-1330 Pe Fr Tc	eriod: com 01/01/2016	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	5/26/2017 12: Intern & Residents Cost & Post Stepdown Adjustments	<u>15 pm</u>
		14.00	15.00	16.00	24.00	25.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT O0200 NEW CAP REL COSTS-MVBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT O0500 ADMINISTRATIVE & GENERAL O0700 OPERATION OF PLANT O0701 BIO-MEDICAL 00702 UTILITIES - HOSPITAL O0703 UTILITIES - OFFSITE BLDGS O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	00000	51, 887 0	73, 481			$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 7. \ 00\\ 7. \ 01\\ 7. \ 02\\ 7. \ 03\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	24 177	500 714	0	20.00
30.00 31.00 40.00 43.00 44.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY	0 0 0 0	0 0 0 0 0	24, 177 1, 552 4, 792 140 0	509, 714 97, 709 207, 750 47, 722 0	0 0 0 0	30.00 31.00 40.00 43.00 44.00
50.00	ANCI LLARY SERVICE COST CENTERS	o	0	6, 855	312, 951	0	50.00
52.00 53.00 54.00 60.00 65.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY	0 0 0 0	0 0 0 0	99 0 963 0	33, 330 0 249, 786 115, 766	0 0 0 0 0	52.00 53.00 54.00 60.00 65.00
66. 00 67. 00 68. 00 69. 00	06500 PHYSI CAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	000000000000000000000000000000000000000	0 0 0 0	664 0 0 0 0	114, 544 99, 588 11, 690 3, 538 0	0 0 0 0	66. 00 67. 00 68. 00 69. 00
71.00 72.00 73.00 76.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03020 OP PSYCH OUTPATIENT SERVICE COST CENTERS	0 0 0 0	0 0 51, 887 0	0 0 0 1, 582	12, 122 0 58, 384 9, 422	0 0 0 0	71.00 72.00 73.00 76.00
90. 02 90. 03	09000 CLINIC 09001 CLINIC - AMO 09002 CLINIC - AMH NEURO 09003 CLINIC - NIGLIAZZO 04950 INTENSIVE OP BEHAVIORAL HEALTH 09100 EMERGENCY	0 0 0 0 0 0	0 0 0 0 0	206 281 37 135 34 31, 271	27, 776 15, 098 2, 664 14, 014 21, 638 194, 176	0 0 0 0 0 0 0	90. 01 90. 02 90. 03 90. 04 91. 00
97.00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 0	0 0 0	0 0 0	42, 050 0 0	0 0 0	
116.00 118.00	11600 HOSPI CE	0	0 51, 887	0 72, 788	0 2, 201, 432		116. 00 118. 00
194.00 194.01 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 TITLE XX 07951 OTHER NRCC 207952 OTHER MOBS 07953 MONROE Cross Foot Adjustments Negative Cost Centers		0 0 0 0 51, 887	0 545 56 92 0 73, 481	15, 926 0 106, 447 16, 729 12, 763 0 2, 353, 297	0 0 0 0 0	190.00 194.00 194.01 194.02 194.03 200.00 201.00 202.00

Heal th	Financial Systems	ADAMS MEMORIA	L HOSPI TAL	In Lieu	of Form CMS-2552-10
	TION OF CAPITAL RELATED COSTS		Provi der CCN: 15-1330	Period: W	Vorksheet B
				To 12/31/2016 D	Part II Date/Time Prepared:
	Cost Center Description	Total			5/26/2017 12:15 pm
		26.00			
	GENERAL SERVICE COST CENTERS	1 1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				4.00 5.00
7.00	00700 OPERATI ON OF PLANT				7.00
7.00	00701 BI 0-MEDI CAL				7.01
7.02	00702 UTI LI TI ES - HOSPI TAL				7. 02
7.03	00703 UTILITIES - OFFSITE BLDGS				7.03
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	I I			10.00
30.00	03000 ADULTS & PEDIATRICS	509, 714			30.00
31.00	03100 I NTENSI VE CARE UNI T	97, 709			31.00
40.00	04000 SUBPROVI DER – I PF	207, 750			40.00
43.00	04300 NURSERY	47, 722			43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0			44.00
F0 00	ANCI LLARY SERVICE COST CENTERS	212 051			F0.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	312, 951 33, 330			50.00 52.00
52.00	05300 ANESTHESI OLOGY	33, 330			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	249, 786			54.00
60.00	06000 LABORATORY	115, 766			60.00
65.00	06500 RESPI RATORY THERAPY	114, 544			65.00
66.00	06600 PHYSI CAL THERAPY	99, 588			66.00
67.00	06700 OCCUPATI ONAL THERAPY	11, 690			67.00
68.00	06800 SPEECH PATHOLOGY	3, 538			68.00
69.00		0			69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	12, 122			71.00 72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	58, 384			72.00
76.00	03020 OP PSYCH	9, 422			76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	27, 776			90.00
90.01	09001 CLINIC - AMO	15, 098			90. 01
90.02	09002 CLINIC - AMH NEURO	2,664			90.02
90.03	09003 CLINIC - NIGLIAZZO	14,014			90.03
90.04	04950 I NTENSI VE OP BEHAVI ORAL HEALTH 09100 EMERGENCY	21, 638 194, 176			90. 04 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	174, 170			92.00
72.00	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVI CES	42,050			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0			97.00
101.00	10100 HOME HEALTH AGENCY	0			101.00
44.5	SPECIAL PURPOSE COST CENTERS	-			
		0			116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	2, 201, 432			118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 926			190, 00
	07950 TITLE XX	0			194.00
	07951 OTHER NRCC	106, 447			194. 01
	07952 OTHER MOBS	16, 729			194. 02
	07953 MONROE	12, 763			194. 03
200.00		0			200.00
201.00		0			201.00
202.00	TOTAL (sum lines 118-201)	2, 353, 297			202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	ADAMS MEMORI	AL HOSPITAL Provider CO		Period:	eu of Form CMS-: Worksheet B-1	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	pared:
		CAPITAL RE	LATED COSTS			5/26/2017 12:	15 pm
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FLXT		BENEFITS		& GENERAL	
		(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT (GROSS		(ACCUM. COST)	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	116, 728	0				1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	25, 035, 880			4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	11, 746		1, 983, 960 183, 004			•
7.01	00701 BI 0-MEDI CAL	304		3, 518			
7.02	00702 UTI LI TI ES - HOSPI TAL	0	0	0	-		•
7.03 8.00	00703 UTILITIES - OFFSITE BLDGS 00800 LAUNDRY & LINEN SERVICE	1, 729		43, 966			
9.00	00900 HOUSEKEEPI NG	2, 354	0	437, 869	0	778, 802	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 244 5, 710		123, 634 567, 452			•
13.00	01300 NURSI NG ADMI NI STRATI ON	587		843, 588			•
14.00	01400 CENTRAL SERVICES & SUPPLY	0	-	0	-		
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 646 2, 539		721, 117 395, 414			•
101 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		,		
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	16,840		2, 518, 833 590, 494			•
40.00	04000 SUBPROVIDER - IPF	3, 151		795, 561			•
43.00	04300 NURSERY	1, 674	0	185, 464	0	287, 208	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	C	0 0	0	44.00
50.00	05000 OPERATING ROOM	10, 965		2, 516, 270	0	2, 364, 322	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 188		131, 620			•
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	8,855		C 1, 018, 844	-	0 2, 407, 950	
60.00	06000 LABORATORY	3, 212	0	1, 042, 939		3, 371, 589	60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 089 3, 475		647, 774 789, 050			•
67.00	06700 OCCUPATIONAL THERAPY	100		267, 444		.,,	•
68.00	06800 SPEECH PATHOLOGY	50		178, 590			•
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0					
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C C	0		I
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03020 OP PSYCH	0	-	0 329, 248			•
78.00	OUTPATIENT SERVICE COST CENTERS		ή <u></u>	329, 240		402, 649	76.00
	09000 CLI NI C	0	0	1, 039, 404			
90. 01 90. 02	09001 CLINIC - AMO 09002 CLINIC - AMH NEURO	0	0	1, 098, 398 240, 764			
90.02	09003 CLINIC - NIGLIAZZO	0	0	1, 116, 147			
90. 04 91. 00	04950 I NTENSI VE OP BEHAVI ORAL HEALTH	863		18, 192			•
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 560	0	2, 399, 109	0	1, 635, 228	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	1	1				
95.00 97.00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD			1, 129, 980 C			
	10100 HOME HEALTH AGENCY	0		C			101.00
11/ 00	SPECIAL PURPOSE COST CENTERS						11/ 00
118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117)	0 112, 927			-		116.00 118.00
	NONREIMBURSABLE COST CENTERS					1	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0				190.00 194.00
	07951 OTHER NRCC	3, 147	-	741, 842	-		
194.02	07952 OTHER MOBS	0	0	385, 197	0	728, 522	194. 02
194.03 200.00	07953 MONROE Cross Foot Adjustments	0	0	551, 194	0	838, 564	194.03 200.00
201.00	Negative Cost Centers						201.00
202.00		2, 353, 297	0	18, 988	3	9, 517, 647	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	20. 160518	0. 000000	0. 000758	3	0. 271049	203. 00
204.00	Cost to be allocated (per Wkst. B,			C		236, 805	•
205.00	Part II) Unit cost multiplier (Wkst. B, Part			0. 000000		0. 006744	205, 00

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Heal th Financial Systems	ADAMS MEMORIA		N 45 4000 D		u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO	F	eriod: rom 01/01/2016	Worksheet B-1	
				0 12/31/2016	Date/Time Pre 5/26/2017 12:	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	BIO-MEDICAL (COST)	UTILITIES - HOSPITAL (SQUARE FEET)	UTILITIES - OFFSITE BLDGS (COST)	LAUNDRY &	
	7.00	7.01	7.02	7.03	8.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 7. 01 00701 BI 0-MEDI CAL 7. 02 00702 UTI LI TI ES - HOSPI TAL	109, 904 304 0	15, 528, 021 0	86, 781			2.00 4.00 5.00 7.00 7.01 7.02
7. 03 00703 UTILITIES - OFFSITE BLDGS 8. 00 00800 LAUNDRY & LINEN SERVICE	0 1, 729	0 0	0 1, 729		207, 314	7.03 8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	2, 752 1, 244 5, 710 587	43, 924 5, 290 24, 281 0	1, 244 5, 710	0	31, 006 1, 542 7, 078 0	9.00 10.00 11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL_RECORDS & LI BRARY	1, 646 2, 539	29, 461 0	1, 646 2, 539		0	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	2, 337				0	10.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	16, 840 3, 151	2, 269, 592 79, 410			26, 518 6, 954	30. 00 31. 00
40. 00 04000 SUBPROVIDER - IPF	7, 149	18, 226			4, 556	40.00
43. 00 04300 NURSERY	1, 674	190, 204			12, 219	
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	44.00
50. 00 05000 OPERATI NG ROOM	10, 965	3, 517, 140			30, 145	50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI 0LOGY	1, 188 0	127, 243 0	1, 188 0		4, 950 0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 855	6, 837, 239		-	21, 026	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	3, 926 4, 089	647, 436 766, 651	3, 212 4, 089		86 5, 842	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	3, 475	261, 153			12, 610	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	100	0			0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	50 0	0	50 0		0	68.00 69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	-	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			0	72.00 73.00
76.00 03020 OP PSYCH	400	0	0		1, 706	
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC	4, 386	5, 551	0	0	1, 392	90.00
90. 01 09001 CLINIC - AMO	1, 955	0	0	6, 605	22	
90. 02 09002 CLINIC - AMH NEURO 90. 03 09003 CLINIC - NIGLIAZZO	0 2, 325	24, 275 49, 167		-	0 453	
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	863	49, 107	863		202	90.03
91.00 09100 EMERGENCY	5, 560	116, 271	5, 560	0	28, 417	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	4, 323	486, 411	0		8, 928	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 101. 00 10100 HOME HEALTH AGENCY	0	0			0	97.00 101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1-117)	0 97, 785	0 15, 498, 925			0 205, 652	116.00 118.00
NONREI MBURSABLE COST CENTERS	1		1	· · · · · · · · · · · · · · · · · · ·		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194. 00 07950 TITLE XX	654 0	0	654	0		190. 00 194. 00
194.0107951 OTHER NRCC	6, 951	29, 096	3, 147	-		194.00
194. 02 07952 OTHER MOBS 194. 03 07953 MONROE	2, 800 1, 714	0	0	74, 180 6, 426		194. 02 194. 03
200.00 Cross Foot Adjustments	1,714	0		0, 420	507	200.00
201.00 Negative Cost Centers	1 412 01/	22.454	055 440	101 071		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 413, 816	22, 156	855, 469	131, 271	336, 058	202.00
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B, Part II)	12. 864100 368, 312	0. 001427 7, 245		697		204.00
205.00 Unit cost multiplier (Wkst. B, Part	3. 351216	0. 000467	0. 052304	0. 006410	0. 204120	205. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	ADAMS MEMORI	AL HOSPITAL Provider CCN		Period:	u of Form CMS-2 Worksheet B-1	2552-10
					From 01/01/2016 To 12/31/2016		
	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS.	CENTRAL SERVI CES & SUPPLY (COSTED	
		9.00	10.00	11.00	HRS.) 13.00	REQUIS.) 14.00	
	GENERAL SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			10100		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 BIO-MEDICAL 00702 UTILITIES - HOSPITAL 00703 UTILITIES - OFFSITE BLDGS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	105, 119 1, 244 5, 710 587	17, 220 0 0	722, 12 29, 84	8 288, 060		1.00 2.00 4.00 5.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0			0 6 0	0	14.00 15.00
15.00 16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 646 2, 539		17, 85 20, 13		0	15.00 16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 31. 00 40. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	16, 840 3, 151 7, 149 1, 674	1, 194 4, 650 0	100, 90 34, 49 43, 00 8, 50	9 34, 499 9 43, 009	0 0 0 0	30. 00 31. 00 40. 00 43. 00 44. 00
50.00 52.00 53.00 54.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	10, 965 1, 188 0 8, 855	0 0	56, 73 6, 03 53, 08	9 6, 039 0 0	0 0 0 0	50.00 52.00 53.00 54.00
60. 00 65. 00 66. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 926 4, 089 3, 475	0 0 0	59, 999 35, 25 25, 01	9 0 5 0 6 0	0 0 0	60. 00 65. 00 66. 00
67.00 68.00 69.00 71.00 72.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	100 50 0 0	0 0 0	33, 66 3, 64		0 0 0 0	67.00 68.00 69.00 71.00 72.00
73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0		0 0	0	73.00
76.00	03020 OP PSYCH OUTPATI ENT SERVICE COST CENTERS	400	0	13, 76	/ 0	0	76.00
90. 01	09000 CLINIC - AMO 09002 CLINIC - AMH NEURO	4, 386 1, 955 0	0	25, 040 15, 63 3, 500	7 0	0	90. 00 90. 01 90. 02
90. 03 90. 04 91. 00 92. 00	09003 CLINIC - NIGLIAZZO 04950 INTENSIVE OP BEHAVIORAL HEALTH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 325 863 5, 560	0	10, 56 93 38, 36	в О	0 0 0	90. 03 90. 04 91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD 10100 HOME HEALTH AGENCY	4, 323	0		2 0 0 0 0 0	0	95.00 97.00 101.00
	SPECIAL PURPOSE COST CENTERS 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	093,000	0	692, 210		0	116. 00 118. 00
194.OC	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 TITLE XX 07951 OTHER NRCC	654 0 6, 951	0	29, 91	0 0 0 0 1 0	0	190. 00 194. 00 194. 01
194.02	07952 OTHER MOBS 07953 MONROE Cross Foot Adjustments	2, 800 1, 714	0	(0 0 0 0	0 0	194. 02 194. 03 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 098, 829		1, 260, 97			202.00
203.00 204.00	Cost to be allocated (per Wkst. B, Part II)	10. 453191 68, 408	32, 356	1. 74621 145, 34	7 27, 520		204. 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 650767	1. 878978	0. 20127	B 0. 095536	0. 000000	∠up. 00

5/26/2017 12:15 pm Y: \10500 - Adams County Memorial Hospital \300 - Medicare Cost Report \20161231 \10500-16.mcrx

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1330	Period: \ From 01/01/2016	Vorksheet B-1
			To 12/31/2016	Date/Time Prepared: 5/26/2017 12:15 pm
Cost Center Description	PHARMACY	MEDI CAL		
	(COSTED REQUI S.)	RECORDS & LI BRARY		
	15.00	(TIME SPENT)		
GENERAL SERVICE COST CENTERS	15.00	16.00		
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500 ADMINISTRATIVE & GENERAL				5.00
7. 00 00700 OPERATION OF PLANT 7. 01 00701 BIO-MEDICAL				7.00 7.01
7. 02 00702 UTI LI TI ES - HOSPI TAL				7. 02
7.03 00703 UTILITIES - OFFSITE BLDGS				7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8.00 9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON				11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00 01500 PHARMACY	100			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	1, 385, 235		16.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	455, 778		30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	29, 252		31.00
40. 00 04000 SUBPROVI DER – I PF 43. 00 04300 NURSERY	0	90, 345 2, 638		40.00 43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	129, 235		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 872		52.00
53.00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	18, 158 0		54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0	12, 515		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0		66. 00 67. 00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	100	0		73.00
76.00 03020 OP PSYCH	0	29, 828		76.00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	3, 885		90.00
90. 01 09001 CLINIC - AMO	0	5, 293		90. 01
90. 02 09002 CLINIC - AMH NEURO 90. 03 09003 CLINIC - NIGLIAZZO	0	692 2, 537		90. 02 90. 03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	639		90.03
91.00 09100 EMERGENCY	0	589, 500		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS				92.00
95. 00 09500 AMBULANCE SERVI CES	0	0		95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS				101. 00
116. 00 11600 HOSPI CE	0			116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	100	1, 372, 167		118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194. 00 07950 TI TLE XX 194. 01 07951 OTHER NRCC	0	0 10, 283		194. 00 194. 01
194. 02 07952 OTHER MOBS	0	1, 054		194.01
194. 03 07953 MONROE	0	1, 731		194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers				200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 673, 089	1, 616, 826		201.00
Part I)	14 720 000000	1 147105		
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B,	16, 730. 890000 51, 887			203.00 204.00
Part II)				
205.00 Unit cost multiplier (Wkst. B, Part	518. 870000	0. 053046		205.00
	н П			1

lealth Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	ADAMS MEMORI	Provi der C	CN: 15-1330	Peri od:	u of Form CMS- Worksheet C	2002 .
				From 01/01/2016	Part I	
				To 12/31/2016	Date/Time Pre 5/26/2017 12:	15 nm
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	5 0 10 70 (5 9 49 79		E 040 B 04	
30. 00 03000 ADULTS & PEDIATRICS	5, 849, 796		5, 849, 79		5, 849, 796	
31.00 03100 I NTENSI VE CARE UNI T	1, 526, 592		1, 526, 59		1, 526, 592	
40. 00 04000 SUBPROVIDER - IPF	2, 145, 882		2, 145, 88		2, 145, 882	
43.00 04300 NURSERY	501, 353		501, 35		501, 353	
14. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0 0	0	44.00
ANCI LLARY SERVICE COST CENTERS	3, 957, 737		2 057 73	37 0	3, 957, 737	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 937, 737		3, 957, 73 392, 65		3, 937, 737	
53.00 05300 ANESTHESI OLOGY	392,000		392,00	0 0	392, 003 0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	3, 512, 106		3, 512, 10	-	3, 512, 106	
50. 00 06000 LABORATORY	4, 514, 493		4, 514, 49		4, 514, 493	
55. 00 06500 RESPIRATORY THERAPY	1, 394, 740	0			1, 394, 740	
56. 00 06600 PHYSI CAL THERAPY	1, 633, 026	0	1, 633, 02		1, 633, 026	
57. 00 06700 OCCUPATI ONAL THERAPY	531, 869		531, 86		531, 869	
58. 00 06800 SPEECH PATHOLOGY	308, 267		308, 26		308, 267	
59. 00 06900 ELECTROCARDI OLOGY	000,207	0	500,20		000, 207	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 284, 642		2, 284, 64	12 0	2, 284, 642	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,201,012		2,201,0	0 0	2, 201, 012	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 897, 588		2, 897, 58	38 0	2, 897, 588	
76.00 03020 0P PSYCH	659, 251		659, 25		659, 251	
OUTPATIENT SERVICE COST CENTERS	007/201		007720		007/201	
20. 00 09000 CLINIC	1, 036, 983		1, 036, 98	33 0	1, 036, 983	90.00
90. 01 09001 CLINIC - AMO	803, 230		803, 23	30 0	803, 230	90.0
20.02 09002 CLINIC - AMH NEURO	366, 948		366, 94	18 0	366, 948	90.0
90. 03 09003 CLINIC - NIGLIAZZO	515, 861		515, 86	51 0	515, 861	90.0
0. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	121, 041		121, 04	11 0	121, 041	90.0
91.00 09100 EMERGENCY	3, 256, 946		3, 256, 94	16 0	3, 256, 946	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 463, 374		1, 463, 37	74	1, 463, 374	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 361, 042		2, 361, 04	12 0	2, 361, 042	95.0
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	1
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS	T		I			-
116. 00 11600 HOSPI CE	0			0		116. 0
200.00 Subtotal (see instructions)	42,035,420	0	,,		42, 035, 420	
201.00 Less Observation Beds	1, 463, 374	_	1, 463, 37		1, 463, 374	
202.00 Total (see instructions)	40, 572, 046	0	40, 572, 04	16 0	40, 572, 046	202.00

	Financial Systems	ADAMS MEMORIA		N 45 4000		u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO	JN: 15-1330	Period: From 01/01/2016	Worksheet C Part I	
					To 12/31/2016	Date/Time Pre	pared:
						5/26/2017 12:	
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 751, 120		4, 751, 12			30.00
31.00	03100 I NTENSI VE CARE UNI T	831, 615		831, 61			31.00
40.00	04000 SUBPROVI DER – I PF	2,077,227		2,077,22			40.00
43.00	04300 NURSERY	246, 598		246, 59	98		43.00
44.00	04400 SKILLED NURSING FACILITY	0			0		44.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 467, 058	5, 768, 979	7, 236, 03	0. 546948	0.00000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	126, 202	48, 806	175, 00	2. 243629	0.00000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 470, 666	17, 675, 040	19, 145, 70	0. 183441	0.000000	54.00
60.00	06000 LABORATORY	2, 862, 285	15, 310, 360	18, 172, 64	45 0. 248422	0.00000	60.00
65.00	06500 RESPI RATORY THERAPY	2, 623, 015	2, 658, 487	5, 281, 50	0. 264080	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	485, 340	3, 177, 252	3, 662, 59	0. 445866	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	380, 653	576, 537	957, 19	0. 555657	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	109, 139	545, 891	655, 03	0. 470615	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 830, 027	1, 255, 141	3, 085, 16	0. 740524	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 130, 883	6, 002, 906	10, 133, 78	0. 285933	0. 000000	73.00
76.00	03020 OP PSYCH	0	685, 808	685, 80	0. 961276	0. 000000	76.00
	OUTPATIENT SERVICE COST CENTERS	· · · ·					
90.00	09000 CLI NI C	361	2, 423, 475	2, 423, 83	0. 427827	0. 000000	90.00
90.01	09001 CLINIC - AMO	0	3, 302, 292	3, 302, 29	0. 243234	0.000000	90.01
90.02	09002 CLINIC - AMH NEURO	0	431, 681	431, 68	0. 850044	0.000000	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	1, 583, 025	1, 583, 02	0. 325870	0.000000	90.03
90.04	04950 INTENSIVE OP BEHAVIORAL HEALTH	0	14, 700	14, 70		0. 000000	90.04
91.00	09100 EMERGENCY	187, 875	2, 502, 490	2, 690, 36	1. 210596	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	28, 134	2, 170, 297	2, 198, 43		0.000000	
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	2, 611, 322	2, 611, 32	0. 904156	0. 000000	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0.000000	0. 000000	
	10100 HOME HEALTH AGENCY	0	0		0		101.00
	SPECIAL PURPOSE COST CENTERS						1
116.00	11600 HOSPI CE	0	0		0		116.00
		23, 608, 198	68, 744, 489	92, 352, 68	37		200.00
200.00					1		1
200.00	Less Observation Beds						201.00

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/26/2017 12:15 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
40. 00 04000 SUBPROVI DER - I PF				40.00
43. 00 04300 NURSERY				43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY				44.00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 546948			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2. 243629			52.00
53.00 05300 ANESTHESI OLOGY	0.000000			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 183441			54.00
60. 00 06000 LABORATORY	0. 248422			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 264080			65.00
66. 00 06600 PHYSI CAL THERAPY	0, 445866			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 555657			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 470615			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 285933			73.00
76.00 03020 OP PSYCH	0.961276			76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 427827			90.00
90.01 09001 CLINIC - AMO	0. 243234			90.01
90. 02 09002 CLINIC - AMH NEURO	0. 850044			90.02
90. 03 09003 CLINIC - NIGLIAZZO	0. 325870			90.03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	8. 234082			90.04
91.00 09100 EMERGENCY	1. 210596			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 665645			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 904156			95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000			97.00
101.0010100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 H0SPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1330	Peri od:	Worksheet C	
				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	pared:
					5/26/2017 12:	15 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	2.00	2.00	4.00	F 00	-
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
0. 00 03000 ADULTS & PEDIATRICS	5, 849, 796		5, 849, 79	0	5, 849, 796	30.0
1. 00 03100 INTENSIVE CARE UNIT	1, 526, 592		1, 526, 59		1, 526, 592	
0. 00 04000 SUBPROVIDER - IPF	2, 145, 882		2, 145, 88		2, 145, 882	
3. 00 04300 NURSERY	501, 353		2, 143, 80		501, 353	
4. 00 04400 SKI LLED NURSI NG FACI LI TY	0		501, 50	0 0	01, 353	
ANCI LLARY SERVICE COST CENTERS	0			0 0	0	44.0
60. 00 05000 OPERATING ROOM	3, 957, 737		3, 957, 73	37 0	3, 957, 737	50.0
22.00 05200 DELIVERY ROOM & LABOR ROOM	392, 653		392, 65		392, 653	
3. 00 05300 ANESTHESI OLOGY	0,2,000		372,00	0 0	0,2,000	
44. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 512, 106		3, 512, 10	-	3, 512, 106	
0. 00 06000 LABORATORY	4, 514, 493		4, 514, 49		4, 514, 493	
5. 00 06500 RESPIRATORY THERAPY	1, 394, 740				1, 394, 740	
6. 00 06600 PHYSI CAL THERAPY	1, 633, 026		1, 633, 02		1, 633, 026	
57. 00 06700 OCCUPATI ONAL THERAPY	531, 869		531, 86		531, 869	
8. 00 06800 SPEECH PATHOLOGY	308, 267	0	308, 26		308, 267	
9.00 06900 ELECTROCARDI OLOGY	0	-		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 284, 642		2, 284, 64	2 0	2, 284, 642	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			0 0	0	
3.00 07300 DRUGS CHARGED TO PATIENTS	2, 897, 588		2, 897, 58	88 0	2, 897, 588	73.0
76.00 03020 OP PSYCH	659, 251		659, 25	51 0	659, 251	76.0
OUTPATIENT SERVICE COST CENTERS					· · · · · · · · · · · · · · · · · · ·	1
0.00 09000 CLINIC	1,036,983		1, 036, 98	33 0	1, 036, 983] 90. C
0.01 09001 CLINIC - AMO	803, 230		803, 23	0 0	803, 230	90.0
0. 02 09002 CLINIC - AMH NEURO	366, 948		366, 94	18 0	366, 948	90.0
0. 03 09003 CLINIC - NIGLIAZZO	515, 861		515, 86	0	515, 861	90.0
0.04 04950 INTENSIVE OP BEHAVIORAL HEALTH	121, 041		121, 04	1 0	121, 041	90.0
1. 00 09100 EMERGENCY	3, 256, 946		3, 256, 94	6 0	3, 256, 946	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 463, 374		1, 463, 37	4	1, 463, 374	92.0
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVI CES	2, 361, 042		2, 361, 04	2 0	2, 361, 042	
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	
01.00 10100 HOME HEALTH AGENCY	0			0	0	101.0
SPECIAL PURPOSE COST CENTERS		Γ	L	1		-
16. 00 11600 HOSPI CE	0			0		116. C
200.00 Subtotal (see instructions)	42,035,420		,,		42, 035, 420	
201.00 Less Observation Beds	1, 463, 374		1, 463, 37		1, 463, 374	
202.00 Total (see instructions)	40, 572, 046	0	40, 572, 04	6 0	40, 572, 046	202.0

	Financial Systems	ADAMS MEMORIA				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1330	Period: From 01/01/2016	Worksheet C Part I	
					To 12/31/2016		epared:
						5/26/2017 12:	
				e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				1		
30.00	03000 ADULTS & PEDIATRICS	4, 751, 120		4, 751, 12			30.00
31.00	03100 I NTENSI VE CARE UNI T	831, 615		831, 61			31.00
40.00	04000 SUBPROVI DER – I PF	2,077,227		2, 077, 22			40.00
43.00	04300 NURSERY	246, 598		246, 59			43.00
44.00	04400 SKILLED NURSING FACILITY	0			0		44.00
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	1, 467, 058	5, 768, 979				
52.00	05200 DELIVERY ROOM & LABOR ROOM	126, 202	48, 806	175, 00		0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 0. 000000	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 470, 666	17, 675, 040	19, 145, 70	0. 183441	0.00000	54.00
60.00	06000 LABORATORY	2, 862, 285	15, 310, 360	18, 172, 64	0. 248422	0.00000	60.00
65.00	06500 RESPI RATORY THERAPY	2, 623, 015	2, 658, 487	5, 281, 50	0. 264080	0.00000	65.00
66.00	06600 PHYSI CAL THERAPY	485, 340	3, 177, 252	3, 662, 59	0. 445866	0.00000	66.00
67.00	06700 OCCUPATIONAL THERAPY	380, 653	576, 537	957, 19	0. 555657	0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	109, 139	545, 891	655, 03	0. 470615	0.00000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.00000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 830, 027	1, 255, 141	3, 085, 16	0. 740524	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0.000000	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 130, 883	6, 002, 906	10, 133, 78	0. 285933	0. 000000	73.00
76.00	03020 OP PSYCH	0	685, 808	685, 80	0. 961276	0. 000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	361	2, 423, 475	2, 423, 83	0. 427827	0. 000000	90.00
90.01	09001 CLINIC - AMO	0	3, 302, 292	3, 302, 29	0. 243234	0. 000000	90.01
90.02	09002 CLINIC - AMH NEURO	0	431, 681	431, 68	0. 850044	0. 000000	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	1, 583, 025	1, 583, 02	0. 325870	0. 000000	90.03
90.04	04950 INTENSIVE OP BEHAVIORAL HEALTH	0	14, 700	14, 70	8. 234082	0. 000000	90.04
91.00	09100 EMERGENCY	187, 875	2, 502, 490	2, 690, 36	1. 210596	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	28, 134	2, 170, 297	2, 198, 43		0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	2, 611, 322	2, 611, 32	0. 904156	0.00000	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0.000000	0.00000	
	10100 HOME HEALTH AGENCY	0	0		0		101.00
	SPECIAL PURPOSE COST CENTERS						1
116.00	11600 HOSPI CE	0	0		0		116.00
200.00	Subtotal (see instructions)	23, 608, 198	68, 744, 489	92, 352, 68	37		200.00
		1			1		
201.00	Less Observation Beds						201.00

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2!	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prep 5/26/2017 12:1	ared:
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
40. 00 04000 SUBPROVIDER - IPF					40.00
43. 00 04300 NURSERY					43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY					44.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 546948				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2. 243629				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 183441				54.00
60. 00 06000 LABORATORY	0. 248422				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 264080				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 445866				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 555657				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 470615				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 740524				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 285933				73.00
76.00 03020 OP PSYCH	0. 961276				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 427827				90.00
90. 01 09001 CLINIC - AMO	0. 243234				90.01
90. 02 09002 CLINIC - AMH NEURO	0. 850044				90.02
90. 03 09003 CLINIC - NIGLIAZZO	0. 325870				90.03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	8. 234082				90.04
91. 00 09100 EMERGENCY	1. 210596				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 665645				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	0. 904156				95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.00
101.00 10100 HOME HEALTH AGENCY				1	101.00
SPECIAL PURPOSE COST CENTERS	· · · ·				
116.00 11600 HOSPI CE				1	116.00
200.00 Subtotal (see instructions)				2	200.00
201.00 Less Observation Beds				2	201.00
202.00 Total (see instructions)				2	202.00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	ATION OF OUTPATIENT SERVICE COST TO CHARGE RA IONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Pre 5/26/2017 12:	pared: 15 pm
			Ti tl	e XIX	Hospi tal	PPS	•
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 957, 737	312, 951			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	392, 653	33, 330	359, 3	23 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0)	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 512, 106	249, 786	3, 262, 3	20 0	0	54.00
60.00	06000 LABORATORY	4, 514, 493	115, 766	4, 398, 7	27 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	1, 394, 740	114, 544	1, 280, 1	96 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 633, 026	99, 588	1, 533, 4	38 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	531, 869	11, 690	520, 1	79 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	308, 267	3, 538	304, 7	29 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 284, 642	12, 122	2, 272, 5	20 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 897, 588	58, 384	2, 839, 20	04 0	0	73.00
76.00	03020 OP PSYCH	659, 251	9, 422	649, 8	29 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS		•				1
90.00	09000 CLI NI C	1, 036, 983	27, 776	1, 009, 20	0 07	0	90.00
90.01	09001 CLINIC - AMO	803, 230			32 0	0	90.01
90.02	09002 CLINIC - AMH NEURO	366, 948	2, 664	364, 2	84 0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	515, 861			47 0	0	90.03
90.04	04950 INTENSIVE OP BEHAVIORAL HEALTH	121,041	21, 638	99, 40	03 0	0	90.04
91.00	09100 EMERGENCY	3, 256, 946	194, 176	3, 062, 7	70 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 463, 374	127, 510	1, 335, 8	64 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		·				1
95.00	09500 AMBULANCE SERVI CES	2, 361, 042	42, 050	2, 318, 9	92 0	0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	•
101.00	10100 HOME HEALTH AGENCY	0			0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						1
116,00	11600 HOSPI CE	0	0)	0 0	0	1116.00
200.00		32, 011, 797					200.00
201.00		1, 463, 374					201.00
202.00		30, 548, 423					202.00
			, , , , , , , , , , , , , , , , , , , ,		-	-	

To 12/31/2016 Date Time P Visit of Cost Center Description Cost Net of Capital and Operating Cost Charge Outpatient Cost Center Description Cost Net of Capital and Operating Cost Part 1, colum Ratio (col. 6 ANCILLARY SERVICE COST CENTERS Outpatient Outpatient ANCILLARY SERVICE COST CENTERS O 05200 DELIVERY ROOM & 1A80R ROOM 3.957,737 7.236,037 O 5.46948 Service Cost CENTERS O O O 0 O 0 South Cost Operating Cost Mathematic Cost Cost Centers O O 0 O 0 O 0 South Cost Operating Cost Mathematic Cost Cost Cost Cost Cost Cost Cost Cost	S ADAMS MEMORIAL	Provider CCN: 15-1330	In Lieu of Form CMS Period: Worksheet C From 01/01/2016 Part II	
Cost Center Description Cost Net of Capital and Operating CostPart 1, column Ratio (col. 6 8.00 Hospital PPS ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 50.00 05000 (DEPATING ROOM 3,957,737 7.236,037 0.546948 52.00 05200 (DEUVERY ROOM & LABOR ROOM 392,653 175,008 2.248629 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 54.00 05400 (RADI OLOGY-DI AGNOSTI C 3,512,106 19,145,706 0.183441 66.00 06500 (RESPI RATORY THERAPY 1,334,740 5,281,502 0.244822 65.00 0600 (DEUVERY HERAPY 1,334,740 5,281,502 0.244826 66.00 0600 (PHYSI GLA THERAPY 1,334,740 5,281,502 0.244826 67.00 06700 (DCUPATI ONAL THERAPY 1,334,740 5,281,502 0.445866 67.00 06700 (DCUPATI ONAL THERAPY 1,33869 957,190 0.555657 68.00 04800 SPEECH PATHOLOGY 308,267 655,030 0.470615 69.00 0000000 IMPL, ECV. CHARGED TO PATI ENTS			To 12/31/2016 Date/Time Pr	epared:
Cost Center Description Cost Net of Reduction Total Charges (Worksheet C. Cost to Charge (Worksheet C. C		Title XIX		<u>. 15 piii</u>
ANCI LLARY SERVICE COST CENTERS Operating Cost Part 1, column Ratio (col. 7) ANCI LLARY SERVICE COST CENTERS 6.00 7.00 8.00 S0 05000 DERATING ROM 3,957,737 7,236,037 0.546948 S1 00 05300 ANESTHESI OLGGY 0 0.0000000 54.00 05400 RADIOLGGY-DI AGNOSTI C 3,512,106 19,145,706 0.183441 60.00 0.6000 RESPI RATORY THERAPY 1,334,740 5,241,502 0.264080 66.00 06000 RESPI RATORY THERAPY 1,342,740 5,281,502 0.264080 66.00 06600 RESPI RATORY THERAPY 1,633,026 3,662,592 0.445866 67.00 06600 SPEECH PATHOLOGY 308,267 655,030 0.470615 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 73.00 07200 IMPL DEV. CHARGED TO PATIENTS 2,884,42 3,085,186 0.470615 70.00 07000 CLINIC 1,036,983 2,423,836 0.427827 70.00 07000 CLINIC 1,036,983 2,423,836 0.427827 70.01 <td>r Description Cost Net of To</td> <td></td> <td></td> <td></td>	r Description Cost Net of To			
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200.03 09003 CLINIC - NIGLIAZZO 515,861 1,583,025 0.325870 20.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 121,041 14,700 8.234082 20.00 09100 EMERGENCY 3,256,946 2,690,365 1.210596 20.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,463,374 2,198,431 0.665645 OTHER REIMBURSABLE COST CENTERS OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 2,361,042 2,611,322 0.904156 07.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0.000000 0101.00 HOME HEALTH AGENCY 0 0 0.000000 SPECIAL PURPOSE COST CENTERS UHOOD HOSPICE O 0 0 0.000000 SPECIAL PURPOSE COST CENTERS UIACO HOSPICE O 0 0 0.000000 SUBTOR O 0 0 0.000000 SPECIAL PURPOSE COST CENTERS UIACO 0 0.000000				90.0
00.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 121,041 14,700 8.234082 01.00 09100 EMERGENCY 3,256,946 2,690,365 1.210596 02.00 OBSERVATION BEDS (NON-DISTINCT PART) 1,463,374 2,198,431 0.665645 0THER REI MBURSABLE COST CENTERS 2,361,042 2,611,322 0.904156 07.00 09500 AMBULANCE SERVI CES 2,361,042 2,611,322 0.90000 010.00 10100 HOME HEALTH AGENCY 0 0 0 0.000000 SPECIAL PURPOSE COST CENTERS 5 0 0 0.000000 0 0.000000 116.00 11600 HOSPI CE 0 0 0.000000 0 0.000000 200.00 Subtotal (sum of lines 50 thru 199) 32,011,797 84,446,127 0.000000 0				90.0
01.00 09100 EMERGENCY 3, 256, 946 2, 690, 365 1. 210596 02.00 0BSERVATI ON BEDS (NON-DI STINCT PART) 1, 463, 374 2, 198, 431 0. 665645 0THER REI MBURSABLE COST CENTERS 2, 361, 042 2, 611, 322 0. 904156 05.00 09500 AMBULANCE SERVI CES 2, 361, 042 2, 611, 322 0. 904156 07.00 0PTOO DURABLE MEDI CAL EQUI P-SOLD 0 0 0. 000000 01.00 HOME HEALTH AGENCY 0 0 0.000000 SPECI AL PURPOSE COST CENTERS 50 0 0.000000 200.00 1600 HOSPI CE 0 0.000000 200.00 Subtotal (sum of lines 50 thru 199) 32, 011, 797 84, 446, 127 0				90.0
D22.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 1,463,374 2,198,431 0.665645 OTHER REI MBURSABLE COST CENTERS 2,361,042 2,611,322 0.904156 05.00 O9700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0.000000 101.00 HOME HEALTH AGENCY 0 0 0.000000 SPECIAL PURPOSE CENTERS 2,011,797 84,446,127 0.000000				91.0
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 361, 042 2, 611, 322 0. 904156 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0.000000 101.00 HOME HEALTH AGENCY 0 0 0.000000 SPECIAL PURPOSE COST CENTERS 116.00 110SPI CE 0 0.000000 200.00 Subtotal Subtotal Subtotal Subtotal 0.000000 0.000000				92.0
095:00 AMBULANCE SERVICES 2, 361, 042 2, 611, 322 0.904156 07:00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0.000000 101:00 HOME HEALTH AGENCY 0 0 0 0.000000 SPECIAL PURPOSE COST CENTERS 116:00 11600 HOSPICE 0 0.000000 200:00 Subtotal (sum of lines 50 thru 199) 32,011,797 84,446,127 0.000000		2, 198, 431 0. 0050	45	- 72.0
OP7.00 OURABLE MEDI CAL EQUI P-SOLD O O O.000000 101.00 HOME HEALTH AGENCY O O O.000000 SPECIAL PURPOSE COST CENTERS Subtotal (sum of lines 50 thru 199) 32,011,797 84,446,127 O O.000000		2 611 222 0 0041	56	95.0
101.00 HOME HEALTH AGENCY 0 0.000000 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPICE 0 0.000000 200.00 Subtotal (sum of lines 50 thru 199) 32,011,797 84,446,127 0				95.0
SPECIAL PURPOSE COST CENTERS 116.00 H0SPI CE 0 0.000000 200.00 Subtotal (sum of lines 50 thru 199) 32,011,797 84,446,127				101.0
116.00 11600 HOSPICE 0 0.000000 200.00 Subtotal (sum of lines 50 thru 199) 32,011,797 84,446,127		0, 0000		$-1^{101.0}$
200.00 Subtotal (sum of lines 50 thru 199) 32,011,797 84,446,127		0 0 0000	00	116.0
				200.0
201. UU LESS UDSELVATION BEAS I, 403, 374 U		84, 440, 127		
202.00 Total (line 200 minus line 201) 30,548,423 84,446,127				201.0

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	1	-	
50.00 05000 OPERATI NG ROOM	312, 951				5, 385	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 330				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	-	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	249, 786					
60. 00 06000 LABORATORY	115, 766					60.00
65. 00 06500 RESPI RATORY THERAPY	114, 544					65.00
66. 00 06600 PHYSI CAL THERAPY	99, 588				4, 280	66.00
67.00 06700 OCCUPATI ONAL THERAPY	11, 690	957, 190			1, 371	67.00
68.00 06800 SPEECH PATHOLOGY	3, 538	655, 030			318	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 122	3, 085, 168	0. 00392	996, 367	3, 915	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0.0000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 384	10, 133, 789	0.00576	1, 433, 426	8, 258	73.00
76.00 03020 OP PSYCH	9, 422	685, 808	0. 01373	39 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	27, 776	2, 423, 836	0. 01146	50 361	4	90.00
90.01 09001 CLINIC - AMO	15, 098	3, 302, 292	0.00457	2 0	0	90. 01
90.02 09002 CLINIC - AMH NEURO	2, 664	431, 681	0.00617	/1 0	0	90. 02
90. 03 09003 CLINIC - NIGLIAZZO	14, 014	1, 583, 025	0. 00885	53 0	0	90. 03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	21, 638	14, 700	1. 47197	/3 0	0	90.04
91.00 09100 EMERGENCY	194, 176	2, 690, 365	0. 07217	4, 738	342	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	127, 510	2, 198, 431	0. 05800	28, 134	1, 632	92.00
OTHER REIMBURSABLE COST CENTERS	·	·	•			
95.00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.0000	0 0	0	97.00
200.00 Total (lines 50-199)	1, 423, 997	81, 834, 805		5, 739, 774	65, 527	200. 00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	VICE OTHER PASS	S Provider C	CN: 15-1330	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016		norod.
				10 12/31/2010	Date/Time Pre 5/26/2017 12:	
		Title	e XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	5	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	C		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03020 OP PSYCH	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90.01 09001 CLINIC - AMO	0	C		0 0	0	90.01
90. 02 09002 CLINIC - AMH NEURO	0	C		0 0	0	90. 02
90. 03 09003 CLINIC - NIGLIAZZO	0	C		0 0	0	90. 03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	C		0 0	0	90.04
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
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	C		0 0	0	
200.00 Total (lines 50-199)	0	C	1	0 0	0	200. 00

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016	Part IV	norod.
				10 12/31/2010	Date/Time Pre 5/26/2017 12:	15 pm
		Title	e XVIII	Hospi tal	Cost	10 pm
Cost Center Description	Total	Total Charges	Ratio of Cos	0utpati ent	Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	0	7 00/ 007	0.0000	0 0 000000	404 540	50.00
50. 00 05000 OPERATING ROOM	0	7, 236, 037			124, 510	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	175, 008			0	
53. 00 05300 ANESTHESI OLOGY	0	0	0100000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	19, 145, 706			439, 165	
	0	18, 172, 645			1, 137, 477	•
65. 00 06500 RESPIRATORY THERAPY	0	5, 281, 502			1, 247, 039	•
66. 00 06600 PHYSI CAL THERAPY	0	3, 662, 592			157, 402	•
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	957, 190			112, 247	•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	655, 030			58, 908	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 085, 168 0			996, 367 0	
72.00 07200 TMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 133, 789			1, 433, 426	
75.00 07500 DR0GS CHARGED TO PATTENTS 76.00 03020 0P PSYCH	0	685, 808			1, 433, 420	76.00
OUTPATIENT SERVICE COST CENTERS	0	085, 808	0.00000	0 0.00000	0	76.00
90. 00 09000 CLINIC	0	2, 423, 836	0.00000	0 0. 000000	361	90.00
90. 01 09001 CLINIC - AMO	0	3, 302, 292			0	90.00
90. 02 09002 CLINIC - AMH NEURO	0	431, 681			0	90.02
90. 03 09003 CLINIC - NIGLIAZZO	0	1, 583, 025			0	90.02
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	14, 700			0	90.03
91. 00 09100 EMERGENCY	0	2, 690, 365			4, 738	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 198, 431			28, 134	
OTHER REIMBURSABLE COST CENTERS	0	2,170,431	0.00000	0 0.000000	20, 134	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	0 0. 000000	0	•
200.00 Total (lines 50-199)	0				5, 739, 774	
		,,	1	1	-, , - , - , - , - , - , - , - ,	

Health Financial Systems	ADAMS MEMORIA	L HOSPI TAL			In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1330		iod: m 01/01/2016 12/31/2016	Worksheet D Part IV Date/Time Pr 5/26/2017 12	epared: :15 pm
		Title	XVIII		Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent				
	Program	Program	Program				
	Pass-Through	Charges	Pass-Throug				
	Costs (col. 8		Costs (col.				
	x col. 10)		x col. 12)				
	11.00	12.00	13.00				_
ANCI LLARY SERVI CE COST CENTERS	-1	-	1	_			
50. 00 05000 OPERATI NG ROOM	0	C		0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0			52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0			54.00
60. 00 06000 LABORATORY	0	C		0			60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0			67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	C		0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0			73.00
76.00 03020 OP PSYCH	0	C		0			76.00
OUTPATIENT SERVICE COST CENTERS	1 1		1				_
90. 00 09000 CLINIC	0	C		0			90.00
90. 01 09001 CLINIC - AMO	0	C		0			90.01
90. 02 09002 CLINIC - AMH NEURO	0	C		0			90.02
90. 03 09003 CLINIC - NIGLIAZZO	0	C		0			90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	C		0			90.04
91. 00 09100 EMERGENCY	0	C		0			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	C		0			92.00
OTHER REIMBURSABLE COST CENTERS	1		1				
95. 00 09500 AMBULANCE SERVICES							95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	C		0			97.00
200.00 Total (lines 50-199)	0	C	1	0			200.00

Health Financial Systems	ADAMS MEMORIA			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
				10 12/31/2010	5/26/2017 12:	15 pm
		Title	XVIII	Hospi tal	Cost	
			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.54/040		1.045.44	7		50.00
50.00 O5000 OPERATING ROOM	0. 546948		., = ,		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2. 243629	0	16		0	
53. 00 05300 ANESTHESI OLOGY	0.00000	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 183441	0	3, 923, 32		0	
	0. 248422	0	1, 823, 40		0	00.00
65. 00 06500 RESPI RATORY THERAPY	0. 264080	0	1, 381, 75		0	00.00
66.00 06600 PHYSI CAL THERAPY	0. 445866	0	960, 99		0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 555657	0	94, 33		0	
68. 00 06800 SPEECH PATHOLOGY	0. 470615	0	48, 71	2 0	0	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0.00000	0	1 057 00	0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 740524 0. 000000	0	1, 057, 29	4 0	0	
72.00 07200 TMPL. DEV. CHARGED TO PATTENT 73.00 07300 DRUGS CHARGED TO PATTENTS	0. 285933	0	1, 630, 92	1 5, 401	0	
75.00 07500 DR0GS CHARGED TO PATTENTS 76.00 03020 0P PSYCH	0. 265933		64, 87		0	
OUTPATIENT SERVICE COST CENTERS	0.901270	0	04, 87	9 0	0	70.00
90. 00 09000 CLINIC	0. 427827	0	248, 20	4 1, 967	0	90.00
90. 01 09001 CLINIC - AMO	0. 243234		240,20		0	
90. 02 09002 CLINIC - AMH NEURO	0. 850044	0		0 0	0	
90. 03 09003 CLINIC - NIGLIAZZO	0. 325870	0		0 0	0	
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	8. 234082	0		0 0	0	
91. 00 09100 EMERGENCY	1. 210596	0	528, 01	8 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 665645		467, 71		0	
OTHER REIMBURSABLE COST CENTERS				·		
95. 00 09500 AMBULANCE SERVICES	0. 904156			0		95.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000	0		0 0	0	97.00
200.00 Subtotal (see instructions)		0	13, 474, 85	6 7, 368	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	13, 474, 85	6 7, 368	0	202.00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-1330	Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	oparod:
				10 12/31/2010	5/26/2017 12:	15 pm
		Title	XVIII	Hospi tal	Cost	
	Cos			· · · · · · · · · · · · · · · · · · ·		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	681,031	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	372	0				50.00
53. 00 05300 ANESTHESI OLOGY	372	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	719, 699	0				54.00
60. 00 06000 LABORATORY	452, 973	0				60.00
65. 00 06500 RESPIRATORY THERAPY	364, 894	0				65.00
66. 00 06600 PHYSI CAL THERAPY	428, 473	0				66.00
67. 00 06700 OCCUPATIONAL THERAPY	52, 417	0				67.00
68. 00 06800 SPEECH PATHOLOGY	22, 925	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	22, 725	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	782, 952	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	, 02, 702	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	466, 334	1, 544				73.00
76.00 03020 0P PSYCH	62, 367	0	1			76.00
OUTPATIENT SERVICE COST CENTERS		-				
90. 00 09000 CLI NI C	106, 188	842				90.00
90. 01 09001 CLINIC - AMO	0	0				90.01
90. 02 09002 CLINIC - AMH NEURO	0	0				90.02
90. 03 09003 CLINIC - NIGLIAZZO	0	0				90.03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0	0				90.04
91.00 09100 EMERGENCY	639, 216	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	311, 329	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0					95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.00
200.00 Subtotal (see instructions)	5, 091, 170	2, 386				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	F 001 170	0.00/				
202.00 Net Charges (line 200 +/- line 201)	5, 091, 170	2, 386				202.00

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-1330	Period:	Worksheet D	
			001 45 1000	From 01/01/2016	Part II	
		Component	CCN: 15-M330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	pared:
		Title	× XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	312, 951	7, 236, 037			0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 330	175, 008			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	249, 786	19, 145, 706	0. 0130	47 14, 026	183	54.00
60. 00 06000 LABORATORY	115, 766	18, 172, 645	0.0063	70 51, 301	327	60.00
65. 00 06500 RESPI RATORY THERAPY	114, 544	5, 281, 502	0. 0216	38 16, 909	367	65.00
66. 00 06600 PHYSI CAL THERAPY	99, 588	3, 662, 592	0. 0271	91 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	11, 690	957, 190	0. 0122	13 180	2	67.00
68.00 06800 SPEECH PATHOLOGY	3, 538	655, 030	0.00540	01 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 00	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 122	3, 085, 168	0.00393	6, 197	24	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		0.0000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 384	10, 133, 789			607	73.00
76.00 03020 OP PSYCH	9,422	685, 808	0.0137		0	76.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLINIC	27, 776	2, 423, 836	0.0114	50 0	0	90.00
90.01 09001 CLINIC - AMO	15, 098	3, 302, 292	0.0045	72 0	0	90.01
90.02 09002 CLINIC - AMH NEURO	2,664	431, 681	0.0061	71 0	0	90.02
90. 03 09003 CLINIC - NIGLIAZZO	14,014	1, 583, 025	0. 0088	53 0	0	90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	21,638				0	90.04
91.00 09100 EMERGENCY	194, 176	2, 690, 365	0.0721	75 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0.0000	0 00	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.0000	0 00	0	97.00
200.00 Total (lines 50-199)	1, 296, 487	81, 834, 805		194, 011	1, 510	200. 00

Health Financial Systems	ADAMS MEMORIAL	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1330	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-M330	From 01/01/2016 To 12/31/2016		narod
		component	JUN. 10-1030	10 12/31/2010	5/26/2017 12:	
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician N	lursi ng School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03020 0P PSYCH	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 90. 01 09001 CLINIC - AMO	0	0		0 0	-	90. 00 90. 01
90.02 09002 CLINIC - AMO 90.02 09002 CLINIC - AMH NEURO	0	0		0 0	0	90.01
90. 02 109002 CLINIC - AMH NEORO	0	0		0 0	0	90.02
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	0		0 0	0	90.03
91. 00 09100 EMERGENCY	0	0			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				0		12100
95. 00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2016 To 12/31/2016		norod.
		component	CCN: 15-M330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	15 pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Total	Total Charges			I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS	-				-	
50. 00 05000 OPERATI NG ROOM	0	.,			0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	Ŭ	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				14, 026	54.00
60. 00 06000 LABORATORY	0	10/1/2/010			51, 301	60.00
65. 00 06500 RESPI RATORY THERAPY	0	5, 281, 502			16, 909	65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 662, 592				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	957, 190				67.00
68.00 06800 SPEECH PATHOLOGY	0	655, 030				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0100000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 085, 168			6, 197	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0.00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0				105, 398	
76.00 03020 OP PSYCH	0	685, 808	0.00000	0 0.00000	0	76.00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLINIC	0	=1 .==1 .==			0	90.00
90.01 09001 CLINIC - AMO	0	0,002,272			0	90.01
90.02 09002 CLINIC - AMH NEURO	0	431, 681			0	90.02
90. 03 09003 CLINIC - NIGLIAZZO	0	1, 583, 025			0	90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	14, 700			0	90.04
91. 00 09100 EMERGENCY	0	-/ - /			0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 198, 431	0.00000	0 0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0. 000000		
200.00 Total (lines 50-199)	0	81, 834, 805			194, 011	200. 00

Health Financial Systems	ADAMS MEMORI AL	- HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-1330	Peri od:	Worksheet D	
THROUGH COSTS		Comment	CON 15 M000	From 01/01/2016	Part IV	
		Component	CCN: 15-M330	To 12/31/2016	Date/Time Pro 5/26/2017 12:	
		Title	× XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
76.00 03020 OP PSYCH	0	0		0		76.00
OUTPATIENT SERVICE COST CENTERS	· ·		•			
90. 00 09000 CLINIC	0	0	I	0		90.00
90.01 09001 CLINIC - AMO	0	0		0		90.01
90.02 09002 CLINIC - AMH NEURO	0	0		0		90.02
90. 03 09003 CLINIC - NIGLIAZZO	0	0		0		90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	0		0		90.04
91. 00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · ·					
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0		97.00
200.00 Total (lines 50-199)	0	0		0		200.00
			•	1		

Health Financial Systems	ADAMS MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
		Component		From 01/01/2016	Part V	norod.
		Component	CCN: 15-Z330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	
		Title	XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. , ,	
	Part I, col. 9	· ·	Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 546948	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2. 243629	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 183441	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 248422	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 264080	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 445866	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 555657	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 470615	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 740524	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 285933	0		0 0	0	73.00
76.00 03020 OP PSYCH	0. 961276	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLI NI C	0. 427827	0		0 0	0	90.00
90.01 09001 CLINIC - AMO	0. 243234	0	1	0 0	0	90.01
90. 02 09002 CLINIC - AMH NEURO	0. 850044	0	1	0 0	0	90.02
90. 03 09003 CLINIC - NIGLIAZZO	0. 325870	0	1	0 0	0	90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	8. 234082	0	1	0 0	0	90.04
91.00 09100 EMERGENCY	1. 210596	0	1	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 665645	0	1	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0. 904156			0		95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1330	Peri od:	Worksheet D	
		Composit	CON 15 7000	From 01/01/2016	Part V	
		Component	CCN: 15-Z330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	
		Title	e XVIII	Swing Beds - SNF		15 piii
	Cos					
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	1					_
50.00 05000 OPERATING ROOM	0	C				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C				52.00
53. 00 05300 ANESTHESI OLOGY	0	C				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
60. 00 06000 LABORATORY	0	C				60.00
65. 00 06500 RESPI RATORY THERAPY	0	C				65.00
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C				67.00
68.00 06800 SPEECH PATHOLOGY	0	C				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C				73.00
76.00 03020 OP PSYCH	0	C				76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C				90.00
90.01 09001 CLINIC - AMO	0	C				90.01
90.02 09002 CLINIC - AMH NEURO	0	C				90.02
90. 03 09003 CLINIC - NIGLIAZZO	0	C				90.03
90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0	C				90.04
91. 00 09100 EMERGENCY	0	C				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C				97.00
200.00 Subtotal (see instructions)	0	C				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	C	0			202.00

Health Financial Systems	ADAMS MEMORI			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/26/2017 12:	pared: 15 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	509, 714		481, 00	6 5, 070	94.87	30.00
31.00 INTENSIVE CARE UNIT	97, 709		97,70	9 398	245.50	31.00
40. 00 SUBPROVIDER - IPF	207, 750	0	207, 75	0 1, 550	134.03	40.00
43.00 NURSERY	47, 722		47,72	2 380	125.58	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30-199)	862, 895		834, 18	7, 398		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDIATRICS	171	16, 223				30.00
31. 00 INTENSIVE CARE UNIT	4	982				31.00
40. 00 SUBPROVIDER - IPF	106					40.00
43. 00 NURSERY	59	7, 409				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30-199)	340	38, 821				200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CON: 15-1330 Period: Total 12/321201 Period: Part II S226/217216 Worksheet D Part II S226/217216 Cost Center Description Capital Related Cost (from Wkst. 8, Part II, col. 26) Title XIX Hospital Provider COST Capital Cost Charges Related Cost (col um 4) Provider COST Capital Cost Charges Provider COST Provider COST </th <th>Health Financial Systems</th> <th>ADAMS MEMORIA</th> <th>AL HOSPITAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Capital Related Cost (From Wkst. C, Part I, col. 26) To Capital (From Wkst. C, Part I, col. 2) Inpatient (Column 3 x (column 3 x) Capital Costs (column 3 x) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 DELIVERY NOOM 52.00 05000 AMESTHESI OLOGY 0 0.000000 0 5.00 50.00 05300 AMESTHESI OLOGY 0 0 0.000000 0 0 53.00 50.00 05300 AMESTHESI OLOGY 0 0 0.000000 0 0 53.00 54.00 05500 RESPI RATORY HERAPY 115,766 18,172,645 0.006370 254.468 1.621 60.00 66.00 06700 DECLARDARORY 115,766 18,172,645 0.005471 3.342 91 66.00 67.00 06700 ELCETROCARDI OLOGY 3.538 655,030 0.005401 0 0 68.00 68.00 06600 SPECH PATHORAL THERAPY 116,99 957,190 0.012213 1,797 22 67.00 72.00 0	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			From 01/01/2016 To 12/31/2016	Part II Date/Time Pre 5/26/2017 12:	
ANCI LLARY SERVICE COST Col Umm 3 x Col Umm 3 x 26) 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 312,951 7.236,037 0.043249 50,578 2.187 50.00 52.00 055000 OPERATI NG ROOM 33,330 175,008 0.190448 30,643 5.836 52.00 0 53.00 53.00 53.00 0 54.00 0.000000 0 0 53.00 53.00 0 54.00 0.000000 0 0 53.00 0 54.00 0.000000 0 0 53.00 0 54.00 0.000000 0 <td></td> <td></td> <td>Ti tl</td> <td>e XIX</td> <td>Hospi tal</td> <td>PPS</td> <td></td>			Ti tl	e XIX	Hospi tal	PPS	
ANCI LLARY SERVICE COST CENTERS Part I1, col. 26) Col. 20 Col. 20 <thcol. 20 <thcol. 20 Col. 20</thcol. </thcol. 	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II, col. 8) 2) ANCILLARY SERVICE COST CENTERS							
26) 0					. Charges	column 4)	
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05600 OPERATI NG ROOM 312,951 7,236,037 0.043249 50,578 2,187 50.00 52.00 05200 DELIVERY ROM & LABOR ROOM 33,330 175,008 0.190448 30,643 5,836 52.00 53.00 05300 ANSTHESI OLOGY 0 0 0.000000 0 0 54.00 54.00 54.00 11,67.66 18,172,445 0.006370 254.468 1,621 60.00 60.00 66.00 6500 6500 6500 6500 6500 6500 6500 6507 114,544 5,281,502 0.021468 19,392 2,373 65.00 66.00 6600 SPECH PATHORY THERAPY 11,690 957,190 0.012213 1,797 22 67.00 68.00 06600 SPECH PATHOLOGY 3,538 655,030 0.005401 0 0 69.00 71.00 70100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12,122			8)	2)			
ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 312,951 7,236,037 0.043249 50,578 2,187 50.00 52.00 05300 ANESTHESI OLOGY 0 0 0.000000 0 0 53.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 249,786 19,145,706 0.013047 80,106 1,045 54.00 60.00 06600 LABORATORY 114,544 5,81,502 0.02168 109,399 2,373 65.00 66.00 06700 CCUPATI ONAL THERAPY 11,690 957,190 0.012213 1,797 22 67.00 68.00 06800 SPEECH PATHOLOGY 3,538 655,030 0.005401 0 66.00 01010MEDI CAL SUPPLIES CHARED TO PATI ENT 12,122 3,085,168 0.03929 72,070 283 71.00 72.00 07200 INPLC. SUPARGED TO PATI ENT 0 0 0.000000 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
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60.00 06000 LABORATORY 115, 766 18, 172, 645 0.006370 254, 468 1, 621 60.00 65.00 06500 RESPI RATORY THERAPY 114, 544 5, 281, 502 0.021688 109, 399 2, 373 65.00 66.00 06400 PHYSI CAL THERAPY 99, 588 3, 662, 592 0.021791 3, 342 91 66.00 67.00 06700 0CCUPATI ONAL THERAPY 11, 690 957, 190 0.012213 1, 797 22 67.00 68.00 06800 SPEECH PATHOLOGY 3, 538 655, 030 0.005401 0 0 68.00 69.00 OF100 DCILAL SUPPLIES CHARGED TO PATI ENTS 12, 122 3, 085, 168 0.03929 72, 070 283 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 12, 122 3, 085, 168 0.03929 72, 070 283 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58, 384 10, 133, 789 0.005761 368, 231 2, 121 73.00 76.00 090001 CLI NI C AMH 15, 098 3, 302, 292		-	0			-	
65.00 06500 RESPI RATORY THERAPY 114,544 5,281,502 0.021688 109,399 2,373 65.00 66.00 06600 PHYSI CAL THERAPY 99,588 3,662,592 0.021791 3,342 91 66.00 67.00 06700 0CCUPATI ONAL THERAPY 11,690 97,190 0.012213 1,797 22 67.00 68.00 06800 SPECH PATHOLOGY 3,538 655.030 0.005401 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12,122 3,085,168 0.003929 72,070 283 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58,384 10,133,789 0.005761 368,231 2,121 73.00 76.00 03020 OP PSYCH 9,422 685,808 0.011460 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		249, 786	19, 145, 706			1, 045	54.00
66.00 06600 PHYSI CAL THERAPY 99, 588 3, 662, 592 0.027191 3, 342 91 66.00 67.00 06700 OCCUPATI ONAL THERAPY 11, 690 957, 190 0.012213 1, 797 22 67.00 68.00 06800 SPEECH PATHOLOGY 3, 538 655, 030 0.005401 0 68.00 69.00 O6900 ELECTROCARDI OLOGY 0 0.000000 0 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12, 122 3, 085, 168 0.003929 72, 070 283 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 58, 384 10, 133, 789 0.005761 368, 231 2, 121 73.00 76.00 03020 OP PSYCH 9, 422 66.4 0.011460 0 0 90.00 90.01 09001 CLI NI C AMO 15, 098 3, 302, 292 0.004572 0 90.02 90.02 90.02 09003 CLI NI C AMI NEURO 2, 664 431, 681 0.006171 0 90.03 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr<>							
67.00 06700 0CCUPATI ONAL THERAPY 11, 690 957, 190 0.012213 1, 797 22 67.00 68.00 06800 SPEECH PATHOLOGY 3, 538 655, 030 0.005401 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 69.00 69.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12, 122 3, 085, 168 0.003929 72, 070 283 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 12, 122 3, 085, 168 0.003929 72, 070 283 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58, 384 10, 133, 789 0.005761 368, 231 2, 121 73.00 76.00 03020 [OP PSYCH 9, 422 685, 808 0.011460 0 0 90.00 90.00 OUTPATI ENT SERVICE COST CENTERS 27, 776 2, 423, 836 0.011460 0 90.01 90.02 90.01 09001 CLI NI C AMM NEURO 2, 664 431, 681 0.006171 0 90.02 90.02 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
68.00 06800 SPEECH PATHOLOGY 3, 538 655, 030 0.005401 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 12, 122 3, 085, 168 0.003929 72, 070 283 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 12, 122 3, 085, 168 0.003929 72, 070 283 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58, 384 10, 133, 789 0.005761 368, 231 2, 121 73.00 76.00 03020 OP PSYCH 9, 422 685, 808 0.011460 0 0 76.00 0010001 CLI NI C AMO 15, 098 3, 302, 292 0.004572 0 90.01 90.01 90.02 09002 CLI NI C - AMO 15, 098 3, 302, 292 0.004572 0 90.03 90.03 90.03 09003 CLI NI C - AMH NEURO 2, 664 431, 681 0.006171 0 90.03 90.03 90.04							
69.00 06900 ELECTROCARDIOLOGY 0 0 0.000000 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 12,122 3,085,168 0.003929 72,070 283 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0.000000 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 58,384 10,133,789 0.005761 368,231 2,121 73.00 76.00 03020 DP PSYCH 9,422 685,808 0.013739 0 0 0 00 90.00 0000 09000 CLI NI C AMO 15,098 3,302,292 0.004572 0 0 90.01 90.02 09002 CLI NI C AMH 15,098 3,302,292 0.004572 0 0 90.03 90.03 09003 CLI NI C AMH NEURO 2,664 431,681 0.006171 0 0 90.03 90.04	67.00 06700 OCCUPATI ONAL THERAPY	11, 690	957, 190	0. 0122	1, 797	22	67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 12,122 3,085,168 0.003929 72,070 283 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58,384 10,133,789 0.005761 368,231 2,121 73.00 76.00 03020 OP PSYCH 9,422 685,808 0.013739 0 0 76.00 00000 CLI NI C AMO 15,098 3,302,292 0.004572 0 90.01 90.01 09001 CLI NI C AMO 15,098 3,302,292 0.004572 0 90.02 90.02 09002 CLI NI C AMO 15,098 3,302,292 0.004572 0 90.02 90.03 09003 CLI NI C AMO 15,098 3,302,292 0.008553 0 90.03 90.04 04950 INTENSI VE OP BEHAVI ORAL HEALTH 21,638 14,700 1.471973 0 90.04 91.00 09100 EMERENCY 194	68.00 06800 SPEECH PATHOLOGY	3, 538	655, 030	0.00540	01 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 58,384 10,133,789 0.005761 368,231 2,121 73.00 76.00 03020 OP PSYCH 9,422 685,808 0.013739 0 0 76.00 00TPATIENT SERVICE COST CENTERS 27,776 2,423,836 0.011460 0 90.00 90.01 09000 CLINIC AMO 15,098 3,302,292 0.004572 0 90.01 90.02 90.02 09002 CLINIC AMH NEURO 2,664 431,681 0.006171 0 90.02 90.02 90.04 09003 CLINIC - NI GLIAZZO 14,014 1,583,025 0.008853 0 90.03 90.04 90.04 04950 INTENSI VE OP BEHAVI ORAL HEALTH 21,638 14,700 1.471973 0 90.04 90.04 91.00 O9100 EMERENCY 194,176 2,690,365 0.072175 38,904 2,808 91.00 92.00 OBSERVATI ON BEDS (N	69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 58,384 10,133,789 0.005761 368,231 2,121 73.00 76.00 03020 OP PSYCH 9,422 685,808 0.013739 0 0 00 09000 CLI NI C SERVICE COST CENTERS 27,776 2,423,836 0.011460 0 90.00 90.01 09001 CLI NI C AMO 15,098 3,302,292 0.004572 0 90.01 90.02 09002 CLI NI C AMH NEURO 2,664 431,681 0.006171 0 90.02 90.03 09003 CLI NI C NI GLI AZZO 14,014 1,583,025 0.008853 0 90.03 90.04 04950 INTENSI VE OP BEHAVI ORAL HEALTH 21,638 14,700 1.471973 0 90.04 91.00 09100 EMERGENCY 194,176 2,690,365 0.072175 38,904 2,808 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 127,510 2,198,431 0.058000 0 0 92.00 95.00 OPSOOI AMBULANCE S	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 122	3, 085, 168	0.00392	29 72, 070	283	71.00
76. 00 03020 OP PSYCH 9,422 685,808 0.013739 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0 0 76.00 0 90.00 0 0 0 0 90.00 0 90.00 0 90.00 90.00 90.00 90.01 0 90.00 90.01 90.01 0 90.00 90.01 90.01 0.011460 0 0 90.01 90.01 90.01 0.01160 0 90.01 90.01 90.01 0.004572 0 0 90.02 90.02 0.004572 0 0 90.02 90.02 90.02 0.004572 0 0 90.02 90.02 90.02 0.004572 0 0 90.02 90.02 90.02 90.02 90.02 14,014 1,583,025 0.008853 0 0 90.03 90.04 90.03 90.04 91.00 91.04 194,176 2,690,365 0.072175 38,904 2,808 91.00 92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0.0000	0 00	0	72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 27,776 2,423,836 0.011460 0 0 90.00 90.01 09001 CLINIC AMO 15,098 3,302,292 0.004572 0 0 90.01 90.02 09002 CLINIC AMH NEURO 2,664 431,681 0.006171 0 0 90.02 90.03 09003 CLINIC NIGLIAZZO 14,014 1,583,025 0.008853 0 0 90.03 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 21,638 14,700 1.471973 0 90.04 91.00 09100 EMERGENCY 194,176 2,690,365 0.072175 38,904 2,808 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 127,510 2,198,431 0.058000 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 0.000000 0 97.00 97.00 0 0 0.000000 97.00 <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td>58, 384</td> <td>10, 133, 789</td> <td>0.00576</td> <td>51 368, 231</td> <td>2, 121</td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS	58, 384	10, 133, 789	0.00576	51 368, 231	2, 121	73.00
90.00 09000 CLINIC 27,776 2,423,836 0.011460 0 0 90.00 90.01 09001 CLINIC - AMO 15,098 3,302,292 0.004572 0 0 90.01 90.02 09002 CLINIC - AMH NEURO 2,664 431,681 0.006171 0 90.02 90.03 09003 CLINIC - NIGLIAZZO 14,014 1,583,025 0.008853 0 90.03 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 21,638 14,700 1.471973 0 90.04 91.00 09100 EMERGENCY 194,176 2,690,365 0.072175 38,904 2,808 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 127,510 2,198,431 0.058000 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 0 0 0 97.00 97.00 09700 DURABLE MEDICAL EQUI P-SOLD 0 0 0.000000 0 97.00	76.00 03020 OP PSYCH	9, 422	685, 808	0. 01373	39 0	0	76.00
90. 01 09001 CLI NI C - AMO 15,098 3,302,292 0.004572 0 0 90.01 90. 02 09002 CLI NI C - AMH NEURO 2,664 431,681 0.006171 0 90.02 90. 03 09003 CLI NI C - NI GLI AZZO 14,014 1,583,025 0.008853 0 90.03 90. 04 04950 INTENSI VE OP BEHAVI ORAL HEALTH 21,638 14,700 1.471973 0 90.04 91. 00 09100 EMERGENCY 194,176 2,690,365 0.072175 38,904 2,808 91.00 92. 00 095ERVATI ON BEDS (NON-DI STI NCT PART) 127,510 2,198,431 0.058000 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 97.00 0.000000 0 97.00 97.00	OUTPATIENT SERVICE COST CENTERS						
90. 02 09002 CLINIC - AMH NEURO 2,664 431,681 0.006171 0 90.02 90. 03 09003 CLINIC - NIGLIAZZO 14,014 1,583,025 0.008853 0 90.03 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH 21,638 14,700 1.471973 0 90.04 91. 00 09100 EMERGENCY 194,176 2,690,365 0.072175 38,904 2,808 91.00 92. 00 09SERVATI ON BEDS (NON-DI STINCT PART) 127,510 2,198,431 0.058000 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 97.00 0,0700 0 0 0 97.00 97.00 0 0 0 97.00 0 0 97.00 0 0 97.00 0 0 97.00 0 97.00 0 0 0 97.00 97.00	90. 00 09000 CLINIC	27, 776	2, 423, 836	0.01140	50 0	0	90.00
90. 03 09003 CLINIC - NIGLIAZZO 14,014 1,583,025 0.008853 0 90.03 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH 21,638 14,700 1.471973 0 90.04 91. 00 09100 EMERCENCY 194,176 2,690,365 0.072175 38,904 2,808 91.00 92. 00 OBSERVATI ON BEDS (NON-DI STINCT PART) 127,510 2,198,431 0.058000 0 0 92.00 0THER RI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 97.00 00700 DURABLE MEDICAL EQUI P-SOLD 0 0 0.000000 0 97.00	90.01 09001 CLINIC - AMO	15, 098	3, 302, 292	0.0045	72 0	0	90.01
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH 21, 638 14, 700 1. 471973 0 0 90. 04 91. 00 09100 EMERGENCY 194, 176 2, 690, 365 0. 072175 38, 904 2, 808 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 127, 510 2, 198, 431 0. 058000 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0. 000000 0 97. 00	90.02 09002 CLINIC - AMH NEURO	2,664	431, 681	0.0061	71 0	0	90.02
91. 00 09100 EMERGENCY 194, 176 2, 690, 365 0. 072175 38, 904 2, 808 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 127, 510 2, 198, 431 0. 058000 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 0 09500 AMBULANCE SERVICES 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0. 000000 0 97. 00	90. 03 09003 CLINIC - NIGLIAZZO	14,014	1, 583, 025	0. 0088	53 0	0	90.03
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 127, 510 2, 198, 431 0. 058000 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00	90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	21, 638	14, 700	1. 4719	73 0	0	90.04
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00	91.00 09100 EMERGENCY	194, 176	2, 690, 365	0. 0721	75 38, 904	2, 808	91.00
95. 00 09500 AMBULANCE SERVI CES 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 97. 00 97. 00 0 0 0 0 97. 00 97. 00 97. 00 97. 00 0 0 0 97. 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	127, 510	2, 198, 431	0. 05800	0 00	0	92.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0.000000 0 97. 00	OTHER REIMBURSABLE COST CENTERS			•			1
	95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (Lines 50-199) 1,423,997 81,834,805 1,009,538 18,387 200.00	97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.0000	0 0	0	97.00
	200.00 Total (lines 50-199)	1, 423, 997	81, 834, 805		1, 009, 538	18, 387	200. 00

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 12:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
	-	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	l o		0 0	l o	40.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		-	0	
200.00 Total (lines 30-199)	0			0	-	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		200100
	Days	$5 \div col. 6)$	Program Days			
	baye			Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7.00	8,00	9,00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	
30, 00 03000 ADULTS & PEDI ATRI CS	5,070	0.00	17	/1 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	398			4 0		31.00
40. 00 04000 SUBPROVIDER - IPF	1, 550			0		40.00
43. 00 04300 NURSERY	380			i9 0		43.00
44. 00 04400 SKILLED NURSING FACILITY	0	0.00				44.00
200.00 Total (lines 30-199)	7, 398		34			200.00
200.00 10tal (11165 30-199)	7,390	l	1 54	0		1200.00

Heal th Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C	CN: 15-1330	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/26/2017 12:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist	0		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C)	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	0	73.00
76.00 03020 OP PSYCH	0	0)	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 CLINIC - AMO	0	0		0 0	0	90.01
90. 02 09002 CLINIC - AMH NEURO	0	0		0 0	0	90. 02
90. 03 09003 CLINIC – NIGLIAZZO	0	0		0 0	0	90. 03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0	0		0 0	0	90.04
91.00 09100 EMERGENCY	0	C)	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0	P	0 0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1330 Period: Worksheet	D
THROUGH COSTS From 01/01/2016 Part IV	
To 12/31/2016 Date/Time 5/26/2017	Prepared:
Title XIX Hospital PF	
Cost Center Description Total Total Charges Ratio of Cost Outpatient Inpatien	
Outpatient (from Wkst. C, to Charges Ratio of Cost Program	
Cost (sum of Part I, col. (col. 5 ÷ col. to Charges Charges	
col. 2, 3 and 8) 7) (col. 6 ÷ col.	
4) 7)	
<u>6.00</u> 7.00 8.00 9.00 10.00	
ANCI LLARY SERVI CE COST CENTERS	
	578 50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 175,008 0.000000 0.000000 30,	
53. 00 05300 ANESTHESI OLOGY 0 0. 000000 0. 000000	0 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 19, 145, 706 0. 000000 0. 000000 80,	106 54.00
60. 00 06000 LABORATORY 0 18, 172, 645 0. 000000 0. 000000 254,	
65. 00 06500 RESPI RATORY THERAPY 0 5, 281, 502 0. 000000 0. 000000 109,	399 65.00
	342 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 957, 190 0. 000000 1,	797 67.00
68. 00 06800 SPEECH PATHOLOGY 0 655, 030 0. 000000 0. 000000	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0. 000000 0. 000000	0 69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 3, 085, 168 0. 000000 0. 000000 72,	070 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 0.000000 0.000000	0 72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 10, 133, 789 0. 000000 0. 000000 368,	231 73.00
76. 00 03020 OP PSYCH 0 685, 808 0. 000000 0. 000000	0 76.00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0 2, 423, 836 0. 000000 0. 000000	0 90.00
90. 01 09001 CLINIC - AMO 0 3, 302, 292 0. 000000 0. 000000	0 90.01
90. 02 09002 CLINIC - AMH NEURO 0 431, 681 0.000000 0.000000	0 90.02
90. 03 09003 CLINIC - NIGLIAZZO 0 1, 583, 025 0. 000000 0. 000000	0 90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH 0 14, 700 0. 000000 0. 000000	0 90.04
91.00 09100 EMERGENCY 0 2,690,365 0.000000 0.000000 38,	904 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 198, 431 0. 000000 0. 000000	0 92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVICES	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0.000000	0 97.00
200.00 Total (lines 50-199) 0 81, 834, 805 1, 009,	538 200. 00

Health Financial Systems	ADAMS MEMORI AL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-1330	Period: From 01/01/2016	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2016	Date/Time Pre	
			e XIX	Hospi tal	5/26/2017 12: PPS	15 pm
Cost Center Description	Inpati ent	Outpatient	Outpatient			
oost oontor beschiption	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	J	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS	-		-			
50. 00 05000 OPERATI NG ROOM	0	0		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
76.00 03020 OP PSYCH	0	0		0		76.00
90.00 OUTPATIENT SERVICE COST CENTERS		0	1	0		
90. 00 09000 CLINIC 90. 01 09001 CLINIC - AMO	0	0		0		90.00 90.01
90.02 09002 CLINIC - AMH NEURO	0	0		0		90.01
90. 02 109002 CLINIC - AMH NEORO 90. 03 109003 CLINIC - NIGLIAZZO	0	0		0		90.02
90. 03 09003 CETNIC - NIGETAZZO 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0	0		0		90.03
91. 00 09100 EMERGENCY	0	0		0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS	<u>ч</u>	0		0		72.00
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.00
200.00 Total (lines 50-199)	0	0		0		200.00
			•	1		

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-1330	Period:	Worksheet D	
				From 01/01/2016	Part II	
		Component (CCN: 15-M330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	pared:
		Ti +1	e XIX	Subprovider -	PPS	to pili
			e XIX	IPF	115	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	312, 951	7, 236, 037			0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 330	175, 008	0. 1904	48 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	249, 786	19, 145, 706	0. 0130	47 948	12	54.00
60. 00 06000 LABORATORY	115, 766	18, 172, 645	0.0063	70 37, 653	240	60.00
65. 00 06500 RESPI RATORY THERAPY	114, 544	5, 281, 502	0. 0216	38 10, 171	221	65.00
66. 00 06600 PHYSI CAL THERAPY	99, 588	3, 662, 592	0. 0271	91 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	11, 690	957, 190	0. 0122	13 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	3, 538	655, 030	0.00540	01 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 00	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 122	3, 085, 168	0.00393	29 2,683	11	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0.0000	0 00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 384	10, 133, 789	0.0057	62, 157	358	73.00
76.00 03020 OP PSYCH	9,422	685, 808	0.0137	39 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLI NI C	27, 776	2, 423, 836	0.0114	50 0	0	90.00
90.01 09001 CLINIC - AMO	15, 098	3, 302, 292	0.0045	72 0	0	90.01
90.02 09002 CLINIC - AMH NEURO	2,664	431, 681	0.0061	71 0	0	90.02
90. 03 09003 CLINIC - NIGLIAZZO	14,014	1, 583, 025	0. 0088	53 0	0	90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	21, 638	14, 700	1. 4719	73 0	0	90.04
91.00 09100 EMERGENCY	194, 176	2, 690, 365	0. 0721	75 361	26	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 198, 431	0.0000	0 00	0	92.00
OTHER REIMBURSABLE COST CENTERS			·			
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.0000	0 00	0	97.00
200.00 Total (lines 50-199)	1, 296, 487	81, 834, 805		113, 973	868	200. 00

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-1330	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-M330	From 01/01/2016 To 12/31/2016		narod
		Component	JUN. 10-1030	10 12/31/2010	5/26/2017 12:	
		Titl	e XIX	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician N	ursing School	Allied Healt		Total Cost	
	Anestheti st			Medical	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03020 OP PSYCH	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS				0		
90. 00 09000 CLINIC 90. 01 09001 CLINIC - AMO	0	0		0 0	-	90. 00 90. 01
90. 02 09002 CLINIC - AMH NEURO	0	0		0 0	0	90.01
90. 02 109002 CLINIC - AMH NEORO 90. 03 109003 CLINIC - NIGLIAZZO	0	0		0 0	0	90.02
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	0		0 0	0	90.03
91. 00 09100 EMERGENCY	0	0			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					12100
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2016 To 12/31/2016		norod.
		component	CCN: 15-M330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	15 pm
		Titl	e XIX	Subprovider -	PPS	<u>10 piii</u>
				I PF		
Cost Center Description		Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)	10.00	
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		7 00/ 007	0.00000		0	
50. 00 05000 OPERATING ROOM	0	7, 236, 037				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	175, 008				52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	19, 145, 706				54.00
	0	18, 172, 645				
65. 00 06500 RESPI RATORY THERAPY	0	5, 281, 502				65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 662, 592				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	957, 190				67.00
68. 00 06800 SPEECH PATHOLOGY	0	655, 030				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000			69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	3, 085, 168				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	10, 133, 789				
76. 00 03020 OP PSYCH OUTPATI ENT SERVICE COST CENTERS	0	685, 808	0.00000	0 0.00000	0	76.00
90. 00 09000 CLINIC	0	2, 423, 836	0.00000	0 0.00000	0	90.00
90. 01 09001 CLINIC - AMO	0	3, 302, 292				90.00
90. 02 09002 CLINIC - AMH NEURO	0	431, 681				90.01
90. 03 09003 CLINIC - NIGLIAZZO	0	1, 583, 025				90.02
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	14, 700				
91. 00 09100 EMERGENCY	0	2, 690, 365				90.04
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 198, 431				
OTHER REIMBURSABLE COST CENTERS	U 0	2, 170, 431	0.00000	0 0.000000	0	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	٥	0. 00000	0. 000000	0	
200.00 Total (lines 50-199)	0	81, 834, 805		0.00000	113, 973	
	1 9	= ., == ., 000	1	1		1

Health Financial Systems	ADAMS MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-1330	Peri od:	Worksheet D	
THROUGH COSTS		Company	CON 15 N000	From 01/01/2016	Part IV	
		Component	CCN: 15-M330	To 12/31/2016	Date/Time Pro 5/26/2017 12:	
		Titl	e XIX	Subprovider -	PPS	
				I PF		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						_
50. 00 05000 OPERATI NG ROOM	0	0		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
76.00 03020 OP PSYCH	0	0		0		76.00
OUTPATIENT SERVICE COST CENTERS	· · ·		•			
90. 00 09000 CLINIC	0	0	I	0		90.00
90.01 09001 CLINIC - AMO	0	0		0		90.01
90.02 09002 CLINIC - AMH NEURO	0	0		0		90.02
90. 03 09003 CLINIC - NIGLIAZZO	0	0		0		90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	0		0		90.04
91. 00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS	· · · · ·					
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0		97.00
200.00 Total (lines 50-199)	0	0		0		200.00
			•	1		

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/26/2017 12:	parec
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			5, 652 5, 070	1.
	Private room days (excluding swing-bed and observation bed day	5,	ivate room days,	0,070	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed dave)		3, 726	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	265	
~~	reporting period	am dava) oftan Daaamban	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private row reporting period (if calendar year, enter 0 on this line)	om days) arter December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	317	7.
00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	1, 594	9.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	room days)	265	10.
~~	through December 31 of the cost reporting period (see instruction of the cost reporting period (see instruction)				
	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, end		room days) arter	0	11.
	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI.	Y only (including privat	e room dave)	0	13.
	after December 31 of the cost reporting period (if calendar y			0	13.
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost		17.
. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s through December 31 of	the cost	129. 14	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s after December 31 of t	he cost	0.00	20
. 00	reporting period	s arter becember 51 01 1	the cost	0.00	20
	Total general inpatient routine service cost (see instruction			5, 849, 796	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	40, 937	24
	7 x line 19)			10, 707	
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			329, 474	26
1	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 520, 322	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		la ges)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min		tions)	0.00	
	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 2 x line 25)			0. 00 0	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	5, 520, 322	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 088. 82	38
	Program general inpatient routine service cost (line 9 x line			1, 735, 579	
0. 00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)			40.
00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 735, 579	41

OMPUTATION OF INPATIENT OPERATING COST	Worksheet D-1	2552-
	01/2016 31/2016 Date/Time Prep 5/26/2017 12:1	
	tal Cost	
Cost Center Description	m Days Program Cost (col. 3 x col.	
	4) 00 5.00	
2.00 NURSERY (title V & XIX only)	0 0	42.
Intensive Care Type Inpatient Hospital Units	200 7(7,122	42
3. 00 INTENSIVE CARE UNIT 4. 00 CORONARY CARE UNIT	200 767, 132	43. 44.
5. 00 BURN INTENSIVE CARE UNIT		45.
6.00 SURGI CAL I NTENSI VE CARE UNI T		46.
7. 00 OTHER SPECIAL CARE (SPECIFY)		47.
Cost Center Description	1.00	
8.00 Program inpatient ancillary service cost (Wkst. D		48.
9.00 Total Program inpatient costs (sum of lines 41 th	4, 595, 853	49.
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program inpatien	s L and 0	50.
		50.
1.00 Pass through costs applicable to Program inpatien	rts II 0	51.
and IV)		50
2.00 Total Program excludable cost (sum of lines 50 an 3.00 Total Program inpatient operating cost excluding		52. 53.
medical education costs (line 49 minus line 52)		33.
TARGET AMOUNT AND LIMIT COMPUTATION		
4.00 Program di scharges		
5.00 Target amount per discharge 5.00 Target amount (line 54 x line 55)	0.00	55. 56.
7.00 Difference between adjusted inpatient operating c		57.
B. 00 Bonus payment (see instructions)		58.
9.00 Lesser of lines 53/54 or 55 from the cost reporti	by the 0.00	59.
market basket D.00 Lesser of lines 53/54 or 55 from prior year cost	0.00	60.
1.00 If line 53/54 is less than the lower of lines 55,		61.
which operating costs (line 53) are less than exp	get	
amount (line 56), otherwise enter zero (see instr 2.00 Relief payment (see instructions)	0	62.
3.00 Allowable Inpatient cost plus incentive payment (63.
PROGRAM INPATIENT ROUTINE SWING BED COST		
4.00 Medicare swing-bed SNF inpatient routine costs th instructions) (title XVIII only)	d (See 288, 537	64.
5.00 Medicare swing-bed SNF inpatient routine costs af	(See 0	65.
instructions)(title XVIII only)		
6.00 Total Medicare swing-bed SNF inpatient routine co	For 288, 537	66.
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient routine cos	period 0	67.
(line 12 x line 19)		07.
8.00 Title V or XIX swing-bed NF inpatient routine cos	ri od 0	68.
(line 13 x line 20) 9.00 Total title V or XIX swing-bed NF inpatient routi	0	69.
PART III - SKILLED NURSING FACILITY, OTHER NURSIN		07.
0.00 Skilled nursing facility/other nursing facility/I		70.
1.00 Adjusted general inpatient routine service cost p		71.
 Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable 		72. 73.
4.00 Total Program general inpatient routine service of		74.
5.00 Capital-related cost allocated to inpatient routi	column	75.
26, line 45) 6.00 Per diem capital-related costs (line 75 ÷ line 2)		76.
6.00 Per diem capital-related costs (line 75 ÷ line 2) 7.00 Program capital-related costs (line 9 x line 76)		77.
8.00 Inpatient routine service cost (line 74 minus lin		78.
9.00 Aggregate charges to beneficiaries for excess cos	70)	79.
 00 Total Program routine service costs for comparison 00 Inpatient routine service cost per diem limitation 	(9)	80. 81.
2.00 Inpatient routine service cost per drem finitation 2.00 Inpatient routine service cost limitation (line 9		82.
8. 00 Reasonable inpatient routine service costs (see i		83.
4.00 Program inpatient ancillary services (see instruc		84.
5.00 Utilization review - physician compensation (see		85. 86
6. 00 Total Program inpatient operating costs (sum of I PART IV - COMPUTATION OF OBSERVATION BED PASS THR		86.
7.00 Total observation bed days (see instructions)		
8.00 Adjusted general inpatient routine cost per diem	1, 088. 82	
9.00 Observation bed cost (line 87 x line 88) (see ins	1, 463, 374	

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		pared: 15 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	509, 714	5, 849, 796	0. 08713	4 1, 463, 374	127, 510	90.00
91.00 Nursing School cost	0	5, 849, 796	0.00000	0 1, 463, 374	0	91.00
92.00 Allied health cost	0	5, 849, 796	0.00000	0 1, 463, 374	0	92.00
93.00 All other Medical Education	0	5, 849, 796	0.00000	0 1, 463, 374	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1330 Component CCN: 15-M330 Title XVIII	Peri od: From 01/01/2016 To 12/31/2016 Subprovi der - I PF	Worksheet D-1 Date/Time Prep 5/26/2017 12: PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~ ~	INPATIENT DAYS			1.550	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 550 1, 550	
00	Private room days (excluding swing-bed and observation bed da		ivate room davs.	1, 330	3.
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observation b		- 01 -6 +6+	1, 550	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				_
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	31 of the cost	0	7.
00	Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)	•		-	
00	Total inpatient days including private room days applicable t newborn days)	the Program (excluding	swing-bed and	357	9.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days)	0	10.
	through December 31 of the cost reporting period (see instruc	tions)	5 /		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.
	through December 31 of the cost reporting period	<u> </u>	3 /	5	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.
. 00	Total nursery days (title V or XIX only)	and (exchading swing bed	uuys)	0	
. 00	Nursery days (title V or XIX only)			0	16.
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ac through December 21 a	f the cost		17.
. 00	reporting period	es thi ough becember 31 0	T the cost		17.
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	c through December 21 of	the cost	0.00	10
. 00	reporting period	in ough becember 31 of	the cost	0.00	17.
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.
. 00	reporting period Total general inpatient routine service cost (see instruction			2, 145, 882	21.
. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	2, 143, 002	
	5 x line 17)	·	0.1		
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23.
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25.
. 00	Total swing-bed cost (see instructions)			0	26.
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 145, 882	27.
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation had a	argoc)	0	28.
. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	and observation bed ch	ai yes)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
. 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	, ,		0.00	35.
. 00	Private room cost differential adjustment (line 3 x line 35)	and polyate many and "	fforonticl (1)	0	
. 00 . 00	Concercial important mouther are descent of C in the interview	and private room cost di	iierentiai (line	2, 145, 882	37.
. 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)				1
. 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
. 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 384. 44 494 - 245	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	e instructions) e 38)		1, 384. 44 494, 245 0	39.

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	ADAMS MEMORI AL		CN: 15-1330	Peri od:	eu of Form CMS- Worksheet D-1	
			CCN: 15-M330	From 01/01/2016 To 12/31/2016	Date/Time Pre	epare
		Title	e XVIII	Subprovider -	5/26/2017 12: PPS	15 p
			1	I PF		-
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00) 42
.00 <u>NURSERY (title V & XIX only)</u> Intensive Care Type Inpatient Hospital U		(<u> </u>			42
. OO INTENSIVE CARE UNIT	0	(0.	0 00	C	
. OO CORONARY CARE UNIT						44
5.00 BURN INTENSIVE CARE UNIT 5.00 SURGICAL INTENSIVE CARE UNIT						45
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description			·		1.00	
.00 Program inpatient ancillary service cost	Wkst D-3 col 3	line 200)			1.00	2 48
0.00 Total Program inpatient costs (sum of li	•		ons)		548, 853	
PASS THROUGH COST ADJUSTMENTS					-	
.00 Pass through costs applicable to Program	n inpatient routine s	ervices (from	n Wkst. D, sur	n of Parts I and	C	50
.00 Pass through costs applicable to Program	n inpatient ancillary	services (fr	rom Wkst. D, s	sum of Parts II	1, 510	51
and IV)			·			
2.00 Total Program excludable cost (sum of li 3.00 Total Program inpatient operating cost e		atad non nh	cician anasti	actict and	1, 510 547, 343	
medical education costs (line 49 minus l		ateu, non-phy	ysi ci all'allesti	letist, and	547, 545	
TARGET AMOUNT AND LIMIT COMPUTATION					1	
1.00 Program discharges 5.00 Target amount per discharge					0.00	
0.00 Target amount (line 54 x line 55)					0.00	
00 Difference between adjusted inpatient op	perating cost and tar	get amount (I	ine 56 minus	line 53)	0	
B. 00 Bonus payment (see instructions)					0	
0.00 Lesser of lines 53/54 or 55 from the cos market basket	st reporting period e	nding 1996, i	updated and co	ompounded by the	0.00	59
0.00 Lesser of lines 53/54 or 55 from prior y	vear cost report, upc	ated by the r	market basket		0.00	60
1.00 If line 53/54 is less than the lower of					0	61
which operating costs (line 53) are less amount (line 56), otherwise enter zero ((lines 54 x	60), or 1% of	f the target		
2.00 Relief payment (see instructions)					0	62
3.00 Allowable Inpatient cost plus incentive		tions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine		bor 21 of the	o cost roporti	na pari ad (Soo	0	64
instructions) (title XVIII only)	costs through becen		e cost report	ng period (see		
5.00 Medicare swing-bed SNF inpatient routine	e costs after Decembe	r 31 of the d	cost reporting	g period (See	C	65
instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inpatient r	routine costs (line A	4 nlus line /	55)(title XVI)	Lonly) For	c c	66
CAH (see instructions)				r only). Tor		100
7.00 Title V or XIX swing-bed NF inpatient ro	outine costs through	December 31 d	of the cost re	eporting period	C	67
line 12 x line 19) 3.00 Title V or XIX swing-bed NF inpatient ro	utine costs after De	cember 31 of	the cost rep	orting period	c	68
(line 13 x line 20)				si ting por ou		
9.00 Total title V or XIX swing-bed NF inpati					0) 69
PART III - SKILLED NURSING FACILITY, OTH D. 00 Skilled nursing facility/other nursing f)	1	70
1.00 Adjusted general inpatient routine servi				,		71
2.00 Program routine service cost (line 9 x l	,	(1)	25)			72
6.00 Medically necessary private room cost ap .00 Total Program general inpatient routine						73
5.00 Capital-related cost allocated to inpati	•			Part II, column		75
26, line 45)						
 00 Per diem capital-related costs (line 75 00 Program capital-related costs (line 9 x 						76
. 00 Inpatient routine service cost (line 74						78
.00 Aggregate charges to beneficiaries for e	excess costs (from pr					79
.00 Total Program routine service costs for	•	st limitation	n (line 78 min	nus line 79)		80
.00 Inpatient routine service cost per diem 2.00 Inpatient routine service cost limitatio						81
00 Reasonable inpatient routine service cost rum tarte	•					83
. 00 Program inpatient ancillary services (se						84
00 Utilization review - physician compensat						85
D. 00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		ouyii 85)			I	86
7.00 Total observation bed days (see instruct					C	87
8.00 Adjusted general inpatient routine cost		line 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)	(see instructions)				1 0) 89

Health Financial Systems	ADAMS MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2016	Worksheet D-1	
		Component (CCN: 15-M330	To 12/31/2016		pared: 15 pm
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	0	2, 145, 882	0.00000	0 0	0	90.00
91.00 Nursing School cost	C	2, 145, 882	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 145, 882	0. 00000	0 0	0	92.00
93.00 All other Medical Education	c	2, 145, 882		0 0	0	93.00

)MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	5/26/2017 12: PPS	15 p
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		5, 652	1 1
00	Inpatient days (including private room days, excluding swing			5, 070	
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	bed days)		3, 726	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	265	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	317	7
	reporting period	<u> </u>			
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Program (evoluding	swing_bed_and	171	9
50	newborn days)		g swillig bed and	171	'
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	5 4 5 1	room days)	0	10
00	through December 31 of the cost reporting period (see instruction of the cost reporting period (see instruction)		and dave) often	0	11
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		room days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period			_	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)			380	
. 00	Nursery days (title V or XIX only)			59	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		1 17
	reporting period	°,			
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	129.14	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	ne)		5, 849, 796	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		tina period (line	3, 049, 790	
	5 x line 17)			-	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportir	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	40, 937	24
	7 x line 19)				- ·
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			329, 474	26
-	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 520, 322	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		·		
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		ctions)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 520, 322	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PARTITE - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
					1
. 00	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 088. 82	
. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	e 38)		1, 088. 82 186, 188 0	39

OMPUT	Financial Systems TATION OF INPATIENT OPERATING COST		Provider (CCN: 15-1330	Peri od:	worksheet D-1	
					From 01/01/2016 To 12/31/2016		pare
				le XIX	Hospi tal	5/26/2017 12: PPS	15 pr
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	501, 353					42.
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT	1, 526, 592	39	3, 835. б	6 4	15, 343	
4.00							44.
5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
00	Program inpatient ancillary service cost (Wks	+ D 2 col 2	Lino 200)			1.00	10
3.00 9.00				nns)		411, 461 690, 834	
. 00	PASS THROUGH COST ADJUSTMENTS		See Thisti detri	51137		0,001	
. 00	Pass through costs applicable to Program inpa	tient routine	services (fro	n Wkst. D, sun	of Parts I and	24, 614	50
						40.007	-
. 00	Pass through costs applicable to Program inpa and IV)	itient anciiiar	y services (T	rom WKST. D, S	sum of Parts II	18, 387	51
2. 00	Total Program excludable cost (sum of lines 5	i0 and 51)				43, 001	52
3. 00	Total Program inpatient operating cost exclud		lated, non-ph	ysician anesth	etist, and	647, 833	
	medical education costs (line 49 minus line 5	52)					
I. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	5					0.00	
. 00	5 I S					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and ta	irget amount (line 56 minus	line 53)	0	57
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period	endi ng 1996,	updated and co	mpounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	ost report, up	dated by the	market basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	0	61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
2.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62
3.00		ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	5 1	s through Dece	ember 31 of th	e cost reporti	ng period (See	0	64
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the	cost reporting	neriod (See	0	65
. 00	instructions) (title XVIII only)				period (See	0	
6. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66
	CAH (see instructions)			C 11			
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	or the cost re	eporting period	0	67
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
0. 00	Skilled nursing facility/other nursing facili		•				70
. 00	Adjusted general inpatient routine service co						71
2. 00	Program routine service cost (line 9 x line 7	/1)					72
. 00	3 31 11						73
1.00 5.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			Part II column		74
5.00	26, line 45)	outine service		WOLKSHEEL D, F	art II, corumn		/ / 3
6. 00	Per diem capital-related costs (line 75 ÷ lir	ne 2)					76
. 00	Program capital-related costs (line 9 x line						77
. 00			rouldor				78
. 00 . 00		• •		· · · · · · · · · · · · · · · · · · ·	us line 70)		80
. 00	Inpatient routine service cost per diem limit				(13) (11) (17)		81
. 00	Inpatient routine service cost limitation (li)				82
. 00	Reasonable inpatient routine service costs (s	ee instruction	· .				83
I. 00	Program inpatient ancillary services (see ins		>				84
5.00	1 3 1						85
6.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS					1	86
7.00	Total observation bed days (see instructions)					1, 344	87
	Adjusted general inpatient routine cost per o		line 2)			1,088.82	
3. 00	Observation bed cost (line 87 x line 88) (see					1, 463, 374	

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		pared: 15 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	509, 714	5, 849, 796	0. 08713	4 1, 463, 374	127, 510	90.00
91.00 Nursing School cost	0	5, 849, 796	0.00000	0 1, 463, 374	0	91.00
92.00 Allied health cost	0	5, 849, 796	0.00000	0 1, 463, 374	0	92.00
93.00 All other Medical Education	0	5, 849, 796	0.00000	0 1, 463, 374	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1330 Component CCN: 15-M330 Title XIX	Peri od: From 01/01/2016 To 12/31/2016 Subprovi der -	Worksheet D-1 Date/Time Prep 5/26/2017 12: PPS	
	Cost Center Description		I PF	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			1, 550	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivata room dave	1, 550 0	2.00 3.00
5.00	do not complete this line.	ys). Ti you have only pi	i vate i oom uays,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		1, 550	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6.00
5.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becenber	ST OF THE COST	0	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.00
	reporting period		1 .6	0	0.00
3. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	in days) after becember 3	I OI THE COST	0	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	106	9.00
	newborn days)				
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e			_	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI. through December 31 of the cost reporting period	X only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14.00 15.00	Medically necessary private room days applicable to the Progr. Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 380	14.00 15.00
16.00	Nursery days (title V or XIX only)			59	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost		
		e through becomen of or	the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	0			
	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t		0.00	20. 0
21. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction	s after December 31 of t s)	he cost	0. 00 2, 145, 882	20. 00 21. 00
21. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t s)	he cost	0.00	20. 00 21. 00
21. 00 22. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) Swing-bed cost applicable to SNF type services after December	s after December 31 of t s) er 31 of the cost report	he cost ing period (line	0. 00 2, 145, 882	20. 00 21. 00 22. 00
21. 00 22. 00 23. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin	he cost ing period (line g period (line 6	0. 00 2, 145, 882 0 0	20. 00 21. 00 22. 00 23. 00
21. 00 22. 00 23. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) Swing-bed cost applicable to SNF type services after December	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin	he cost ing period (line g period (line 6	0. 00 2, 145, 882 0	20. 00 21. 00 22. 00 23. 00
21.00 22.00 23.00 24.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reporti	he cost ing period (line g period (line 6 ng period (line	0. 00 2, 145, 882 0 0	20. 00 21. 00 22. 00 23. 00 24. 00
21.00 22.00 23.00 24.00 25.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reporti	he cost ing period (line g period (line 6 ng period (line	0.00 2,145,882 0 0 0 0	20.00 21.00 22.00 23.00 24.00 25.00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reporti 31 of the cost reporting	he cost ing period (line g period (line 6 ng period (line	0.00 2,145,882 0 0 0	20.00 21.00 22.00 23.00 24.00 25.00 26.00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26)	he cost ing period (line g period (line 6 ng period (line period (line 8	0.00 2,145,882 0 0 0 0 2,145,882	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26)	he cost ing period (line g period (line 6 ng period (line period (line 8	0.00 2,145,882 0 0 0 0 2,145,882 0	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26)	he cost ing period (line g period (line 6 ng period (line period (line 8	0.00 2,145,882 0 0 0 0 2,145,882	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch	he cost ing period (line g period (line 6 ng period (line period (line 8	0.00 2,145,882 0 0 0 0 2,145,882 0 0	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch	he cost ing period (line g period (line 6 ng period (line period (line 8	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0 0 0 0 0 0.00000 0.00	20.00 21.00 22.00 23.00 24.00 25.00 25.00 27.00 28.00 28.00 30.00 31.00 32.00
21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 33. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28)	he cost ing period (line g period (line 6 ng period (line period (line 8	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0 0.00000 0.00000 0.00	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00
21.00 22.00 23.00 24.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc	he cost ing period (line g period (line 6 ng period (line period (line 8	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0 0 0 0.00000 0.00	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00 34. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average per vate room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33) (see instruc ne 31)	he cost ing period (line g period (line 6 ng period (line period (line 8 arges)	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0.00000 0.00 0.00 0.00 0.00 0.	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00 34. 00 35. 00 36. 00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33) (see instruc ne 31)	he cost ing period (line g period (line 6 ng period (line period (line 8 arges)	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00 21.00 22.00 23.00 24.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 34.00 35.00 36.00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33) (see instruc ne 31)	he cost ing period (line g period (line 6 ng period (line period (line 8 arges)	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0.00000 0.00 0.00 0.00 0.00 0.	21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 34.00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 + line 3) Average semi -private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc ne 31) and private room cost di	he cost ing period (line g period (line 6 ng period (line period (line 8 arges)	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0.00000 0.00 0.00 0.00 0.00 0.	20.00 21.00 22.00 23.00 24.00 25.00 25.00 26.00 27.00 28.00 30.00 31.00 33.00 34.00 35.00 36.00
21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services after December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average per diem private room cost differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc ne 31) and private room cost di	he cost ing period (line g period (line 6 ng period (line period (line 8 arges)	0.00 2, 145, 882 0 0 0 0 0 2, 145, 882 0 0 0 0, 000000 0, 00 0, 0000000	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 31. 00 33. 00 34. 00 35. 00 35. 00 37. 00 38. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decembe 5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 + line 3) Average semi -private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	s after December 31 of t s) er 31 of the cost report 31 of the cost reportin r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33) (see instruc ne 31) and private room cost di	he cost ing period (line g period (line 6 ng period (line period (line 8 arges)	0.00 2,145,882 0 0 0 0 0 2,145,882 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00

alth Financial Systems DMPUTATION OF INPATIENT OPERATING COST	ADAMS MEMORIA		CN: 15-1330	Peri od:	eu of Form CMS- Worksheet D-1	
			CCN: 15-M330	From 01/01/2016 To 12/31/2016	Date/Time Pre	epare
			e XIX	Subprovider -	5/26/2017 12: PPS	15 p
Cast Caster Description	Tatal	Tatal		I PF		
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	12
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital L	ni ts	C	0.0	00 0	<u> </u>	42.
3. 00 INTENSIVE CARE UNIT	0	C	0. (0 00	0	43.
4. OO CORONARY CARE UNI T						44.
5. 00 BURN INTENSIVE CARE UNIT						45.
5. 00 SURGI CAL INTENSIVE CARE UNIT 7. 00 OTHER SPECIAL CARE (SPECIFY)						46.
Cost Center Description			1			
3.00 Program inpatient ancillary service cost	(What D 2 col 2	Lipo 200)			1.00	48.
9.00 Total Program inpatient costs (sum of li	•		ons)		179, 162	
PASS THROUGH COST ADJUSTMENTS						
0.00 Pass through costs applicable to Program [111]	n inpatient routine s	ervices (from	n Wkst. D, sur	n of Parts I and	14, 207	50.
1.00 Pass through costs applicable to Program	n inpatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	868	3 51.
and IV)		-			45 075	
2.00 Total Program excludable cost (sum of li 3.00 Total Program inpatient operating cost e		atod non nh	cician anosti	notict and	15, 075 164, 087	
medical education costs (line 49 minus l		ateu, non-phy		letist, and	104,087	53
TARGET AMOUNT AND LIMIT COMPUTATION					-	
1.00 Program discharges 5.00 Target amount per discharge					0.00	
b. 00 Target amount (line 54 x line 55)					0.00	
00 Difference between adjusted inpatient op	perating cost and tar	get amount (I	ine 56 minus	line 53)	0	
B. 00 Bonus payment (see instructions)					0	
0.00 Lesser of lines 53/54 or 55 from the cos market basket	st reporting period e	nding 1996, ι	ipdated and co	ompounded by the	0.00) 59
0.00 Lesser of lines 53/54 or 55 from prior y	vear cost report, upo	ated by the m	arket basket		0.00	60
1.00 If line 53/54 is less than the lower of					0	61
which operating costs (line 53) are less amount (line 56), otherwise enter zero ((lines 54 x	60), or 1% of	f the target		
2.00 Relief payment (see instructions)					c c	62
3.00 Allowable Inpatient cost plus incentive		tions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine		ber 31 of the	cost reporti	na period (See	0	64
instructions) (title XVIII only)	costs through becen			ng period (see		/ 04
5.00 Medicare swing-bed SNF inpatient routine	e costs after Decembe	r 31 of the c	ost reporting	g period (See	C	65
instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inpatient r	routine costs (line A	4 nlus line A	5)(title XVII	Lonly) For	c c	66
CAH (see instructions)				i oniy). Tor		
7.00 Title V or XIX swing-bed NF inpatient ro	outine costs through	December 31 c	of the cost re	eporting period	C	67
line 12 x line 19) 3.00 Title V or XIX swing-bed NF inpatient ro	utine costs after De	cember 31 of	the cost rep	orting period	c	68
(line 13 x line 20)				in this period		
9.00 Total title V or XIX swing-bed NF inpati					0	69
PART III - SKILLED NURSING FACILITY, OTH D. 00 Skilled nursing facility/other nursing f				1	1	70
1.00 Adjusted general inpatient routine servi						71
2.00 Program routine service cost (line 9 x l	,					72
00 Medically necessary private room cost ap 00 Total Program general inpatient routine						73
00 Total Program general inpatient routine 000 Capital-related cost allocated to inpati	•			Part II, column		75
26, line 45)		、 · -··· ·				
5.00 Per diem capital-related costs (line 75 7.00 Program capital-related costs (line 9 x						76
8.00 Inpatient routine service cost (line 74						78
0.00 Aggregate charges to beneficiaries for e		ovi der record	ls)			79
0.00 Total Program routine service costs for	•	st limitation	n (line 78 mir	nus line 79)		80
.00 Inpatient routine service cost per diem .00 Inpatient routine service cost limitatio						81
. 00 Reasonable inpatient routine service cost frimitation	•					82
. 00 Program inpatient ancillary services (se	•					84
5.00 Utilization review - physician compensat						85
D. 00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		ough 85)				86
7.00 Total observation bed days (see instruct					C	87
3. 00 Adjusted general inpatient routine cost		line 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)	(coo instructions)					89

Health Financial Systems	ADAMS MEMORIA	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
		Component (To 12/31/2016		pared: 15 pm
		Titl	e XIX	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				· ·	4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	207, 750	2, 145, 882	0. 09681	3 0	0	90.00
91.00 Nursing School cost	0	2, 145, 882	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 145, 882	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 145, 882	0.00000	0 0	0	93.00

Health Financial Systems ADAMS MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1330	Peri od:	Worksheet D-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre	pared:
	Ti +1 c	e XVIII	Hospi tal	5/26/2017 12: Cost	15 pm
Cost Center Description	IIIIE	Ratio of Cos	st Inpatient	Inpati ent	
cost center bescription		To Charges		Program Costs	
		10 charges		(col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS		1	1, 747, 291		30.00
31. 00 03100 I NTENSI VE CARE UNI T			387, 175		31.00
40. 00 04000 SUBPROVI DER – I PF			4, 941		40.00
43. 00 04300 NURSERY			1, 711		43.00
ANCI LLARY SERVI CE COST CENTERS		1			40.00
50. 00 05000 OPERATI NG ROOM		0. 5469	48 124, 510	68, 100	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		2. 2436		0	52.00
53.00 05300 ANESTHESI OLOGY		0.0000		0	1
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1834		80, 561	54.00
60, 00 06000 LABORATORY		0. 2484		282, 574	
65. 00 06500 RESPI RATORY THERAPY		0. 2640			
66. 00 06600 PHYSI CAL THERAPY		0. 4458		70, 180	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 5556		62, 371	
68. 00 06800 SPEECH PATHOLOGY		0. 4706		27, 723	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.7405		737, 834	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0.0000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2859		409, 864	73.00
76. 00 03020 0P PSYCH		0.9612		0	76.00
OUTPATIENT SERVICE COST CENTERS		0.7012	70 0	0	/0.00
90. 00 09000 CLINIC		0. 4278	27 361	154	90.00
90. 01 09001 CLINIC - AMO		0. 2432		0	90.01
90. 02 09002 CLINIC - AMH NEURO		0.8500		0	90.02
90. 03 09003 CLINIC - NIGLIAZZO		0. 3258		0	90.02
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH		8. 2340		0	90.03
91. 00 09100 EMERGENCY		1. 2105	· ·	-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6656			92.00
OTHER REIMBURSABLE COST CENTERS		0.0050	40 20, 134	10,727	92.00
95. 00 09500 AMBULANCE SERVICES					95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000	00 0	0	
200.00 Total (sum of lines 50-94 and 96-98)		0.0000	5, 739, 774	2, 093, 142	
201.00 Less PBP Clinic Laboratory Services-Program only charge	ues (line 61)		0, 737, 774	2,075,142	200.00
202.00 Net Charges (line 200 minus line 201)			5, 739, 774		201.00
		1	0,107,114	I	1202.00

Health Financial Systems ADAMS MEMORIA				u of Form CMS-:	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1330	Period:	Worksheet D-3	5
	Component	CCN: 15-M330	From 01/01/2016 To 12/31/2016	Date/Time Pre	narod
	component	CCN. 13-W330	10 12/31/2010	5/26/2017 12:	15 pm
	Title	e XVIII	Subprovider -	PPS	
			I PF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVIDER - IPF			452, 540		40.00
43. 00 O4300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.54(0	48 0	0	1 50 00
50. 00 05000 OPERATING ROOM		0. 5469 2. 2436		-	
52. 00 05200 DELIVERY ROOM & LABOR ROOM				0	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI 0L0GY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 1834 0. 2484		2, 573	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY		0. 2484		12, 744 4, 465	
66. 00 06600 PHYSICAL THERAPY		0. 2840		4, 465	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4458		100	
68. 00 06800 SPEECH PATHOLOGY		0. 5556		0	
69. 00 06900 SELECT FATIBLOGT		0. 4700		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.7405		4, 589	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0000		4, 309	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2859		30, 137	
76. 00 03020 OP PSYCH		0.9612		0	
OUTPATI ENT SERVICE COST CENTERS		0.7012	, 0	Ŭ	/0.00
90. 00 09000 CLINIC		0. 4278	27 0	0	90.00
90. 01 09001 CLINIC - AMO		0. 2432		0	
90. 02 09002 CLINIC - AMH NEURO		0.8500		0	
90. 03 09003 CLINIC - NIGLIAZZO		0. 3258		0	
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH		8. 2340		0	
91. 00 09100 EMERGENCY		1. 2105	96 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6656	45 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			· ·	-	1
95. 00 09500 AMBULANCE SERVICES					95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000	00 0	0	97.00
200.00 Total (sum of lines 50-94 and 96-98)			194, 011	54, 608	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		1	194, 011		202.00

	MEMORIAL HOSPITAL			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1330	Period: From 01/01/2016	Worksheet D-3	
	Component	CCN: 15-Z330	To 12/31/2016		nared
	component	CON. 15 2550	10 12/31/2010	5/26/2017 12:	
	Title	XVIII	Swing Beds - SNI	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		1	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.0
31.00 03100 INTENSIVE CARE UNIT			0		31.0
40. 00 04000 SUBPROVIDER - IPF			0		40.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS		1		I	
50. 00 05000 OPERATI NG ROOM		0. 5469			
52.00 05200 DELIVERY ROOM & LABOR ROOM		2. 2436			
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1834			
60. 00 06000 LABORATORY		0. 2484			60.0
65. 00 06500 RESPI RATORY THERAPY		0. 2640		3, 837	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 4458	66 75, 095	33, 482	66.0
67. 00 06700 OCCUPATI ONAL THERAPY		0. 5556	57 64, 358	35, 761	67.0
68.00 06800 SPEECH PATHOLOGY		0. 4706	15 2, 440	1, 148	68.0
69. 00 06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.7405	24 29, 573	21, 900	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0000	00 0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2859	33 104, 839	29, 977	73.0
76.00 03020 OP PSYCH		0. 9612			76.0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 4278	27 0	0	90.0
90.01 09001 CLINIC - AMO		0. 2432	34 0	0	90.0
90. 02 09002 CLINIC - AMH NEURO		0.8500	44 0	0	90.0
90. 03 09003 CLINIC - NIGLIAZZO		0. 3258	70 0	0	90.0
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH		8. 2340	82 0	0	90.0
91. 00 09100 EMERGENCY		1. 2105	96 0	0	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6656		0	92.0
OTHER REIMBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVICES					95.0
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000	00 O	0	97.0
200.00 Total (sum of lines 50-94 and 96-98)		1	341, 905	138, 887	
201.00 Less PBP Clinic Laboratory Services-Program onl	y charges (line 61)		0		201.0
202.00 Net Charges (line 200 minus line 201)	5 5	1	341, 905	1	202.0

Health Financial Systems A	ADAMS MEMORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1330	Peri od:	Worksheet D-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/26/2017 12:	pared:
	Ti +1	e XIX	Hospi tal	PPS	<u>15 piii</u>
Cost Center Description		Ratio of Cos		Inpati ent	
COST CENTER DESCRIPTION		To Charges	Program	Program Costs	
		l io shargos		$(col \cdot 1 \times col \cdot$	
			51121 955	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			333, 374		30.00
31. 00 03100 I NTENSI VE CARE UNI T			39, 240		31.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
43. 00 04300 NURSERY			38, 783		43.00
ANCI LLARY SERVI CE COST CENTERS		•			1
50. 00 05000 OPERATI NG ROOM		0. 5469	48 50, 578	27, 664	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		2. 2436	29 30, 643	68, 752	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000	0 00	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1834	41 80, 106	14, 695	54.00
60. 00 06000 LABORATORY		0. 2484	22 254, 468	63, 215	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 2640	30 109, 399	28, 890	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4458	56 3, 342	1, 490	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 5556		999	67.00
68.00 06800 SPEECH PATHOLOGY		0. 4706	15 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	0 00	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7405	24 72, 070	53, 370	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0000	0 00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2859	33 368, 231	105, 289	73.00
76.00 03020 OP PSYCH		0. 9612	76 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 4278	27 0	0	90.00
90.01 09001 CLINIC - AMO		0. 2432	34 0	0	90.01
90.02 09002 CLINIC - AMH NEURO		0.8500	44 0	0	90.02
90. 03 09003 CLINIC - NIGLIAZZO		0. 3258	70 0	0	90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH		8. 2340	32 0	0	90.04
91.00 09100 EMERGENCY		1. 2105	38, 904	47, 097	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6656	45 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000	0 00	0	97.00
200.00 Total (sum of lines 50-94 and 96-98)			1, 009, 538	411, 461	200.00
201.00 Less PBP Clinic Laboratory Services-Progra	am only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			1, 009, 538		202.00

Health Financial Systems ADAMS MEMORIAL H	IOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1330	Peri od:	Worksheet D-3	
	Component	CON. 15 M220	From 01/01/2016	Data /Tima Dra	norod.
	component	CCN: 15-M330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	15 nm
	Ti tl	e XIX	Subprovider -	PPS	
			I PF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	5	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		30.00
40. 00 04000 SUBPROVI DER - I PF			496, 427		40.00
43. 00 04300 NURSERY			470, 427		43.00
ANCI LLARY SERVI CE COST CENTERS		1	0		43.00
50. 00 05000 OPERATI NG ROOM		0. 5469	48 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		2. 2436			
53. 00 05300 ANESTHESI OLOGY		0.0000		-	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1834			54.00
60. 00 06000 LABORATORY		0. 2484			60.00
65. 00 06500 RESPI RATORY THERAPY		0. 2640		2,686	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4458	66 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 5556	57 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 4706	15 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 7405		1, 987	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0000		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2859			
76.00 03020 OP PSYCH		0. 9612	76 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			[-	
90. 00 09000 CLINIC		0. 4278			
90. 01 09001 CLINIC - AMO		0. 2432		-	90.01
90. 02 09002 CLINIC - AMH NEURO		0.8500		-	90.02
90. 03 09003 CLINIC - NIGLIAZZO		0. 3258		0	90.03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH 91. 00 09100 EMERGENCY		8. 2340 1. 2105			
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6656		437	91.00 92.00
OTHER REIMBURSABLE COST CENTERS		0.0050	45 0	0	92.00
95. 00 09500 AMBULANCE SERVICES					95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000	0	0	
200.00 Total (sum of lines 50-94 and 96-98)		0.0000	113, 973		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	()		113, 973		202.00

Health Financial Systems	ADAMS MEMORIAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1330	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z330	From 01/01/2016 To 12/31/2016		
	Titl	e XIX	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0.5460	48 0	0	F0 00
		0.5469		-	50.00
		2.2436		0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0000 0. 1834		0	53.00 54.00
60. 00 06000 LABORATORY		0. 1834		0	
65. 00 06500 RESPIRATORY THERAPY		0. 2484		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 2840		-	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4458		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 3330		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 0000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.7405		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2859		-	73.00
76.00 03020 OP PSYCH		0.9612			76.00
OUTPATIENT SERVICE COST CENTERS		0.7012	/0 0	۰ ۱	/0.00
90. 00 09000 CLINIC		0. 4278	27 0	0	90.00
90. 01 09001 CLINIC - AMO		0. 2432			
90. 02 09002 CLINIC - AMH NEURO		0.8500			90.02
90. 03 09003 CLINIC - NIGLIAZZO		0. 3258		0	90.03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH		8, 2340			90.04
91. 00 09100 EMERGENCY		1. 2105	· · · · · · · · · · · · · · · · · · ·	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6656			
OTHER REIMBURSABLE COST CENTERS			<u> </u>		1
95. 00 09500 AMBULANCE SERVICES					95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000	00 00	0	
200.00 Total (sum of lines 50-94 and 96-98)			0		200.00
201.00 Less PBP Clinic Laboratory Services-Progr	ram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	· · · · · ·		0		202.00

	Financial Systems ADAMS MEMORIAL			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2016	Worksheet E Part B	
			To 12/31/2016		
		Title XVIII	Hospi tal	Cost	15 pili
			• • •		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			5, 093, 556	1.00
2.00	Medical and other services reimbursed under OPPS (see instru	ictions)		0	2.00
3.00 4.00	PPS payments Outlier payment (see instructions)			0	3.00 4.00
4.00 5.00	Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	
6.00	Line 2 times line 5	<i>,</i>		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	LV col 13 line 200		0	8.00 9.00
10.00	Organ acquisitions	1V, col. 13, 111e 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 093, 556	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
	Total reasonable charges (sum of lines 12 and 13)	,		0	
	Customary charges				
15.00 16.00	Aggregate amount actually collected from patients liable for		0	0	15.00 16.00
10.00	Amounts that would have been realized from patients liable f had such payment been made in accordance with 42 CFR §413.13		ni a charyebasis	0	10.00
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 o instructions)	nly if line 18 exceeds li	ne 11) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete o	nlvifline 11 exceeds li	ne 18) (see	0	20.00
20100	instructions)		110 10) (000	Ũ	20100
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH s	ee instructions)		5, 144, 492	
22.00 23.00	Interns and residents (see instructions)	tructions)		0	22.00 23.00
	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 8 and 9)	structions)		0	23.00
21100	COMPUTATION OF REIMBURSEMENT SETTLEMENT				21100
25.00	Deductibles and coinsurance (for CAH, see instructions)			66, 960	
26.00	Deductibles and Coinsurance relating to amount on line 24 (f			2, 340, 216	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	2 and 23] (see	2, 737, 316	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2, 737, 316 630	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			2, 736, 686	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	I CES)		2,700,000	02100
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			227, 966	
35.00 36.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		148, 178 227, 966	
37.00	Subtotal (see instructions)			2, 884, 864	37.00
	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50 39. 98	Pioneer ACO demonstration payment adjustment (see instructio Partial or full credits received from manufacturers for repl	2	tions)	0	39.50 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2, 884, 864	
40.01	Sequestration adjustment (see instructions)			57, 697	40.01
41.00 42.00	Interim payments Tentative settlement (for contractors use only)			2, 637, 690 0	41.00 42.00
42.00	Balance due provider/program (see instructions)			189, 477	
44.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	1
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
93.00	5 .			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	F	Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
		I npati ent	t Part A	Par	tВ	
		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, 557, 532		2, 506, 090	1.00
2.00	Interim payments payable on individual bills, either		(D	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
3.01	Program to Provider ADJUSTMENTS TO PROVIDER	08/01/2016	253, 300	0 08/01/2016	131, 600	3. 01
3.02		00/01/2010	200, 000		0	3. 02
3.03			(0	3.03
3.04			()	0	3. 04
3.05)	0	3.05
	Provider to Program	1 1				
3.50 3.51	ADJUSTMENTS TO PROGRAM		(0	3.50 3.51
3.51			(0	3. 52
3.52			(0	3. 53
3.54			(þ	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		253, 300	D	131, 600	3.99
	3. 50-3. 98)				o (o च (o o	
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		3, 810, 832	2	2, 637, 690	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR			1		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVIDER		()	0	5.01
5.02			(0	5.02
5.03			()	0	5.03
	Provider to Program	,		1		
5.50	TENTATI VE TO PROGRAM		(0	5.50 5.51
5.51 5.52			(0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines		(0	5.99
	5. 50-5. 98)				-	
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)		0/0 70	_	400 477	
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		363, 785		189, 477	6. 01 6. 02
6.02 7.00	Total Medicare program liability (see instructions)		4, 174, 617		0 2, 827, 167	6.0∠ 7.00
,			4, 174, 01.	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component (CN: 15-1330 CCN: 15-M330	Period: From 01/01/2010 To 12/31/2010		epared
		Title	XVIII	Subprovider -	PPS	
		Inpatien	t Part A		rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
0.0		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		272, 9	0	C	2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	
04 05				0		
05	Provider to Program			0		<u> </u>
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0) 3
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		272, 9	05	0	
00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		212, 9	95		4
	TO BE COMPLETED BY CONTRACTOR					ł.,
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
51	Program to Provider TENTATIVE TO PROVIDER		-	0	0	
01 02	TENTATIVE TO PROVIDER			0		
03				0		
	Provider to Program		I			
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	C	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		13, 1	30	0	
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		286, 1		0) 7
				Contractor Number	NPR Date (Mo/Day/Yr)	
)		(-

VALY	Financial Systems ADAMS MEMORI/ SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED ADAMS MEMORI/	Provider C	CN: 15-1330	Period: From 01/01/2016	Worksheet E-1 Part I	
		Component (CCN: 15-Z330	To 12/31/2016		pareo
		Title	× XVIII	Swing Beds - SNI		15 pi
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		465, 65	56	0	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				-	
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	
04 05				0	0	
05	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM		1	0	0	3
51				0	0	
52				0	0	
53				0	0	3
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3
~~	3.50-3.98)		4/5 /1	- /	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		465, 65	00	0	4
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1		1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER		1	0	0	5
02	TENTATIVE TO FROVIDER			0	0	
03				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
99	5. 50-5. 98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		49, 23	34	0	
00	Total Medicare program liability (see instructions)		416, 42		0	
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr)	
00	Name of Contractor	(J	1.00	2.00	8

Heal th	Financial Systems ADAMS MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1330 Period:				
			From 01/01/2016 To 12/31/2016		parod
			10 12/31/2010	5/26/2017 12:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	5			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT				
1.00	Total hospital discharges as defined in AARA §4102 from W		e 14	1, 597	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12		1, 794	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			668	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	1, 8-12		4, 124	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			92, 352, 687	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.			178, 551	6.00
7.00	CAH only - The reasonable cost incurred for the purchase (of certified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions	5)		0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00 10.00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00 31. 00
	31.00 Other Adjustment (specify)				
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	nd line 31) (see instructior	is)	0	32.00

Heal th	Financial Systems AI	DAMS MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1330 Component CCN: 15-Z330	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Pre 5/26/2017 12:	pared:
		Title XVIII	Swing Beds - SNF		
			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)	291, 422	0	1.00
2.00	Inpatient routine services - swing bed-NF (see i	nstructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line	200, for Part A, and sum of Wkst. D,	140, 276	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (Fo	or CAH, see instructions)			
4.00	Per diem cost for interns and residents not in a	ipproved teaching program (see		0.00	4.00
	instructions)				
5.00	Program days		265	0	5.00
6.00	Interns and residents not in approved teaching p	orogram (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SN		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6	and 7)	431, 698	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		431, 698	0	10.00
11.00	Deductibles billed to program patients (exclude professional services)	amounts applicable to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		431, 698	0	12.00
13.00	Coinsurance billed to program patients (from pro for physician professional services)	ovi der records) (excl ude coi nsurance	7, 406	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	e 13, or line 14)	424, 292	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (se	e instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		966	0	17.00
17.01	Adjusted reimbursable bad debts (see instruction		628	0	17.01
18.00	Allowable bad debts for dual eligible beneficiar	ies (see instructions)	966	0	18.00
19.00	Total (see instructions)		424, 920	0	19.00
19.01	Sequestration adjustment (see instructions)		8, 498	0	19.01
20.00	Interim payments		465, 656	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus line	es 19.01, 20, and 21)	-49, 234	0	22.00
23.00	Protested amounts (nonallowable cost report item chapter 1, §115.2	ns) in accordance with CMS Pub. 15-2,	0	0	23.00

Heal th	Financial Systems ADAMS MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1330	Peri od:	Worksheet E-2	2
		Component CCN, 15, 7000	From 01/01/2016	Data /Tima Dra	norod.
		Component CCN: 15-Z330	To 12/31/2016	Date/Time Pre 5/26/2017 12:	
		Title XIX	Swing Beds - SNF		10 pm
			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)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		0		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in				
4.00	Per diem cost for interns and residents not in approved teach	ing program (see	0.00		4.00
F 00	instructions)				F 00
5.00	Program days		0		5.00
6.00	Interns and residents not in approved teaching program (see i		0		6.00
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8.00
9.00	Primary payer payments (see instructions)		0		9.00
10.00 11.00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts appli	apple to physician	0		10.00
11.00	professional services)	cable to physician	0		11.00
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0		13.00
10.00	for physician professional services)		Ŭ		10.00
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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instruction	s)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0		18.00
19.00	Total (see instructions)		0		19.00
19.01	Sequestration adjustment (see instructions)		0		19.01
20.00	Interim payments		0		20.00
21.00	Tentative settlement (for contractor use only)		0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20,		0		22.00
23.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0		23.00
	chapter 1, §115.2				1

	2	AL HOSPITAL		u of Form CMS-2		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Pre 5/26/2017 12:	pared:	
		Title XVIII	Hospi tal	Cost	ro pii	
			illoopi tui	0001		
				1.00		
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COST	REIMBURSEMENT			
1.00	Inpatient services			4, 595, 853	1.00	
2.00	Nursing and Allied Health Managed Care payment (see instru	ctions)		0		
3.00	Organ acqui si ti on			0		
4.00	Subtotal (sum of lines 1 through 3)			4, 595, 853		
5.00	Primary payer payments			0		
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		4, 641, 812	6.00	
	COMPUTATION OF LESSER OF COST OR CHARGES				-	
	Reasonabl e charges					
7.00	Routine service charges			0	7.00	
8.00	Ancillary service charges			0		
9.00 10.00	Organ acquisition charges, net of revenue Total reasonable charges			0		
10.00	Customary charges			0	10.00	
11.00	Aggregate amount actually collected from patients liable f	or navment for services on	a charge basis	0	11.00	
12.00	Amounts that would have been realized from patients liable	1 5	5	0		
12.00	had such payment been made in accordance with 42 CFR 413.1		in a charge basis	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			
15.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	15.00	
	instructions)	5	, ,			
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	ie 14) (see	0	16.00	
	instructions)					
17.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17.00	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0		
19.00	Cost of covered services (sum of lines 6, 17 and 18)			4, 641, 812		
20.00 21.00	Deductibles (exclude professional component)			417, 256 0		
21.00	Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21)			4, 224, 556		
22.00	Coi nsurance			4, 224, 556 8, 050		
23.00	Subtotal (line 22 minus line 23)			4, 216, 506	1	
25.00	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		66, 626		
26.00	Adjusted reimbursable bad debts (see instructions)			43, 307		
27.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		66, 626	1	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4, 259, 813		
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		
29.50	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	29.50	
29.99	Recovery of Accel erated Depreciation	0				
30.00						
30. 01						
31.00						
32.00	Tentative settlement (for contractor use only)			0		
33.00	Balance due provider/program (line 30 minus lines 30.01, 3			363, 785		
34.00	Protested amounts (nonallowable cost report items) in acco	rdance with CMS Dub 15 2	chaptor 1	0	34.00	

		RIAL HOSPITAL			2552
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2016	Worksheet E-3 Part II	
		Component CCN: 15-M330	To 12/31/2016		
		Title XVIII	Subprovider -	PPS	<u>15 p</u>
				1.00	
	PART II – MEDICARE PART A SERVICES – IPF PPS			1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	d medical education payments)		317, 231	1.
. 00	Net IPF PPS Outlier Payments			6, 418	2.
. 00	Net IPF PPS ECT Payments		с. N. I	0	3.
. 00	Unweighted intern and resident FTE count in the most rece	ent cost report filed on or b	efore November	0.00	4.
l. 01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE	count for residents that wer	e displaced by	0.00	4.
. 01	program or hospital closure, that would not be counted wi			0.00	<u>_</u>
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	······································			
5.00	New Teaching program adjustment. (see instructions)			0.00	5.
. 00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth p	eriod of a "new	0.00	6.
	teaching program" (see instuctions)				
. 00	Current year's unweighted I&R FTE count for residents wit	thin the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instuctions)				
. 00	Intern and resident count for IPF PPS medical education a	adjustment (see instructions)		0.00	8
. 00	Average Daily Census (see instructions)			4.234973	
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	a to the power of .5150 -1}.		0.000000	
1.00 2.00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and	11)		0	11 12
2.00 3.00	Nursing and Allied Health Managed Care payment (see inst			323, 649 0	12
1. 00	Organ acquisition (DO NOT USE THIS LINE)			0	14
5.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	15
5.00	Subtotal (see instructions)			323, 649	
7.00	Primary payer payments			020,017	17
3.00	Subtotal (line 16 less line 17).			323, 649	
9.00	Deducti bl es			45, 080	
0. 00	Subtotal (line 18 minus line 19)			278, 569	20
I. 00	Coinsurance			0	21
2.00	Subtotal (line 20 minus line 21)			278, 569	22
3.00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		20, 608	
1.00	Adjusted reimbursable bad debts (see instructions)			13, 395	
5.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		20, 608	25
b. 00	Subtotal (sum of lines 22 and 24)			291, 964	26
7.00	Direct graduate medical education payments (from Wkst. E-	-4, line 49)		0	27
8.00	Other pass through costs (see instructions)			0	28
9.00	Outlier payments reconciliation			0	29
). 00). 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruc	stions)		0	30 30
). 50). 99	Recovery of Accel erated Depreciation			0	30
1.00	Total amount payable to the provider (see instructions)			291, 964	
1.01	Sequestration adjustment (see instructions)			5, 839	
2.00	Interim payments			272, 995	
3.00	Tentative settlement (for contractor use only)			0	
4.00	Balance due provider/program (line 31 minus lines 31.01,	32 and 33)		13, 130	
5.00	Protested amounts (nonallowable cost report items) in acc §115.2		chapter 1,	0	35
	TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount from Worksheet E-3, Part II, line			6, 418	
1.00	Outlier reconciliation adjustment amount (see instruction	าร)		0	51
2.00	The rate used to calculate the Time Value of Money			0.00	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-1330	Period: From 01/01/2016 To 12/31/2016		
		General Fund	Specific Purpose Func		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	536, 428		0 0	0	1.
00	Temporary investments	0		0 0	0	2.
00	Notes receivable	0		0 0	-	
00	Accounts receivable	21, 043, 860		0 0	0	
00	Other receivable	-7, 938, 760		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-9, 588, 768		0 0	0	
00 00	Inventory Prepaid expenses	638, 401		0 0	0	
00	Other current assets	191, 457 94, 263		0 0	0	
00	Due from other funds	, 203		0 0		
00	Total current assets (sum of lines 1-10)	4, 976, 881		0 0		
00	FIXED ASSETS	17 77 67 66 1		<u> </u>		1
00	Land	367, 244		0 0	0	12
00	Land improvements	1, 613, 861		0 0	0	13
00	Accumulated depreciation	-1, 407, 079		0 0	0	14
	Bui I di ngs	40, 366, 746		0 0	0	
	Accumulated depreciation	-17, 080, 163		0 0	0	
00	Leasehold improvements	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
00 00	Fixed equipment Accumulated depreciation	4, 614, 940		0 0	0	
	Automobiles and trucks	-2, 639, 266		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	24, 244, 457		0 0	0	
	Accumulated depreciation	-19, 576, 555		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
00	HIT designated Assets	0		0 0	0	27
00	Accumulated depreciation	0		0 0	0	28
00	Mi nor equipment-nondepreciable	0		0 0	0	29
00	Total fixed assets (sum of lines 12-29)	30, 504, 185		0 0	0	30
~ ~	OTHER ASSETS					1
	Investments	7, 069, 363		0 0	-	
00 00	Deposits on Leases Due from owners/officers	0		0 0	0	
00	Other assets	0		0 0	0	
00	Total other assets (sum of lines 31-34)	7, 069, 363		0 0		
00	Total assets (sum of lines 11, 30, and 35)	42, 550, 429		0 0		
00	CURRENT LIABILITIES	12,000,127		<u> </u>		
00	Accounts payable	1, 237, 370		0 0	0	37
00	Salaries, wages, and fees payable	2, 859, 450		0 0	0	38
00	Payroll taxes payable	282, 120		0 0	0	39
00	Notes and loans payable (short term)	0		0 0	0	40
00	Deferred income	0		0 0	0	
00	Accelerated payments	0				42
00	Due to other funds	0		0 0	0	
	Other current liabilities	2, 164, 412		0 0	-	
00	Total current liabilities (sum of lines 37 thru 44)	6, 543, 352		0 0	0	45
00	LONG TERM LIABILITIES Mortgage payable	31, 177, 428		0 0	0	46
00	Notes payable	51, 177, 420 N		0 0		
00	Unsecured Loans	0		0 0	0	
	Other long term liabilities	211, 271		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	31, 388, 699		0 0	-	
00	Total liabilities (sum of lines 45 and 50)	37, 932, 051		0 0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	4, 618, 378				52
00	Specific purpose fund			0	1	53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0	-	56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion				1	1
00	Total fund balances (sum of lines 52 thru 58)	4, 618, 378		0 0	0	59

Heal th	Financial Systems	ADAMS MEMORIAL	. HOSPI TAL			In Lie	u of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES			Provider CCN: 15-1330		Period: From 01/01/2016			
					То	12/31/2016	Date/Time Pre 5/26/2017 12:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
1 00	Fund halanage at heginning of namind	1.00	2.00	3.00		4.00	5.00	1.00
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		6, 949, 867 -2, 269, 647			0		2.00
3.00	Total (sum of line 1 and line 2)		4, 680, 220			0		3.00
4.00	Additions (credit adjustments) (specify)	0	.,,		0	-	0	
5.00		0			0		0	
6.00		0			0		0	
7.00		0			0		0	
8.00 9.00		0			0		0	
10.00	Total additions (sum of line 4-9)	0	0		0	0	0	10.00
11.00	Subtotal (line 3 plus line 10)		4, 680, 220			0		11.00
12.00	CHANGE IN PY FUND BALANCE	61, 842	.,,		0	-	0	1
13.00		0			0		0	13.00
14.00		0			0		0	
15.00		0			0		0	
16.00		0			0		0	
17.00 18.00	Total deductions (sum of lines 12-17)	0	61, 842		0	0	0	17.00 18.00
18.00	Fund balance at end of period per balance		4, 618, 378			0		19.00
17.00	sheet (line 11 minus line 18)		1, 010, 070			Ũ		17.00
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00	_			
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00 6.00			0					5.00 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	CHANGE IN PY FUND BALANCE		0					12.00
13.00 14.00			0					13.00
14.00 15.00			0					14.00
16.00			0					16.00
17.00			0					17.00
18.00	Total deductions (sum of lines 12-17)	0	Ű		0			18.00
19.00	Fund balance at end of period per balance	0			0			19.00
	sheet (line 11 minus line 18)							

	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN:	15-1330	Pei	ri od:	Worksheet G-2	2552-10
				10 1000		om 01/01/2016	Parts I & II Date/Time Pre	pared:
	Cast Cantan Description			1		0	5/26/2017 12:	15 pm
	Cost Center Description			Inpatient 1.00		Outpatient 2.00	<u>Total</u> 3.00	
	PART I – PATIENT REVENUES			1.00		2.00	3.00	
	General Inpatient Routine Services							-
1.00	Hospi tal		- T	5, 612, 6	55		5, 612, 655	1.00
2.00	SUBPROVIDER - IPF			2,077,2			2,077,227	
3.00	SUBPROVIDER - IRF			2,011,2	~ '		2,011,221	3.00
4.00	SUBPROVIDER							4.00
5.00	Swing bed - SNF				0		0	
6.00	Swing bed - NF				0		0	
7.00	SKILLED NURSING FACILITY				0		0	
8.00	NURSI NG FACI LI TY				-		-	8.00
9.00	OTHER LONG TERM CARE							9.00
10.00	Total general inpatient care services (sum of lines 1-9)			7, 689, 8	82		7, 689, 882	
	Intensive Care Type Inpatient Hospital Services				-			
11.00	INTENSIVE CARE UNIT			831, 6	15		831, 615	11.00
12.00	CORONARY CARE UNI T							12.00
13.00	BURN INTENSIVE CARE UNIT							13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T							14.00
15.00	OTHER SPECIAL CARE (SPECIFY)							15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		831, 6	15		831, 615	16.00
	11-15)							
17.00	Total inpatient routine care services (sum of lines 10 and 16)		8, 521, 49	97		8, 521, 497	17.00
18.00	Ancillary services			11, 084, 59	92	50, 985, 390	62, 069, 982	18.00
19.00	Outpatient services			296, 70	07	14, 877, 241	15, 173, 948	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					0	0	22.00
23.00	AMBULANCE SERVICES				0	2, 611, 322	2, 611, 322	23.00
24.00	СМНС							24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)							25.00
26.00	HOSPI CE				0	0	0	
27.00	TRANSPORTATION REVENUE				0	9, 184	9, 184	
27.01	RX REVENUE			3, 912, 6	80	4, 403, 419	8, 316, 099	
27.02	OTHER				57	3, 138, 744	3, 138, 801	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.		23, 815, 5	33	76, 025, 300	99, 840, 833	28.00
	G-3, line 1)							
	PART II - OPERATING EXPENSES							
29.00	Operating expenses (per Wkst. A, column 3, line 200)					53, 216, 580		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 (SPECI FY)				0			37.00
38.00 39.00					0			38.00
202 (11)					0			39.00
					0			40.00
40.00			1					
40. 00 41. 00					0			41.00
40.00	Total deductions (sum of lines 37–41) Total operating expenses (sum of lines 29 and 36 minus line 4				0	0 53, 216, 580		41.00 42.00 43.00

Heal th	Financial Systems	ADAMS MEMORIAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-	-1330	Peri od:	Worksheet G-3	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	norod.
					10 12/31/2016	5/26/2017 12:	
1						1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part					99, 840, 833	1.00
2.00	Less contractual allowances and discounts or	n patrents' account	S			52, 851, 166	
3.00	Net patient revenues (line 1 minus line 2)		•			46, 989, 667	
4.00	Less total operating expenses (from Wkst. G-		3)			53, 216, 580	
5.00	Net income from service to patients (line 3	minus line 4)				-6, 226, 913	5.00
	OTHER I NCOME				1	530.054	6 00
6.00	Contributions, donations, bequests, etc					572, 251	
7.00	Income from investments					219, 797	
8.00	Revenues from telephone and other miscellane	eous communication	servi ces			0	
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					0	10.00
11.00	Rebates and refunds of expenses					0	11.00
12.00	5					0	12.00
13.00						0	
14.00		ests				448, 232	
15.00						0	15.00
16.00	Revenue from sale of medical and surgical su	upplies to other th	an patients			0	16.00
17.00	Revenue from sale of drugs to other than pat	tients				606, 060	17.00
18.00	Revenue from sale of medical records and abs	stracts				25, 363	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen				0	20.00
21.00	Rental of vending machines					0	21.00
22.00	Rental of hospital space					280, 246	22.00
23.00	Governmental appropriations					0	23.00
24.00	MISC					213, 882	24.00
24.01	CEDIT INCOME					1, 348, 152	24.01
24.02	FI TNESS REVENUE					103, 804	24.02
24.03	MANAGEMENT REVENUE					139, 479	24.03
25.00	Total other income (sum of lines 6-24)					3, 957, 266	
	Total (line 5 plus line 25)					-2, 269, 647	
	OTHER EXPENSES (SPECI FY)					0	
		oscripts)				0	28.00
	Net income (or loss) for the period (line 26					-2, 269, 647	
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