Health Financial Systems | Lafayette Regional Rehabilitation Hospit | In Lieu of Form CMS-2552-10

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S Parts I-III | Date/Time Prepared: 5/19/2016 12:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/19/2016 Time: 12:39 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Lafayette Regional Rehabilitation Hospital (153042) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

Encryption Information
ECR: Date: 5/19/2016 Time: 12:39 pm
R42BxCxUCnJZnuT:T6YcCTutDJKXD0
QoLuM0mE5uQ9pov0chgyBgymOFMJxZ
0saH0Bgd5L0Nfhmd
PI: Date: 5/19/2016 Time: 12:39 pm
kBn6qBuRy9zQLXCEgDvOd3Q12LcRS0
pOKt90T75uIGY0EycD0vvKJxYrK:gM
b72k0JtXde0t8fsL

(Signed) Kristi Duncan
Officer or Administrator of Provider(s)

Title: Vice President

Date: 05/23/2016

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	Title XVIII HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	28,500	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	28,500	0	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 12:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 950 Park East Blvd	PO Box:			1.00
2.00	City: Lafayette	State: IN	Zip Code: 47905	County: Tippecanoe	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	Lafayette Regional Rehabilitation Hospital	153042	29140	5	04/18/2013	N	P	P	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 - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(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.	2	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.	496	55	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 12:38 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.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 12:38 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 12:38 pm

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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.					109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 12:38 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	329003	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ERNEST HEALTH INC	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 04011	141.00
142.00	Street: 7770 JEFFERSON ST NE STE 320	PO Box:		142.00
143.00	City: ALBUQUERQUE	State: NM	Zip Code: 87109	143.00

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

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

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

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

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/19/2016 12:38 pm

		1.00	
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. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/19/2016 12:38 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	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	04/13/2016	Y	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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/19/2016 12:38 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					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.					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					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					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.					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.					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.					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?					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.	Catherine		Christy		41.00
42.00	Enter the employer/company name of the cost report preparer.	ERNEST HEALTH INC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(505) 798-3191		CatherineChristy@ernesthealth.com		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/19/2016 12:38 pm

		Part B Date 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)	04/13/2016			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)				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.				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.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			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.		SR. REIMBURSEMENT ANALYST		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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/19/2016 12:38 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	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)		40	14,600	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)		40	14,600	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	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						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		40				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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/19/2016 12:38 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)	5,068	496	7,671			1.00
2.00	HMO and other (see instructions)	470	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	5,068	496	7,671			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)	5,068	496	7,671	0.00	87.52	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	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						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	87.52	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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/19/2016 12:38 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	378	31	554	1.00
2.00	HMO and other (see instructions)			34	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	378	31	554	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,164,024	2,164,024	176,716	2,340,740	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		484,870	484,870	40,245	525,115	2.00
3.00	00300	OTHER CAP REL COSTS		216,961	216,961	-216,961	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	416,598	677,423	1,094,021	0	1,094,021	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	902,624	2,088,047	2,990,671	0	2,990,671	5.00
7.00	00700	OPERATION OF PLANT	83,526	327,390	410,916	0	410,916	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,813	29,813	0	29,813	8.00
9.00	00900	HOUSEKEEPING	107,213	61,741	168,954	0	168,954	9.00
10.00	01000	DIETARY	228,667	145,519	374,186	0	374,186	10.00
13.00	01300	NURSING ADMINISTRATION	271,849	26,280	298,129	0	298,129	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,888	37,622	100,510	0	100,510	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,438,812	135,728	1,574,540	0	1,574,540	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,467	25,467	-7,032	18,435	54.00
57.00	05700	CT SCAN	0	0	0	5,167	5,167	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,865	1,865	58.00
60.00	06000	LABORATORY	0	88,607	88,607	0	88,607	60.00
65.00	06500	RESPIRATORY THERAPY	99,449	28,313	127,762	0	127,762	65.00
66.00	06600	PHYSICAL THERAPY	460,718	47,364	508,082	-31,537	476,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,010	37,365	376,375	23,736	400,111	67.00
68.00	06800	SPEECH PATHOLOGY	143,793	14,037	157,830	7,801	165,631	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,461	108,928	129,389	0	129,389	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	311,991	232,583	544,574	0	544,574	73.00
74.00	07400	RENAL DIALYSIS	0	58,290	58,290	0	58,290	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	6,052	6,052	0	6,052	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,887,599	7,042,424	11,930,023	0	11,930,023	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	4,887,599	7,042,424	11,930,023	0	11,930,023	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/19/2016 12:38 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	-1,821,437	519,303		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	48,058	573,173		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	242,267	1,336,288		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-317,768	2,672,903		5.00
7.00	00700	OPERATION OF PLANT	-15,559	395,357		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,813		8.00
9.00	00900	HOUSEKEEPING	0	168,954		9.00
10.00	01000	DIETARY	-19,235	354,951		10.00
13.00	01300	NURSING ADMINISTRATION	0	298,129		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,113	98,397		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,574,540		30.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,435		54.00
57.00	05700	CT SCAN	0	5,167		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,865		58.00
60.00	06000	LABORATORY	0	88,607		60.00
65.00	06500	RESPIRATORY THERAPY	0	127,762		65.00
66.00	06600	PHYSICAL THERAPY	0	476,545		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	400,111		67.00
68.00	06800	SPEECH PATHOLOGY	0	165,631		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	129,389		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	544,574		73.00
74.00	07400	RENAL DIALYSIS	0	58,290		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	6,052		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,885,787	10,044,236		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,885,787	10,044,236		200.00

RECLASSIFICATIONS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/19/2016 12:38 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RCLS PCT THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	21,631	2,105	1.00
2.00	SPEECH PATHOLOGY	68.00	7,109	692	2.00
	TOTALS		28,740	2,797	
	B - DEFAULT				
1.00	CT SCAN	57.00	0	5,167	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,865	2.00
	TOTALS		0	7,032	
500.00	Grand Total: Increases		28,740	9,829	500.00

RECLASSIFICATIONS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/19/2016 12:38 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RCLS PCT THERAPY						
1.00	PHYSICAL THERAPY	66.00	28,740	2,797	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		28,740	2,797			
	B - DEFAULT						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,032	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	7,032			
500.00	Grand Total: Decreases		28,740	9,829			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/19/2016 12:38 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	800,183	0	0	0	0	1.00
2.00	Land Improvements	41,998	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,213,591	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,350	0	0	0	0	5.00
6.00	Movable Equipment	2,743,616	2,199	0	2,199	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,800,738	2,199	0	2,199	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,800,738	2,199	0	2,199	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	800,183	0	1.00
2.00	Land Improvements	41,998	0	2.00
3.00	Buildings and Fixtures	11,213,591	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,350	0	5.00
6.00	Movable Equipment	2,745,815	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,802,937	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,802,937	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/19/2016 12:38 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	320,820	0	1,843,204	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	455,884	28,986	0	0	0	2.00
3.00	Total (sum of lines 1-2)	776,704	28,986	1,843,204	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	2,164,024	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	484,870	2.00
3.00	Total (sum of lines 1-2)	0	2,648,894	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/19/2016 12:38 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	12,057,122	0	12,057,122	0.814509	12,904	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,745,815	0	2,745,815	0.185491	2,939	2.00
3.00	Total (sum of lines 1-2)	14,802,937	0	14,802,937	1.000000	15,843	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	163,812	0	176,716	342,587	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37,306	0	40,245	503,942	28,986	2.00
3.00	Total (sum of lines 1-2)	201,118	0	216,961	846,529	28,986	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	12,904	163,812	0	519,303	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,939	37,306	0	573,173	2.00
3.00	Total (sum of lines 1-2)	0	15,843	201,118	0	1,092,476	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/19/2016 12:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP 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)	A	-933	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-15,559	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,518,386			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-19,235	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,113	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INTEREST INCOME	B	-566	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PRE-OPENING AMORTIZATION - CAP	A	4,933	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/19/2016 12:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	PRE-OPENING AMORTIZATION - A&G	A	184,496	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING/MARKETING - MARKETING	A	-30,651	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	ADVERTISING/MARKETING - GENERAL OVER	A	-1,146	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	BAD DEBT EXPENSE - REVENUE DEDUCTION	A	-210,750	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	COMMUNITY EVENTS - MARKETING	A	-2,865	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	CONTRIBUTIONS / SPONSORSHIPS - MARKE	A	-4,850	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	CONTRIBUTIONS / SPONSORSHIPS - GENER	A	-6,500	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	FLOWERS & GIFTS - ADMINISTRATION	A	-420	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	FRANCHISE FEES/BUSINESS TAXES	A	-920	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	GIVEAWAYS - HUMAN RESOURCES	A	-927	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	GIVEAWAYS - ADMINISTRATION	A	-3,743	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	GIVEAWAYS - MARKETING	A	-3,359	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LATE FEES - GENERAL OVERHEAD	A	-402	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MARKETING COLLATERAL - MARKETING	A	-800	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	TAX PENALTY	A	-1,480	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	MARKETING EXPENSE	A	-8,673	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	MARKETING BENEFITS	A	-744	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	TELEPHONE OPERATOR EXPENSE	A	-55,285	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	TELEPHONE BENEFIT EXPENSE	A	-1,192	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	TELEVISION DEPRECIATION	A	-9,809	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.21
33.22	UNALLOWABLE LOBBYING % OF ASSOC DUES	A	-1,391	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	ADJ HEALTH/DENTAL INS TO ACTUAL	A	244,203	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	ADJ LIABILITY INS TO ACTUAL	A	-14,980	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	PHYSICIAN CONTRACT	A	-401,740	ADMINISTRATIVE & GENERAL	5.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,885,787				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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/19/2016 12:38 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO ALLOC CAP - BUILDING	15,756	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO ALLOC CAP - EQUIPMENT	57,867	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO ALLOC - A & G	984,170	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY INTEREST	0	1,843,204	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	210,032	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES - INTERCOMPA	0	544,543	4.02
4.03	0.00			0	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	PRE-OPENING AMORTIZATION - H	20,522	0	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	PRE-OPENING AMORTIZATION - H	1,078	0	4.05
5.00	0		0	1,079,393	2,597,779	5.00

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

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

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

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

6.00	B		0.00	ERNEST HEALTH	100.00	6.00
7.00	B		0.00	MPT	49.00	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:	FINANCIAL				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: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/19/2016 12:38 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	15,756	9		1.00
2.00	57,867	9		2.00
3.00	984,170	0		3.00
4.00	-1,843,204	11		4.00
4.01	-210,032	0		4.01
4.02	-544,543	0		4.02
4.03	0	0		4.03
4.04	20,522	0		4.04
4.05	1,078	9		4.05
5.00	-1,518,386			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	HOME OFFICE		6.00
7.00	RE INVEST TRUST		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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	519,303	519,303				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	573,173		573,173			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,336,288	2,089	2,306	1,340,683		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,672,903	34,601	38,191	270,663	3,016,358	5.00
7.00	00700	OPERATION OF PLANT	395,357	119,429	131,818	25,046	671,650	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,813	0	0	0	29,813	8.00
9.00	00900	HOUSEKEEPING	168,954	3,384	3,735	32,149	208,222	9.00
10.00	01000	DIETARY	354,951	47,658	52,602	68,569	523,780	10.00
13.00	01300	NURSING ADMINISTRATION	298,129	5,451	6,017	81,517	391,114	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,397	5,658	6,245	18,858	129,158	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,574,540	211,918	233,900	431,445	2,451,803	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,435	0	0	0	18,435	54.00
57.00	05700	CT SCAN	5,167	0	0	0	5,167	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,865	0	0	0	1,865	58.00
60.00	06000	LABORATORY	88,607	0	0	0	88,607	60.00
65.00	06500	RESPIRATORY THERAPY	127,762	2,176	2,402	29,821	162,161	65.00
66.00	06600	PHYSICAL THERAPY	476,545	36,854	40,677	129,533	683,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	400,111	20,935	23,107	108,143	552,296	67.00
68.00	06800	SPEECH PATHOLOGY	165,631	2,394	2,642	45,250	215,917	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,389	5,005	5,524	6,135	146,053	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	544,574	6,093	6,725	93,554	650,946	73.00
74.00	07400	RENAL DIALYSIS	58,290	0	0	0	58,290	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	6,052	0	0	0	6,052	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,044,236	503,645	555,891	1,340,683	10,011,296	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,538	17,150	0	32,688	192.00
194.00	07950	MARKETING	0	120	132	0	252	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,044,236	519,303	573,173	1,340,683	10,044,236	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,016,358					5.00
7.00	00700	OPERATION OF PLANT	288,272	959,922				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,796	0	42,609			8.00
9.00	00900	HOUSEKEEPING	89,369	8,944	0	306,535		9.00
10.00	01000	DIETARY	224,806	125,965	0	40,603	915,154	10.00
13.00	01300	NURSING ADMINISTRATION	167,866	14,408	0	4,644	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,434	14,955	0	4,820	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,052,311	560,113	42,609	180,546	915,154	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,912	0	0	0	0	54.00
57.00	05700	CT SCAN	2,218	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	800	0	0	0	0	58.00
60.00	06000	LABORATORY	38,030	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	69,599	5,752	0	1,854	0	65.00
66.00	06600	PHYSICAL THERAPY	293,404	97,407	0	31,398	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,045	55,333	0	17,836	0	67.00
68.00	06800	SPEECH PATHOLOGY	92,671	6,327	0	2,039	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,686	13,229	0	4,264	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	279,385	16,105	0	5,191	0	73.00
74.00	07400	RENAL DIALYSIS	25,018	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	2,598	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,002,220	918,538	42,609	293,195	915,154	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,030	41,068	0	13,238	0	192.00
194.00	07950	MARKETING	108	316	0	102	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,016,358	959,922	42,609	306,535	915,154	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	578,032					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	204,367				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	578,032	93,613	5,874,181	0	5,874,181	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	894	27,241	0	27,241	54.00
57.00	05700	CT SCAN	0	245	7,630	0	7,630	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	88	2,753	0	2,753	58.00
60.00	06000	LABORATORY	0	5,098	131,735	0	131,735	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,135	245,501	0	245,501	65.00
66.00	06600	PHYSICAL THERAPY	0	31,451	1,137,269	0	1,137,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,900	888,410	0	888,410	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,512	325,466	0	325,466	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,505	228,737	0	228,737	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,648	979,275	0	979,275	73.00
74.00	07400	RENAL DIALYSIS	0	2,158	85,466	0	85,466	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	120	8,770	0	8,770	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	578,032	204,367	9,942,434	0	9,942,434	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	101,024	0	101,024	192.00
194.00	07950	MARKETING	0	0	778	0	778	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	578,032	204,367	10,044,236	0	10,044,236	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,089	2,306	4,395	4,395	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	34,601	38,191	72,792	887	5.00
7.00	00700	OPERATION OF PLANT	0	119,429	131,818	251,247	82	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	3,384	3,735	7,119	105	9.00
10.00	01000	DIETARY	0	47,658	52,602	100,260	225	10.00
13.00	01300	NURSING ADMINISTRATION	0	5,451	6,017	11,468	267	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,658	6,245	11,903	62	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	211,918	233,900	445,818	1,414	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,176	2,402	4,578	98	65.00
66.00	06600	PHYSICAL THERAPY	0	36,854	40,677	77,531	425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,935	23,107	44,042	355	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,394	2,642	5,036	148	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,005	5,524	10,529	20	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,093	6,725	12,818	307	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	503,645	555,891	1,059,536	4,395	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,538	17,150	32,688	0	192.00
194.00	07950	MARKETING	0	120	132	252	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	519,303	573,173	1,092,476	4,395	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	73,679					5.00
7.00	00700	OPERATION OF PLANT	7,042	258,371				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	313	0	313			8.00
9.00	00900	HOUSEKEEPING	2,183	2,407	0	11,814		9.00
10.00	01000	DIETARY	5,491	33,905	0	1,565	141,446	10.00
13.00	01300	NURSING ADMINISTRATION	4,100	3,878	0	179	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,354	4,025	0	186	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,703	150,759	313	6,959	141,446	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	193	0	0	0	0	54.00
57.00	05700	CT SCAN	54	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20	0	0	0	0	58.00
60.00	06000	LABORATORY	929	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,700	1,548	0	71	0	65.00
66.00	06600	PHYSICAL THERAPY	7,167	26,218	0	1,210	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,790	14,893	0	687	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,264	1,703	0	79	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,531	3,561	0	164	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,825	4,335	0	200	0	73.00
74.00	07400	RENAL DIALYSIS	611	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	63	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,333	247,232	313	11,300	141,446	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	343	11,054	0	510	0	192.00
194.00	07950	MARKETING	3	85	0	4	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	73,679	258,371	313	11,814	141,446	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	19,892					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,530				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,892	8,032	800,336	0	800,336	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77	270	0	270	54.00
57.00	05700	CT SCAN	0	21	75	0	75	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8	28	0	28	58.00
60.00	06000	LABORATORY	0	437	1,366	0	1,366	60.00
65.00	06500	RESPIRATORY THERAPY	0	526	8,521	0	8,521	65.00
66.00	06600	PHYSICAL THERAPY	0	2,697	115,248	0	115,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,221	67,988	0	67,988	67.00
68.00	06800	SPEECH PATHOLOGY	0	730	9,960	0	9,960	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	215	16,020	0	16,020	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,371	26,856	0	26,856	73.00
74.00	07400	RENAL DIALYSIS	0	185	796	0	796	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	10	73	0	73	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,892	17,530	1,047,537	0	1,047,537	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	44,595	0	44,595	192.00
194.00	07950	MARKETING	0	0	344	0	344	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,892	17,530	1,092,476	0	1,092,476	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	47,726					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		47,726				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	192	192	4,471,000			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,180	3,180	902,624	-3,016,358	7,027,878	5.00
7.00	00700	OPERATION OF PLANT	10,976	10,976	83,526	0	671,650	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	29,813	8.00
9.00	00900	HOUSEKEEPING	311	311	107,213	0	208,222	9.00
10.00	01000	DIETARY	4,380	4,380	228,667	0	523,780	10.00
13.00	01300	NURSING ADMINISTRATION	501	501	271,849	0	391,114	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520	520	62,888	0	129,158	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,476	19,476	1,438,812	0	2,451,803	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	18,435	54.00
57.00	05700	CT SCAN	0	0	0	0	5,167	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,865	58.00
60.00	06000	LABORATORY	0	0	0	0	88,607	60.00
65.00	06500	RESPIRATORY THERAPY	200	200	99,449	0	162,161	65.00
66.00	06600	PHYSICAL THERAPY	3,387	3,387	431,977	0	683,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,924	1,924	360,641	0	552,296	67.00
68.00	06800	SPEECH PATHOLOGY	220	220	150,902	0	215,917	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	460	20,461	0	146,053	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560	560	311,991	0	650,946	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	58,290	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	6,052	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,287	46,287	4,471,000	-3,016,358	6,994,938	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	1,428	0	0	32,688	192.00
194.00	07950	MARKETING	11	11	0	0	252	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	519,303	573,173	1,340,683		3,016,358	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.880924	12.009659	0.299862		0.429199	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,395		73,679	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000983		0.010484	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (NURSING SALARIES)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	33,378					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,671				8.00
9.00	00900	HOUSEKEEPING	311	0	33,067			9.00
10.00	01000	DIETARY	4,380	0	4,380	7,671		10.00
13.00	01300	NURSING ADMINISTRATION	501	0	501	0	1,438,812	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520	0	520	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,476	7,671	19,476	7,671	1,438,812	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	200	0	200	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,387	0	3,387	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,924	0	1,924	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	220	0	220	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	0	460	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560	0	560	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,939	7,671	31,628	7,671	1,438,812	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	0	1,428	0	0	192.00
194.00	07950	MARKETING	11	0	11	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	959,922	42,609	306,535	915,154	578,032	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.759123	5.554556	9.270118	119.300482	0.401743	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	258,371	313	11,814	141,446	19,892	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.740757	0.040803	0.357275	18.439056	0.013825	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/19/2016 12:38 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,054,956		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,896,160		30.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,890		54.00
57.00	05700	CT SCAN	18,023		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,504		58.00
60.00	06000	LABORATORY	375,566		60.00
65.00	06500	RESPIRATORY THERAPY	451,950		65.00
66.00	06600	PHYSICAL THERAPY	2,316,801		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,907,905		67.00
68.00	06800	SPEECH PATHOLOGY	627,060		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,521		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,036,711		73.00
74.00	07400	RENAL DIALYSIS	159,000		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,865		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,054,956		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0		194.01
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)	204,367		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013575		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,530		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001164		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,874,181		5,874,181	0	5,874,181	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,241		27,241	0	27,241	54.00
57.00	05700	CT SCAN	7,630		7,630	0	7,630	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,753		2,753	0	2,753	58.00
60.00	06000	LABORATORY	131,735		131,735	0	131,735	60.00
65.00	06500	RESPIRATORY THERAPY	245,501	0	245,501	0	245,501	65.00
66.00	06600	PHYSICAL THERAPY	1,137,269	0	1,137,269	0	1,137,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	888,410	0	888,410	0	888,410	67.00
68.00	06800	SPEECH PATHOLOGY	325,466	0	325,466	0	325,466	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	228,737		228,737	0	228,737	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	979,275		979,275	0	979,275	73.00
74.00	07400	RENAL DIALYSIS	85,466		85,466	0	85,466	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,770		8,770	0	8,770	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	9,942,434	0	9,942,434	0	9,942,434	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	9,942,434	0	9,942,434	0	9,942,434	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,896,160		6,896,160			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,890	0	65,890	0.413431	0.000000	54.00
57.00	05700	CT SCAN	18,023	0	18,023	0.423348	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,504	0	6,504	0.423278	0.000000	58.00
60.00	06000	LABORATORY	375,566	0	375,566	0.350764	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	451,950	0	451,950	0.543204	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,221,120	95,681	2,316,801	0.490879	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,862,860	45,045	1,907,905	0.465647	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	601,300	25,760	627,060	0.519035	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,521	0	184,521	1.239626	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,036,711	0	2,036,711	0.480812	0.000000	73.00
74.00	07400	RENAL DIALYSIS	159,000	0	159,000	0.537522	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,865	0	8,865	0.989284	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	14,888,470	166,486	15,054,956			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,888,470	166,486	15,054,956			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.413431	54.00
57.00	05700	CT SCAN	0.423348	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.423278	58.00
60.00	06000	LABORATORY	0.350764	60.00
65.00	06500	RESPIRATORY THERAPY	0.543204	65.00
66.00	06600	PHYSICAL THERAPY	0.490879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465647	67.00
68.00	06800	SPEECH PATHOLOGY	0.519035	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.239626	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.480812	73.00
74.00	07400	RENAL DIALYSIS	0.537522	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.989284	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,874,181		5,874,181	0	5,874,181	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,241		27,241	0	27,241	54.00
57.00	05700	CT SCAN	7,630		7,630	0	7,630	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,753		2,753	0	2,753	58.00
60.00	06000	LABORATORY	131,735		131,735	0	131,735	60.00
65.00	06500	RESPIRATORY THERAPY	245,501	0	245,501	0	245,501	65.00
66.00	06600	PHYSICAL THERAPY	1,137,269	0	1,137,269	0	1,137,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	888,410	0	888,410	0	888,410	67.00
68.00	06800	SPEECH PATHOLOGY	325,466	0	325,466	0	325,466	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	228,737		228,737	0	228,737	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	979,275		979,275	0	979,275	73.00
74.00	07400	RENAL DIALYSIS	85,466		85,466	0	85,466	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,770		8,770	0	8,770	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	9,942,434	0	9,942,434	0	9,942,434	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	9,942,434	0	9,942,434	0	9,942,434	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/19/2016 12:38 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,896,160		6,896,160			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,890	0	65,890	0.413431	0.000000	54.00
57.00	05700	CT SCAN	18,023	0	18,023	0.423348	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,504	0	6,504	0.423278	0.000000	58.00
60.00	06000	LABORATORY	375,566	0	375,566	0.350764	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	451,950	0	451,950	0.543204	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,221,120	95,681	2,316,801	0.490879	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,862,860	45,045	1,907,905	0.465647	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	601,300	25,760	627,060	0.519035	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,521	0	184,521	1.239626	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,036,711	0	2,036,711	0.480812	0.000000	73.00
74.00	07400	RENAL DIALYSIS	159,000	0	159,000	0.537522	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,865	0	8,865	0.989284	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	14,888,470	166,486	15,054,956			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,888,470	166,486	15,054,956			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.413431	54.00
57.00	05700	CT SCAN	0.423348	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.423278	58.00
60.00	06000	LABORATORY	0.350764	60.00
65.00	06500	RESPIRATORY THERAPY	0.543204	65.00
66.00	06600	PHYSICAL THERAPY	0.490879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465647	67.00
68.00	06800	SPEECH PATHOLOGY	0.519035	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.239626	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.480812	73.00
74.00	07400	RENAL DIALYSIS	0.537522	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.989284	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,241	270	26,971	0	0	54.00
57.00	05700	CT SCAN	7,630	75	7,555	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,753	28	2,725	0	0	58.00
60.00	06000	LABORATORY	131,735	1,366	130,369	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	245,501	8,521	236,980	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,137,269	115,248	1,022,021	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	888,410	67,988	820,422	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	325,466	9,960	315,506	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	228,737	16,020	212,717	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	979,275	26,856	952,419	0	0	73.00
74.00	07400	RENAL DIALYSIS	85,466	796	84,670	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,770	73	8,697	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
200.00		Subtotal (sum of lines 50 thru 199)	4,068,253	247,201	3,821,052	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	4,068,253	247,201	3,821,052	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,241	65,890	0.413431		54.00
57.00	05700	CT SCAN	7,630	18,023	0.423348		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,753	6,504	0.423278		58.00
60.00	06000	LABORATORY	131,735	375,566	0.350764		60.00
65.00	06500	RESPIRATORY THERAPY	245,501	451,950	0.543204		65.00
66.00	06600	PHYSICAL THERAPY	1,137,269	2,316,801	0.490879		66.00
67.00	06700	OCCUPATIONAL THERAPY	888,410	1,907,905	0.465647		67.00
68.00	06800	SPEECH PATHOLOGY	325,466	627,060	0.519035		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	228,737	184,521	1.239626		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	979,275	2,036,711	0.480812		73.00
74.00	07400	RENAL DIALYSIS	85,466	159,000	0.537522		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,770	8,865	0.989284		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000		117.00
200.00		Subtotal (sum of lines 50 thru 199)	4,068,253	8,158,796			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	4,068,253	8,158,796			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

	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)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	800,336	0	800,336	7,671	104.33	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	800,336		800,336	7,671		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	5,068	528,744		30.00
40.00	SUBPROVIDER - IPF	0	0		40.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	5,068	528,744		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	270	65,890	0.004098	51,044	209	54.00
57.00	05700	CT SCAN	75	18,023	0.004161	10,783	45	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28	6,504	0.004305	4,351	19	58.00
60.00	06000	LABORATORY	1,366	375,566	0.003637	257,860	938	60.00
65.00	06500	RESPIRATORY THERAPY	8,521	451,950	0.018854	332,013	6,260	65.00
66.00	06600	PHYSICAL THERAPY	115,248	2,316,801	0.049744	1,488,620	74,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,988	1,907,905	0.035635	1,247,835	44,467	67.00
68.00	06800	SPEECH PATHOLOGY	9,960	627,060	0.015884	357,870	5,684	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,020	184,521	0.086819	124,020	10,767	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,856	2,036,711	0.013186	1,334,388	17,595	73.00
74.00	07400	RENAL DIALYSIS	796	159,000	0.005006	154,600	774	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	73	8,865	0.008235	2,670	22	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	247,201	8,158,796		5,366,054	160,830	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/19/2016 12:38 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	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		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	7,671	0.00	5,068	0		30.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	7,671		5,068	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,890	0.000000	0.000000	51,044	54.00
57.00	05700	CT SCAN	0	18,023	0.000000	0.000000	10,783	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,504	0.000000	0.000000	4,351	58.00
60.00	06000	LABORATORY	0	375,566	0.000000	0.000000	257,860	60.00
65.00	06500	RESPIRATORY THERAPY	0	451,950	0.000000	0.000000	332,013	65.00
66.00	06600	PHYSICAL THERAPY	0	2,316,801	0.000000	0.000000	1,488,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,907,905	0.000000	0.000000	1,247,835	67.00
68.00	06800	SPEECH PATHOLOGY	0	627,060	0.000000	0.000000	357,870	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	184,521	0.000000	0.000000	124,020	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,036,711	0.000000	0.000000	1,334,388	73.00
74.00	07400	RENAL DIALYSIS	0	159,000	0.000000	0.000000	154,600	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	8,865	0.000000	0.000000	2,670	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	8,158,796			5,366,054	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

	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)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	800,336	0	800,336	7,671	104.33	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	800,336		800,336	7,671		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	496	51,748				30.00
40.00	SUBPROVIDER - IPF	0	0				40.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	496	51,748				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	270	65,890	0.004098	0	0	54.00
57.00	05700	CT SCAN	75	18,023	0.004161	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28	6,504	0.004305	0	0	58.00
60.00	06000	LABORATORY	1,366	375,566	0.003637	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,521	451,950	0.018854	0	0	65.00
66.00	06600	PHYSICAL THERAPY	115,248	2,316,801	0.049744	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,988	1,907,905	0.035635	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,960	627,060	0.015884	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,020	184,521	0.086819	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,856	2,036,711	0.013186	0	0	73.00
74.00	07400	RENAL DIALYSIS	796	159,000	0.005006	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	73	8,865	0.008235	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	247,201	8,158,796		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | 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	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		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	7,671	0.00	496	0		30.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	7,671		496	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,890	0.000000	0.000000	0	54.00
57.00	05700	CT SCAN	0	18,023	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,504	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	375,566	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	451,950	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,316,801	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,907,905	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	627,060	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	184,521	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,036,711	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	159,000	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	8,865	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	8,158,796			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/19/2016 12:38 pm

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,671	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,671	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)	7,671	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)	5,068	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)	5,874,181	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)	5,874,181	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)	5,874,181	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)	765.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,880,872	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,880,872	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/19/2016 12:38 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)	2,676,909	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,557,781	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)	528,744	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	160,830	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	689,574	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,868,207	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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	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	800,336	5,874,181	0.136246	0	0	90.00
91.00	Nursing School cost	0	5,874,181	0.000000	0	0	91.00
92.00	Allied health cost	0	5,874,181	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,874,181	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/19/2016 12:38 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,671	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,671	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)	7,671	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)	496	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)	5,874,181	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)	5,874,181	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)	5,874,181	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)	765.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	379,817	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)	379,817	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | 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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	379,817	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)	51,748	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)	51,748	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	328,069	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: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	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	800,336	5,874,181	0.136246	0	0	90.00
91.00	Nursing School cost	0	5,874,181	0.000000	0	0	91.00
92.00	Allied health cost	0	5,874,181	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,874,181	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/19/2016 12:38 pm

Title XVIII | Hospital | PPS

		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		4,561,200		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.413431	51,044	21,103	54.00
57.00	05700	CT SCAN	0.423348	10,783	4,565	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.423278	4,351	1,842	58.00
60.00	06000	LABORATORY	0.350764	257,860	90,448	60.00
65.00	06500	RESPIRATORY THERAPY	0.543204	332,013	180,351	65.00
66.00	06600	PHYSICAL THERAPY	0.490879	1,488,620	730,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465647	1,247,835	581,051	67.00
68.00	06800	SPEECH PATHOLOGY	0.519035	357,870	185,747	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.239626	124,020	153,738	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.480812	1,334,388	641,590	73.00
74.00	07400	RENAL DIALYSIS	0.537522	154,600	83,101	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.989284	2,670	2,641	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,366,054	2,676,909	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)		5,366,054		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/19/2016 12:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.413431	0	0	54.00
57.00	05700	CT SCAN	0.423348	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.423278	0	0	58.00
60.00	06000	LABORATORY	0.350764	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.543204	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.490879	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465647	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.519035	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.239626	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.480812	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.537522	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.989284	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/19/2016 12:38 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		7,163,469		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,163,469		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		28,500		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,191,969		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 5/19/2016 12:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,218,824	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0193	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	202,849	3.00
4.00	Outlier Payments	63,832	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	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	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	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	7.00
8.00	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	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	21.016438	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	7,485,505	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	7,485,505	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	7,485,505	19.00
20.00	Deductibles	92,103	20.00
21.00	Subtotal (line 19 minus line 20)	7,393,402	21.00
22.00	Coinsurance	68,582	22.00
23.00	Subtotal (line 21 minus line 22)	7,324,820	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,421	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	13,924	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,126	26.00
27.00	Subtotal (sum of lines 23 and 25)	7,338,744	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	7,338,744	32.00
32.01	Sequestration adjustment (see instructions)	146,775	32.01
33.00	Interim payments	7,163,469	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	28,500	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	63,832	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/19/2016 12:38 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	2,251	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	3,334,147	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,550,432	0	0	0	6.00
7.00	Inventory	93,170	0	0	0	7.00
8.00	Prepaid expenses	17,227	0	0	0	8.00
9.00	Other current assets	22,806	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)	1,919,169	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	800,183	0	0	0	12.00
13.00	Land improvements	41,998	0	0	0	13.00
14.00	Accumulated depreciation	-11,775	0	0	0	14.00
15.00	Buildings	11,213,591	0	0	0	15.00
16.00	Accumulated depreciation	-887,765	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	1,350	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	62,244	0	0	0	21.00
22.00	Accumulated depreciation	-42,228	0	0	0	22.00
23.00	Major movable equipment	2,683,571	0	0	0	23.00
24.00	Accumulated depreciation	-1,221,975	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)	12,639,194	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	43,964,162	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	43,964,162	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,522,525	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	146,672	0	0	0	37.00
38.00	Salaries, wages, and fees payable	228,137	0	0	0	38.00
39.00	Payroll taxes payable	87,765	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	47,807,870	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	48,270,444	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,704,501	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	279,512	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	16,984,013	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	65,254,457	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-6,731,932				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)	-6,731,932	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,522,525	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/19/2016 12:38 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		-5,001,413		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,730,521				2.00
3.00	Total (sum of line 1 and line 2)		-6,731,934		0		3.00
4.00	ROUNDING	2		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)		2		0		10.00
11.00	Subtotal (line 3 plus line 10)		-6,731,932		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)		-6,731,932		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 153042 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/19/2016 12:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,896,160		6,896,160	1.00
2.00	SUBPROVIDER - IPF	0		0	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	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,896,160		6,896,160	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,896,160		6,896,160	17.00
18.00	Ancillary services	7,992,311	166,487	8,158,798	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,888,471	166,487	15,054,958	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		11,930,023		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)		11,930,023		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 153042	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/19/2016 12:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	15,054,958	1.00
2.00	Less contractual allowances and discounts on patients' accounts	4,883,411	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,171,547	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	11,930,023	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,758,476	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	607	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	19,235	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	2,113	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INC, TRANSPORT, EMP PHYS SVCS	6,000	24.00
25.00	Total other income (sum of lines 6-24)	27,955	25.00
26.00	Total (line 5 plus line 25)	-1,730,521	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,730,521	29.00