

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 3:26 pm
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/30/2017 Time: 3:26 pm

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CENTERPOINT HOSPITAL (26-4012) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-266,066	-262,013	0	1,718,617	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-266,066	-262,013	0	1,718,617	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 3:24 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 4801 WELDON SPRINGS PARKWAY	PO Box:						1.00		
2.00	City: ST. CHARLES	State: MO	Zip Code: 63304	County: ST. CHARLES				2.00		
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	CENTERPOINTE HOSPITAL	264012	41180	4	12/31/1980	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2016	12/31/2016		20.00	
21.00	Type of Control (see instructions)					4			21.00	
<u>Inpatient PPS Information</u>										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 3:24 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N		N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.20
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N		63.00
		Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
				1.00	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V	XIX				
		1.00	2.00				
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00		
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00		
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00		
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	103,110	0	0		118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02		
119.00	DO NOT USE THIS LINE			119.00			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00		
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00		
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00			
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00			
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00			
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 3:24 pm
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 3:24 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/09/2017	N	05/09/2017		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 3:24 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 3:24 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 3:24 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	104	38,064	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		104	38,064	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		104	38,064	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	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)		104			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 3:24 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,611	3,164	38,010			1.00
2.00 HMO and other (see instructions)	1,360	1,007				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	7,611	3,164	38,010			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	7,611	3,164	38,010	0.00	328.12	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	328.12	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					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	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 3:24 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	616	302	4,670	1.00
2.00 HMO and other (see instructions)				156	113		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	616	302		4,670	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC	0.00						25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		301,471	301,471	2,505,455	2,806,926	1.00
2.00	00200		722,510	722,510	414,555	1,137,065	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	202,094	5,030,737	5,232,831	-4,368	5,228,463	4.00
5.00	00500	4,919,736	7,199,305	12,119,041	-1,764,098	10,354,943	5.00
6.00	00600	313,553	657,720	971,273	-10,258	961,015	6.00
8.00	00800	0	117,652	117,652	0	117,652	8.00
9.00	00900	0	401,586	401,586	0	401,586	9.00
10.00	01000	342,905	783,094	1,125,999	0	1,125,999	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	731,116	104,140	835,256	-4,550	830,706	13.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	374,627	149,099	523,726	-17,419	506,307	16.00
17.00	01700	574,662	14,726	589,388	-92	589,296	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,106,369	1,925,433	9,031,802	-31,018	9,000,784	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	300,345	392,055	692,400	-153	692,247	69.00
73.00	07300	350,376	608,760	959,136	-307	958,829	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,734,015	2,747,354	6,481,369	-4,434,119	2,047,250	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		-5,340	-5,340	5,340	0	113.00
118.00		18,949,798	21,150,302	40,100,100	-3,341,032	36,759,068	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	0	0	0	0	0	191.01
191.02	19102	307,031	3,196,176	3,503,207	-6,568	3,496,639	191.02
191.03	19103	0	0	0	3,323,448	3,323,448	191.03
191.04	19104	995,882	198,009	1,193,891	24,152	1,218,043	191.04
200.00		20,252,711	24,544,487	44,797,198	0	44,797,198	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,806,926	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,137,065	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,228,463	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,920,168	7,434,775	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	961,015	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	117,652	8.00
9.00	00900	HOUSEKEEPING	0	401,586	9.00
10.00	01000	DIETARY	-63,229	1,062,770	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	830,706	13.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,552	500,755	16.00
17.00	01700	SOCIAL SERVICE	0	589,296	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,314,363	7,686,421	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	692,247	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	958,829	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-691,105	1,356,145	90.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,994,417	31,764,651	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	3,496,639	191.02
191.03	19103	NON HOSPITAL O/P	0	3,323,448	191.03
191.04	19104	CHEMICAL DEPENDENCY/S. A. F. E.	0	1,218,043	191.04
200.00		TOTAL (SUM OF LINES 118-199)	-4,994,417	39,802,781	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS POSTAGE & TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,241	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
0			0	42,241	
B - RECLASS SHORT 7 LONG TERM LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,257,135	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	42,534	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
0			0	2,299,669	
E - RECLASS INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	5,340	1.00
0			0	5,340	
G - RECLASS RADIOLOGY EXPENSE					
1.00	CHEMICAL DEPENDENCY/S. A. F. E.	191.04	0	6,311	1.00
0			0	6,311	
H - RECLASS LABORATORY EXPENSE					
1.00	CHEMICAL DEPENDENCY/S. A. F. E.	191.04	0	17,841	1.00
0			0	17,841	
I - TO RECLASS INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	124,552	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	192,127	2.00
0			0	316,679	
J - RECLASS NON HOSPITAL COSTS (IOP)					
1.00	NON HOSPITAL O/P	191.03	1,976,899	1,346,549	1.00
0			1,976,899	1,346,549	
K - TO RECLASS PROPERTY TAX EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	123,768	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	179,894	2.00
0			0	303,662	
L - RECLASS DRIVERS					
1.00	ADMINISTRATIVE & GENERAL	5.00	451,950	0	1.00
0			451,950	0	
500.00	Grand Total: Increases		2,428,849	4,338,292	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS POSTAGE & TELEPHONE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	423	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	412	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	147	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	332	0	4.00
5.00	SOCIAL SERVICE	17.00	0	92	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,326	0	6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	307	0	7.00
8.00	CLINIC	90.00	0	38,224	0	8.00
9.00	RETAIL PHARMACY	191.02	0	978	0	9.00
	0		0	42,241		
B - RECLASS SHORT 7 LONG TERM LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,945	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,632,608	10	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	9,846	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	4,403	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	17,087	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	5,540	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	0	153	0	7.00
8.00	CLINIC	90.00	0	620,497	0	8.00
9.00	RETAIL PHARMACY	191.02	0	5,590	0	9.00
	0		0	2,299,669		
E - RECLASS INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,340	14	1.00
	0		0	5,340		
G - RECLASS RADIOLOGY EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	6,311	0	1.00
	0		0	6,311		
H - RECLASS LABORATORY EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	17,841	0	1.00
	0		0	17,841		
I - TO RECLASS INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	316,679	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	316,679		
J - RECLASS NON HOSPITAL COSTS (IOP)						
1.00	CLINIC	90.00	1,976,899	1,346,549	0	1.00
	0		1,976,899	1,346,549		
K - TO RECLASS PROPERTY TAX EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	303,662	13	1.00
2.00		0.00	0	0	13	2.00
	0		0	303,662		
L - RECLASS DRIVERS						
1.00	CLINIC	90.00	451,950	0	0	1.00
	0		451,950	0		
500.00	Grand Total: Decreases		2,428,849	4,338,292		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2017 3:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,585,068	0	0	0	35,963	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,991,812	0	0	0	2,740,228	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	6,576,880	0	0	0	2,776,191	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	6,576,880	0	0	0	2,776,191	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	1,549,105	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,251,584	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	3,800,689	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	3,800,689	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	301,471	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	722,510	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,023,981	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	301,471				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	722,510				2.00
3.00	Total (sum of lines 1-2)	0	1,023,981				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,549,105	0	1,549,105	0.407585	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,251,584	0	2,251,584	0.592415	0	2.00
3.00	Total (sum of lines 1-2)	3,800,689	0	3,800,689	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	301,471	2,257,135	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	722,510	42,534	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,023,981	2,299,669	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	124,552	123,768	0	2,806,926	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	192,127	179,894	0	1,137,065	2.00
3.00	Total (sum of lines 1-2)	0	316,679	303,662	0	3,943,991	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8

Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,634,950			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	120,101			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-52,469	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-5,552	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-10,760	DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

Provider CCN: 26-4012
 Period: From 01/01/2016 To 12/31/2016
 Worksheet A-8
 Date/Time Prepared: 5/30/2017 3:24 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00		0			0.00	0	33.00
33.01		0			0.00	0	33.01
33.02		0			0.00	0	33.02
33.03		0			0.00	0	33.03
33.04 GAIN ON SALES	A	-34,563	ADMINISTRATIVE & GENERAL	5.00		0	33.04
33.05 DONATIONS & GIFTS	B	-6,400	ADMINISTRATIVE & GENERAL	5.00		0	33.05
33.06 OTHER INCOME	B	-143,682	ADMINISTRATIVE & GENERAL	5.00		0	33.06
33.07 BAD DEBT	B	-2,543,213	ADMINISTRATIVE & GENERAL	5.00		0	33.07
33.08 FRA	A	1,895,340	ADMINISTRATIVE & GENERAL	5.00		0	33.08
33.09 LOBBYING EXPENSE	A	-10,522	ADMINISTRATIVE & GENERAL	5.00		0	33.09
33.10		0			0.00	0	33.10
33.11 CD EDUCATION	B	-16	ADMINISTRATIVE & GENERAL	5.00		0	33.11
33.12 COMMUNITY RELATIONS EXPENSES	A	-567,731	ADMINISTRATIVE & GENERAL	5.00		0	33.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,994,417					50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8-1

Date/Time Prepared:
5/30/2017 3:24 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	CPH INTEREST EXPENSE	114,709	-5,392	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			114,709	-5,392	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.

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

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

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

6.00	B		0.00	CBHS, LLC	100.00	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 non-financial) specify:					100.00

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8-1

Date/Time Prepared:
5/30/2017 3:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	120,101	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	120,101			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

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

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

6.00	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8-2

Date/Time Prepared:
5/30/2017 3:24 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,629,482	1,629,482	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,314,363	1,314,363	0	0	0	2.00
3.00	90.00	CLINIC	691,105	691,105	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,634,950	3,634,950	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,629,482		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,314,363		2.00
3.00	90.00	CLINIC	0	0	0	691,105		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,634,950		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-4012

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,806,926	2,806,926			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,137,065		1,137,065		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,228,463	40,644	16,465	5,285,572	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,434,775	228,161	92,426	1,004,017	5.00
6.00 00600	MAINTENANCE & REPAIRS	961,015	86,227	34,930	91,457	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	117,652	17,105	6,929	0	8.00
9.00 00900	HOUSEKEEPING	401,586	21,526	8,720	0	9.00
10.00 01000	DIETARY	1,062,770	216,300	87,621	100,019	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	830,706	18,477	7,485	213,252	13.00
15.00 01500	PHARMACY	0	10,519	4,261	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	500,755	17,075	6,917	109,271	16.00
17.00 01700	SOCIAL SERVICE	589,296	14,605	5,916	167,617	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,686,421	1,038,294	420,606	2,072,789	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	692,247	52,566	21,294	87,605	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	958,829	0	0	102,198	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,356,145	434,185	175,885	380,691	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	99.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,764,651	2,195,684	889,455	4,328,916	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	0	0	0	191.00
191.01 19101	COMMUNITY RELATIONS	0	1,829	741	0	191.01
191.02 19102	RETAIL PHARMACY	3,496,639	27,502	11,141	89,555	191.02
191.03 19103	NON HOSPITAL O/P	3,323,448	286,824	116,190	576,622	191.03
191.04 19104	CHEMICAL DEPENDENCY/S. A. F. E.	1,218,043	295,087	119,538	290,479	191.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	39,802,781	2,806,926	1,137,065	5,285,572	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	6.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	8,759,379				5.00	
6.00	00600	MAINTENANCE & REPAIRS	331,158	1,504,787			6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	39,979	13,704	195,369		8.00	
9.00	00900	HOUSEKEEPING	121,848	17,246	0	570,926	9.00	
10.00	01000	DIETARY	413,856	173,292	0	67,129	10.00	
11.00	01100	CAFETERIA	0	0	0	161,021	11.00	
13.00	01300	NURSING ADMINISTRATION	301,895	14,803	0	5,734	13.00	
15.00	01500	PHARMACY	4,170	8,428	0	3,265	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	178,898	13,680	0	5,299	16.00	
17.00	01700	SOCIAL SERVICE	219,365	11,701	0	4,533	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,165,356	831,845	160,303	322,234	30.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	0	60.00	
69.00	06900	ELECTROCARDIOLOGY	240,889	42,114	0	16,314	69.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	299,386	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	662,217	118,060	0	45,734	90.00	
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	99.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,979,017	1,244,873	160,303	470,242	1,840,209	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	191.00	
191.01	19101	COMMUNITY RELATIONS	725	1,466	0	568	191.01	
191.02	19102	RETAIL PHARMACY	1,022,806	22,034	0	8,535	191.02	
191.03	19103	NON HOSPITAL O/P	1,214,184	0	0	0	191.03	
191.04	19104	CHEMICAL DEPENDENCY/S. A. F. E.	542,647	236,414	35,066	91,581	280,778	191.04
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers	0	0	0	0	201.00	
202.00		TOTAL (sum lines 118-201)	8,759,379	1,504,787	195,369	570,926	2,120,987	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	161,021					11.00
13.00	01300	8,520	1,400,872				13.00
15.00	01500	0	0	30,643			15.00
16.00	01600	7,668	0	0	839,563		16.00
17.00	01700	8,520	0	0	0	1,021,553	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	97,123	1,260,785	0	764,603	919,398	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	5,112	0	0	0	0	69.00
73.00	07300	0	0	30,643	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	17,891	0	0	37,480	0	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		144,834	1,260,785	30,643	802,083	919,398	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	0	0	0	0	0	191.01
191.02	19102	0	0	0	0	0	191.02
191.03	19103	0	0	0	0	0	191.03
191.04	19104	16,187	140,087	0	37,480	102,155	191.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		161,021	1,400,872	30,643	839,563	1,021,553	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	20,181,396	0	20,181,396	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	0	0	0	60.00
69.00	06900	1,158,141	0	1,158,141	69.00
73.00	07300	1,391,056	0	1,391,056	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	3,465,837	0	3,465,837	90.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	0	0	0	99.00
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		26,196,430	0	26,196,430	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	0	0	0	191.00
191.01	19101	5,329	0	5,329	191.01
191.02	19102	4,678,212	0	4,678,212	191.02
191.03	19103	5,517,268	0	5,517,268	191.03
191.04	19104	3,405,542	0	3,405,542	191.04
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		39,802,781	0	39,802,781	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-4012

Period:
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Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	40,644	16,465	57,109	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	228,161	92,426	320,587	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	86,227	34,930	121,157	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	17,105	6,929	24,034	8.00
9.00 00900	HOUSEKEEPING	0	21,526	8,720	30,246	9.00
10.00 01000	DIETARY	0	216,300	87,621	303,921	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	18,477	7,485	25,962	13.00
15.00 01500	PHARMACY	0	10,519	4,261	14,780	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,075	6,917	23,992	16.00
17.00 01700	SOCIAL SERVICE	0	14,605	5,916	20,521	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,038,294	420,606	1,458,900	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	52,566	21,294	73,860	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,104	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	434,185	175,885	610,070	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	99.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,195,684	889,455	3,085,139	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	0	0	0	191.00
191.01 19101	COMMUNITY RELATIONS	0	1,829	741	2,570	191.01
191.02 19102	RETAIL PHARMACY	0	27,502	11,141	38,643	191.02
191.03 19103	NON HOSPITAL O/P	0	286,824	116,190	403,014	191.03
191.04 19104	CHEMICAL DEPENDENCY/S. A. F. E.	0	295,087	119,538	414,625	191.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,806,926	1,137,065	3,943,991	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	331,437					5.00
6.00	00600	12,531	134,676				6.00
8.00	00800	1,513	1,226	26,773			8.00
9.00	00900	4,611	1,544	0	36,401		9.00
10.00	01000	15,660	15,509	0	4,280	340,451	10.00
11.00	01100	0	0	0	0	25,846	11.00
13.00	01300	11,424	1,325	0	366	0	13.00
15.00	01500	158	754	0	208	0	15.00
16.00	01600	6,769	1,224	0	338	0	16.00
17.00	01700	8,301	1,047	0	289	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	119,762	74,450	21,968	20,545	231,406	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	9,115	3,769	0	1,040	0	69.00
73.00	07300	11,329	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	25,058	10,566	0	2,916	38,130	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		226,231	111,414	21,968	29,982	295,382	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	27	131	0	36	0	191.01
191.02	19102	38,702	1,972	0	544	0	191.02
191.03	19103	45,944	0	0	0	0	191.03
191.04	19104	20,533	21,159	4,805	5,839	45,069	191.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		331,437	134,676	26,773	36,401	340,451	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	25,846					11.00
13.00	01300	1,368	42,749				13.00
15.00	01500	0	0	15,900			15.00
16.00	01600	1,231	0	0	34,735		16.00
17.00	01700	1,368	0	0	0	33,337	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,588	38,474	0	31,633	30,003	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	821	0	0	0	0	69.00
73.00	07300	0	0	15,900	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,872	0	0	1,551	0	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		23,248	38,474	15,900	33,184	30,003	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	0	0	0	0	0	191.01
191.02	19102	0	0	0	0	0	191.02
191.03	19103	0	0	0	0	0	191.03
191.04	19104	2,598	4,275	0	1,551	3,334	191.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		25,846	42,749	15,900	34,735	33,337	202.00

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,065,120	0	2,065,120	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	0	0	0	60.00
69.00	06900	89,552	0	89,552	69.00
73.00	07300	28,333	0	28,333	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	695,277	0	695,277	90.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	0	0	0	99.00
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		2,878,282	0	2,878,282	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	0	0	0	191.00
191.01	19101	2,764	0	2,764	191.01
191.02	19102	80,829	0	80,829	191.02
191.03	19103	455,189	0	455,189	191.03
191.04	19104	526,927	0	526,927	191.04
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		3,943,991	0	3,943,991	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet B-1
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	92,059				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		92,059			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,333	1,333	18,121,119		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,483	7,483	3,442,188	-8,759,379	5.00
6.00 00600	MAINTENANCE & REPAIRS	2,828	2,828	313,553	0	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	561	561	0	0	8.00
9.00 00900	HOUSEKEEPING	706	706	0	0	9.00
10.00 01000	DIETARY	7,094	7,094	342,905	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	606	606	731,116	0	13.00
15.00 01500	PHARMACY	345	345	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	560	560	374,627	0	16.00
17.00 01700	SOCIAL SERVICE	479	479	574,662	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	34,053	34,053	7,106,369	0	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	1,724	1,724	300,345	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	350,376	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	14,240	14,240	1,305,166	0	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	99.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	72,012	72,012	14,841,307	-8,759,379	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	0	0	0	191.00
191.01 19101	COMMUNITY RELATIONS	60	60	0	0	191.01
191.02 19102	RETAIL PHARMACY	902	902	307,031	0	191.02
191.03 19103	NON HOSPITAL O/P	9,407	9,407	1,976,899	0	191.03
191.04 19104	CHEMICAL DEPENDENCY/S. A. F. E.	9,678	9,678	995,882	0	191.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,806,926	1,137,065	5,285,572	8,759,379	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	30.490512	12.351481	0.291680	0.282166	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			57,109	331,437	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003152	0.010677	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet B-1

Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description		MAINTENANCE & REPAIRS (HOSPITAL SQUARE FEE)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOSPITAL SQUARE FEE)	DIETARY (MEALS SERVED)	CAFETERIA (PAID FTES)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	61,601				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	561	38,165			8.00
9.00	00900	HOUSEKEEPING	706	0	60,334		9.00
10.00	01000	DIETARY	7,094	0	7,094	138,215	10.00
11.00	01100	CAFETERIA	0	0	0	10,493	11.00
13.00	01300	NURSING ADMINISTRATION	606	0	606	0	13.00
15.00	01500	PHARMACY	345	0	345	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	560	0	560	0	16.00
17.00	01700	SOCIAL SERVICE	479	0	479	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,053	31,315	34,053	93,945	114
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	1,724	0	1,724	0	6
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,833	0	4,833	15,480	21
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,961	31,315	49,694	119,918	170
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	0
191.01	19101	COMMUNITY RELATIONS	60	0	60	0	0
191.02	19102	RETAIL PHARMACY	902	0	902	0	0
191.03	19103	NON HOSPITAL O/P	0	0	0	0	0
191.04	19104	CHEMICAL DEPENDENCY/S. A. F. E.	9,678	6,850	9,678	18,297	19
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,504,787	195,369	570,926	2,120,987	161,021
203.00		Unit cost multiplier (Wkst. B, Part I)	24.427964	5.119062	9.462757	15.345563	851.962963
204.00		Cost to be allocated (per Wkst. B, Part II)	134,676	26,773	36,401	340,451	25,846
205.00		Unit cost multiplier (Wkst. B, Part II)	2.186263	0.701507	0.603325	2.463199	136.751323

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (NUR ADMIN FTE)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		13.00	15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	10					13.00
15.00	01500	0	100				15.00
16.00	01600	0	0	23,296			16.00
17.00	01700	0	0	0	20,800		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9	0	21,216	18,720		30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0		60.00
69.00	06900	0	0	0	0		69.00
73.00	07300	0	100	0	0		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	1,040	0		90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0		99.00
101.00	10100	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		9	100	22,256	18,720		118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0		191.00
191.01	19101	0	0	0	0		191.01
191.02	19102	0	0	0	0		191.02
191.03	19103	0	0	0	0		191.03
191.04	19104	1	0	1,040	2,080		191.04
200.00							200.00
201.00							201.00
202.00		1,400,872	30,643	839,563	1,021,553		202.00
203.00		140,087.20000	306.430000	36.038934	49.113125		203.00
204.00		42,749	15,900	34,735	33,337		204.00
205.00		4,274.900000	159.000000	1.491029	1.602740		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet C
Part I
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		Total Costs
				1.00	2.00		3.00
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	20,181,396		20,181,396	0	20,181,396 30.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	0		0	0	0 60.00	
69.00	06900 ELECTROCARDIOLOGY	1,158,141		1,158,141	0	1,158,141 69.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	1,391,056		1,391,056	0	1,391,056 73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	3,465,837		3,465,837	0	3,465,837 90.00	
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0		0		0 99.00	
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	26,196,430	0	26,196,430	0	26,196,430 200.00	
201.00	Less Observation Beds	0		0		0 201.00	
202.00	Total (see instructions)	26,196,430	0	26,196,430	0	26,196,430 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet C
Part I
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	27,569,667		27,569,667			30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	0	0	0	0.000000	0.000000	60.00
69.00	06900 ELECTROCARDIOLOGY	1,209,564	3,601,724	4,811,288	0.240713	0.000000	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,043,850	3,571,097	7,614,947	0.182674	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	34,452,479	34,452,479	0.100598	0.000000	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0	0	0			99.00
101.00	10100 HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	32,823,081	41,625,300	74,448,381			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	32,823,081	41,625,300	74,448,381			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
60.00	06000 LABORATORY	0.000000			60.00
69.00	06900 ELECTROCARDIOLOGY	0.240713			69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.182674			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.100598			90.00
	OTHER REIMBURSABLE COST CENTERS				
99.00	09900 CMHC				99.00
101.00	10100 HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE		Total Costs
					Disallowance		
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	20,181,396		20,181,396	0	20,181,396 30.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	0		0	0	0 60.00	
69.00	06900 ELECTROCARDIOLOGY	1,158,141		1,158,141	0	1,158,141 69.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	1,391,056		1,391,056	0	1,391,056 73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	3,465,837		3,465,837	0	3,465,837 90.00	
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0		0		0 99.00	
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	26,196,430	0	26,196,430	0	26,196,430 200.00	
201.00	Less Observation Beds	0		0		0 201.00	
202.00	Total (see instructions)	26,196,430	0	26,196,430	0	26,196,430 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
		Charges			Cost or Other Ratio	10.00		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,569,667		27,569,667			30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	1,209,564	3,601,724	4,811,288	0.240713	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,043,850	3,571,097	7,614,947	0.182674	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	34,452,479	34,452,479	0.100598	0.000000	90.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,823,081	41,625,300	74,448,381			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,823,081	41,625,300	74,448,381			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000			60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/30/2017 3:24 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,065,120	0	2,065,120	38,010	54.33	30.00
200.00	Total (Lines 30-199)	2,065,120		2,065,120	38,010		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	7,611	413,506				
200.00	Total (Lines 30-199)	7,611	413,506				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 5/30/2017 3:24 pm	
Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	89,552	4,811,288	0.018613	556,724	10,362
73.00	07300	DRUGS CHARGED TO PATIENTS	28,333	7,614,947	0.003721	1,248,714	4,646
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	695,277	34,452,479	0.020181	0	0
200.00		Total (lines 50-199)	813,162	46,878,714		1,805,438	15,008

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/30/2017 3:24 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,010	0.00	7,611	0	30.00	
200.00		Total (lines 30-199)	38,010		7,611	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 3:24 pm
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Cost Center Description	Title XVIII			Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY	0	0	0	0	0	60.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 3:24 pm
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Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY	0	0	0.000000	0.000000	0	60.00
69.00 06900 ELECTROCARDIOLOGY	0	4,811,288	0.000000	0.000000	556,724	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7,614,947	0.000000	0.000000	1,248,714	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	34,452,479	0.000000	0.000000	0	90.00
200.00 Total (lines 50-199)	0	46,878,714			1,805,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 3:24 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
60.00	06000 LABORATORY	0	0	0		60.00
69.00	06900 ELECTROCARDIOLOGY	0	1,232,725	0		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	14,702,625	0		90.00
200.00	Total (lines 50-199)	0	15,935,350	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part V Date/Time Prepared: 5/30/2017 3:24 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.240713	1,232,725	0	0	296,733	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182674	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.100598	14,702,625	0	0	1,479,055	90.00
200.00		Subtotal (see instructions)		15,935,350	0	0	1,775,788	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		15,935,350	0	0	1,775,788	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 3:24 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 3:24 pm				
		Title XIX	Hospital	Cost				
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.240713	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.182674	0	0	22,372	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.100598	0	0	0	0	90.00
200.00		Subtotal (see instructions)		0	0	22,372	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	22,372	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 3:24 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,087	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
200.00		Subtotal (see instructions)	0	4,087	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,087	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 3:24 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,010	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,010	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		38,010	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		7,611	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		20,181,396	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		20,181,396	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		20,181,396	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		530.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,041,060	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,041,060	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 3:24 pm	
Title XVIII			Hospital	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				362,119	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				4,403,179	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				413,506	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				15,008	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				428,514	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				3,974,665	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 3:24 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,065,120	20,181,396	0.102328	0	0	90.00
91.00	Nursing School cost	0	20,181,396	0.000000	0	0	91.00
92.00	Allied health cost	0	20,181,396	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,181,396	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 3:24 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,010	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,010	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		38,010	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,164	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		20,181,396	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		20,181,396	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		20,181,396	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		530.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,679,926	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,679,926	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 3:24 pm
Title XIX			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					34,604 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,714,530 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 3:24 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,065,120	20,181,396	0.102328	0	0	90.00
91.00	Nursing School cost	0	20,181,396	0.000000	0	0	91.00
92.00	Allied health cost	0	20,181,396	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,181,396	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 3:24 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,714,030		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0.240713	556,724	134,011	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.182674	1,248,714	228,108	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.100598	0	0	90.00
200.00	Total (sum of lines 50-94 and 96-98)		1,805,438	362,119	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,805,438		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 3:24 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,667,570		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0.240713	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.182674	189,430	34,604	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.100598	0	0	90.00
200.00	Total (sum of lines 50-94 and 96-98)		189,430	34,604	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		189,430		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 3:24 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		1,775,788	2.00
3.00	PPS payments		5,431,809	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		5,431,809	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,101,376	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,330,433	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)		4,330,433	30.00
31.00	Primary payer payments		8,155	31.00
32.00	Subtotal (line 30 minus line 31)		4,322,278	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		4,322,278	37.00
38.00	MSP-LCC reconciliation amount from PS&R		20	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,322,258	40.00
40.01	Sequestration adjustment (see instructions)		86,445	40.01
41.00	Interim payments		4,497,826	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-262,013	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 26-4012		Period: From 01/01/2016 To 12/31/2016		Worksheet E-1 Part I Date/Time Prepared: 5/30/2017 3:24 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,257,038		4,393,326	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	11/16/2016	159,700	11/16/2016	104,500	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		159,700		104,500	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,416,738		4,497,826	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		266,066		262,013	6.02	
7.00	Total Medicare program liability (see instructions)		5,150,672		4,235,813	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/30/2017 3:24 pm
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		5,770,316	1.00
2.00	Net IPF PPS Outlier Payments		4,901	2.00
3.00	Net IPF PPS ECT Payments		102,468	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		103.852459	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		5,877,685	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		5,877,685	16.00
17.00	Primary payer payments		44,974	17.00
18.00	Subtotal (line 16 less line 17).		5,832,711	18.00
19.00	Deductibles		481,760	19.00
20.00	Subtotal (line 18 minus line 19)		5,350,951	20.00
21.00	Coinurance		133,952	21.00
22.00	Subtotal (line 20 minus line 21)		5,216,999	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		59,676	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		38,789	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		59,676	25.00
26.00	Subtotal (sum of lines 22 and 24)		5,255,788	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		5,255,788	31.00
31.01	Sequestration adjustment (see instructions)		105,116	31.01
32.00	Interim payments		5,416,738	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		-266,066	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		4,901	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2017 3:24 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,714,530		1.00
2.00	Medical and other services			4,087	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,714,530	4,087	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,714,530	4,087	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		2,667,570		8.00
9.00	Ancillary service charges		189,430	22,372	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,857,000	22,372	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2,857,000	22,372	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,142,470	18,285	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,714,530	4,087	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,714,530	4,087	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,714,530	4,087	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,714,530	4,087	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,714,530	4,087	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,714,530	4,087	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		1,714,530	4,087	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet G
Date/Time Prepared:
5/30/2017 3:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,999,999	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,753,477	0	0	0	4.00
5.00	Other receivable	118,507	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,607,547	0	0	0	6.00
7.00	Inventory	328,745	0	0	0	7.00
8.00	Prepaid expenses	376,909	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,970,090	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,890,431	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,251,584	0	0	0	23.00
24.00	Accumulated depreciation	-1,151,507	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,990,508	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	100,144	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,805,425	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,905,569	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,866,167	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,334,385	0	0	0	37.00
38.00	Salaries, wages, and fees payable	373,959	0	0	0	38.00
39.00	Payroll taxes payable	25,429	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	858,781	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,592,554	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,781,471	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,781,471	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,374,025	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,492,142				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	15,492,142	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,866,167	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet G-1

Date/Time Prepared:
5/30/2017 3:24 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,730,572			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,238,430				2.00
3.00	Total (sum of line 1 and line 2)		15,492,142			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		15,492,142			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,492,142			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-4012

Period:
From 01/01/2016
To 12/31/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2017 3:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	27,569,667		27,569,667	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	27,569,667		27,569,667	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	27,569,667		27,569,667	17.00
18.00	Ancillary services	5,253,114	7,172,821	12,425,935	18.00
19.00	Outpatient services	0	39,599,184	39,599,184	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				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	3,263,396	3,263,396	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,822,781	50,035,401	82,858,182	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,797,198		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		44,797,198		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 26-4012	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/30/2017 3:24 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	82,858,182	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,408,960	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,449,222	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,797,198	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-347,976	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	6,400	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	52,469	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,552	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	10,760	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	143,713	24.00
24.01	GAIN ON SALES	34,563	24.01
25.00	Total other income (sum of lines 6-24)	253,457	25.00
26.00	Total (line 5 plus line 25)	-94,519	26.00
27.00	NON OPERATING EXPENSES	2,143,911	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,143,911	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,238,430	29.00