

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).  
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY  
 Provider CCN: 153037  
 Period: From 01/01/2015 To 12/31/2015  
 OMB NO. 0938-0050  
 Worksheet 5  
 Parts I-III  
 Date/Time Prepared: 5/18/2016 8:15 am

**PART I - COST REPORT STATUS**

Provider use only: 1.  Electronically filed cost report Date: 5/18/2016 Time: 8:15 am  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.  
 Contractor use only: 5.  Cost Report Status 6. Date Received: 10. NPR Date:  
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4  
 (2) Settled without Audit 8.  Initial Report for this Provider CCN 12.  If line 5, column 1 is 4: Enter  
 (3) Settled with Audit 9.  Final Report for this Provider CCN number of times reopened = 0-9.  
 (4) Reopened  
 (5) Amended

**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 SOUTHERN INDIANA REHAB HOSPITAL ( 153037 ) 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: 5/18/2016 Time: 8:15 am  
 zrgiYX8CcFmdvsFreIEf2RpDecpso0  
 by.Co0fFSdhJ2I9.DvryFh6fpygem0  
 JOUZ06g3Qr07wxjp  
 PI: Date: 5/18/2016 Time: 8:15 am  
 GzYdmz0pTMwpt6uZw6Chg.b1.JSSM0  
 UQD7q0Ops6qT0qREkFI..wKPCr5U7n  
 pwe20KsCs:03r2Nn

(Signed) *Bob Stettinsohl*  
 Officer or Administrator of Provider(s)  
 Title *VP Finance*  
 Date *5/18/16*

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00
		Part A 2.00	Part B 3.00		
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00 Hospital	0	59,490	7,035	0	0
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	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	7.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	10.00
12.00 CMHC I	0	0	0	0	12.00
200.00 Total	0	59,490	7,035	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: 153037		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:11 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 3104 BLACKISTON BOULEVARD	PO Box:					1.00			
2.00	City: NEW ALBANY	State: IN	Zip Code: 47150	County: FLOYD			2.00			
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	SOUTHERN INDIANA REHAB HOSPITAL	153037	31140	5	03/01/2002	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SOUTHERN INDIANA REHAB HOSPITAL	155765	31140		08/03/2007	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
					From:	To:				
					1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)				01/01/2015	12/31/2015		20.00		
21.00	Type of Control (see instructions)				5			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.				3	N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	118	91	3	0	369			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:11 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		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		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N		N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
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: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

		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	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>						
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
<b>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.</b>						
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: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:11 am		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
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
<b>Inpatient Rehabilitation Facility PPS</b>						
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	76.00
					1.00	
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:11 am	
		V 1.00	XIX 2.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	0.00	97.00
<b>Rural Providers</b>					
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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	48,542	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
<b>Transplant Center Information</b>					
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: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:11 am		
		1.00	2.00			
140.00	All Providers 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	18H006	140.00		
		1.00	2.00	3.00		
141.00	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: JHSMH INC	Contractor's Name: CGS		Contractor's Number: 15101		
142.00	Street: 250 EAST LIBERTY STREET	PO Box: SUITE 500				
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00	
				1.00		
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.	N			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	
155.00	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	N	N	N	N	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	N	161.00
				1.00		
165.00	Multi campus Is this hospital part of a Multi campus 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
		0	1.00	2.00	3.00	4.00
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				
				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)				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: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 8:11 am	
				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. 1, 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: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/18/2016 8:11 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
			Y/N	Date	Y/N
			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	04/27/2016	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

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	06/30/2015 38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	BKP LLP		BKP LLP	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435		LVCOSTREPORTS@BKD.COM	43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	04/27/2016		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	
<b>Cost Report Preparer Contact Information</b>				
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.	BKD LLP		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: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	34	12,410	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)		34	12,410	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)		34	12,410	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	26	9,490		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		60				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: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	4,963	118	7,281			1.00
2.00 HMO and other (see instructions)	307	463				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)	4,963	118	7,281			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	4,963	118	7,281	0.00	164.38	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	5,247	0	7,715	0.00	29.03	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	193.41	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: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	407	9	594	1.00
2.00 HMO and other (see instructions)			23	31		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	407	9	594	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
26.00 RURAL HEALTH CLINIC	0.00					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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-7

Date/Time Prepared:  
5/18/2016 8:11 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	14	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	456	0	12.00
13.00		RUB	1,018	0	13.00
14.00		RUA	3,149	0	14.00
15.00		RVC	37	0	15.00
16.00		RVB	79	0	16.00
17.00		RVA	277	0	17.00
18.00		RHC	6	0	18.00
19.00		RHB	5	0	19.00
20.00		RHA	27	0	20.00
21.00		RMC	0	0	21.00
22.00		RMB	25	0	22.00
23.00		RMA	11	0	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	0	28.00
29.00		HE2	0	0	29.00
30.00		HE1	0	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	0	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	0	0	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	6	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	5	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	15	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	29	0	52.00
53.00		CA2	0	0	53.00
54.00		CA1	59	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-7

Date/Time Prepared:  
5/18/2016 8:11 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	12	0	12	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	13	0	13	78.00
199.00		AAA	4	0	4	199.00
200.00	TOTAL		5,247	0	5,247	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		31140	31140	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	SNF EXPENSE WKST A		1,250,210	41.97	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2,978,693			207.00



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	544,603	544,603	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	316,164	316,164	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	94,733	180,163	274,896	1,689,683	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	288,995	2,989,687	3,278,682	-990,737	5.00
6.00	00600	MAINTENANCE & REPAIRS	232,902	462,378	695,280	-41,726	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,347	1,955	12,302	-1,955	8.00
9.00	00900	HOUSEKEEPING	222,644	64,931	287,575	-39,218	9.00
10.00	01000	DIETARY	265,490	493,119	758,609	-47,895	10.00
14.00	01400	CENTRAL SERVICE & SUPPLY	31,951	14,530	46,481	-9,495	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	119,619	68,805	188,424	-25,033	16.00
17.00	01700	SOCIAL SERVICE	790,589	195,937	986,526	-142,056	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,989,317	699,787	2,689,104	-352,701	30.00
44.00	04400	SKILLED NURSING FACILITY	1,164,123	312,230	1,476,353	-207,531	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	3,858	3,858	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,606	44,606	0	54.00
60.00	06000	LABORATORY	0	163,660	163,660	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	46,190	431,124	477,314	-7,908	65.00
66.00	06600	PHYSICAL THERAPY	2,592,252	642,026	3,234,278	-714,788	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,065,454	221,277	1,286,731	-21,490	67.00
68.00	06800	SPEECH PATHOLOGY	613,449	118,043	731,492	-17,922	68.00
69.00	06900	ELECTROCARDIOLOGY	0	361	361	-283	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	219,539	219,539	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	738,229	738,229	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	188,580	212,548	401,128	-35,018	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,716,635	8,278,793	17,995,428	-105,306	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	OTHER NRCC	0	0	0	105,306	194.00
200.00		TOTAL (SUM OF LINES 118-199)	9,716,635	8,278,793	17,995,428	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-19,111	525,492	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	64,424	380,588	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,800	1,957,779	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-868,650	1,419,295	5.00
6.00	00600	MAINTENANCE & REPAIRS	-12,744	640,810	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,347	8.00
9.00	00900	HOUSEKEEPING	0	248,357	9.00
10.00	01000	DIETARY	-7,809	702,905	10.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	36,986	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-23,061	140,330	16.00
17.00	01700	SOCIAL SERVICE	0	844,470	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-181,482	2,154,921	30.00
44.00	04400	SKILLED NURSING FACILITY	-18,612	1,250,210	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1	3,859	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,913	50,519	54.00
60.00	06000	LABORATORY	13,781	177,441	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,003	502,409	65.00
66.00	06600	PHYSICAL THERAPY	-90,058	2,429,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	-250	1,264,991	67.00
68.00	06800	SPEECH PATHOLOGY	-7,920	705,650	68.00
69.00	06900	ELECTROCARDIOLOGY	-78	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,096	231,635	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,596	735,633	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-170,163	195,947	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900	CMHC	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,280,116	16,610,006	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
194.00	07950	OTHER NRCC	0	105,306	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,280,116	16,715,312	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - BENEFITS RECLASS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,690,019	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	O		0	1,690,019	
<b>B - RENT AND LEASE RECLASS</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	127,189	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	O		0	127,189	
<b>C - INSURANCE RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,282	1.00
	O		0	12,282	
<b>D - PUBLIC RELATIONS RECLASS</b>					
1.00	OTHER NRCC	194.00	0	105,306	1.00
	O		0	105,306	
<b>E - THERAPY ADMINISTRATION RECLASS</b>					
1.00	OCCUPATIONAL THERAPY	67.00	158,607	5,784	1.00
2.00	SPEECH PATHOLOGY	68.00	85,006	3,100	2.00
	O		243,613	8,884	
<b>F - DEPRECIATION RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	521,725	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	188,975	2.00
	O		0	710,700	
<b>G - INTEREST EXPENSE RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,596	1.00
	O		0	10,596	
<b>H - EKG RECLASS</b>					
1.00	RESPIRATORY THERAPY	65.00	0	283	1.00
	TOTALS		0	283	
500.00	Grand Total: Increases		243,613	2,665,259	500.00

RECLASSIFICATIONS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-6

Date/Time Prepared:  
5/18/2016 8:11 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - BENEFITS RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,554	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	41,003	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1,955	0		3.00
4.00	HOUSEKEEPING	9.00	0	39,007	0		4.00
5.00	DIETARY	10.00	0	47,012	0		5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	5,588	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	20,925	0		7.00
8.00	SOCIAL SERVICE	17.00	0	137,755	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	349,605	0		9.00
10.00	SKILLED NURSING FACILITY	44.00	0	204,595	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	8,191	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	456,902	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	185,881	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	106,028	0		14.00
15.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	35,018	0		15.00
			0	1,690,019			
<b>B - RENT AND LEASE RECLASS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	336	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	101,299	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	723	0		3.00
4.00	HOUSEKEEPING	9.00	0	211	0		4.00
5.00	DIETARY	10.00	0	883	0		5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	3,907	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,108	0		7.00
8.00	SOCIAL SERVICE	17.00	0	4,301	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	3,096	0		9.00
10.00	SKILLED NURSING FACILITY	44.00	0	2,936	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	5,389	0		11.00
			0	127,189			
<b>C - INSURANCE RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,282	12		1.00
			0	12,282			
<b>D - PUBLIC RELATIONS RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	105,306	0		1.00
			0	105,306			
<b>E - THERAPY ADMINISTRATION RECLASS</b>							
1.00	PHYSICAL THERAPY	66.00	243,613	8,884	0		1.00
2.00		0.00	0	0	0		2.00
			243,613	8,884			
<b>F - DEPRECIATION RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	710,700	9		1.00
2.00		0.00	0	0	9		2.00
			0	710,700			
<b>G - INTEREST EXPENSE RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,596	11		1.00
			0	10,596			
<b>H - EKG RECLASS</b>							
1.00	ELECTROCARDIOLOGY	69.00	0	283	0		1.00
	TOTALS		0	283			
500.00	Grand Total: Decreases		243,613	2,665,259			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	425,000	0	0	0	0	1.00
2.00	Land Improvements	128,046	23,498	0	23,498	0	2.00
3.00	Buildings and Fixtures	14,812,387	174,172	0	174,172	0	3.00
4.00	Building Improvements	517,179	0	0	0	75,592	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,917,941	346,278	0	346,278	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,800,553	543,948	0	543,948	75,592	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,800,553	543,948	0	543,948	75,592	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	425,000	0				1.00
2.00	Land Improvements	151,544	0				2.00
3.00	Buildings and Fixtures	14,986,559	0				3.00
4.00	Building Improvements	441,587	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,264,219	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	21,268,909	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	21,268,909	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/18/2016 8:11 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	16,004,690	0	16,004,690	0.752492	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,264,219	0	5,264,219	0.247508	0	2.00
3.00	Total (sum of lines 1-2)	21,268,909	0	21,268,909	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	502,614	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	253,399	127,189	2.00
3.00	Total (sum of lines 1-2)	0	0	0	756,013	127,189	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	10,596	12,282	0	0	525,492	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	380,588	2.00
3.00	Total (sum of lines 1-2)	10,596	12,282	0	0	906,080	3.00

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8

Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-214,740			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	-612,409			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-8,751	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-7,809	DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00



Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 RENTAL INCOME - DIETARY	B	-7,239	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
34.00 RENTAL INCOME - ADMIN	B	-11,872	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
35.00 MISC INCOME - ADMIN	B	-88	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 MISC INCOME - OT OUTPATIENT	B	-250	OCCUPATIONAL THERAPY	67.00	0	36.00
37.00 MISC INCOME - TRANSPORTATION	B	-800	ADULTS & PEDIATRICS	30.00	0	37.00
38.00 MISC INCOME - ST	B	-7,920	SPEECH PATHOLOGY	68.00	0	38.00
39.00 MISC INCOME - PT	B	-74,034	PHYSICAL THERAPY	66.00	0	39.00
40.00 MISC INCOME - PULMONARY REHAB	B	-4,000	RESPIRATORY THERAPY	65.00	0	40.00
41.00 MISC INCOME - PSYCH	B	-60	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	41.00
42.00 MISC INCOME - NEUROPSYCH LAB	B	-1,200	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	42.00
43.00 TELEPHONE SERVICES	A	-28,792	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00 SCOTT COUNTY THERAPY SERVICES	A	-16,024	PHYSICAL THERAPY	66.00	0	44.00
45.00 SCOTT COUNTY THERAPY SERVICES-BENEFIT	A	-2,066	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
46.00 TRANSPORTATION	A	-177,529	ADULTS & PEDIATRICS	30.00	0	46.00
47.00 TRANSPORTATION-BENEFITS	A	-4,734	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	47.00
48.00 CIVIC ACTIVITIES/COMMUNITY BENEFIT	A	-87,055	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00 CABLE TV	A	-12,744	MAINTENANCE & REPAIRS	6.00	0	49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,280,116				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: 153037  
 Period: From 01/01/2015 To 12/31/2015  
 Worksheet A-8-1  
 Date/Time Prepared: 5/18/2016 8:11 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED COST	64,424	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION-MGMT FEE	494,514	1,220,004	2.00
3.00	6.00	MAINTENANCE & REPAIRS	MAINTENANCE AND REPAIRS	2,400	2,400	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORD & LIBRARY	20,252	34,562	4.00
4.01	30.00	ADULTS & PEDIATRICS	ADULTS AND PEDIATRICS	551	3,704	4.01
4.02	50.00	OPERATING ROOM	OPERATING ROOM	3,859	3,858	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY - DIAGNOSTIC	46,262	40,349	4.03
4.04	60.00	LABORATORY	LABORATORY	177,441	163,660	4.04
4.05	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY	432,010	395,007	4.05
4.06	68.00	SPEECH PATHOLOGY	SPEECH PATHOLOGY	4,824	4,824	4.06
4.07	69.00	ELECTROCARDIOLOGY	ELECTROCARDIOLOGY	283	361	4.07
4.08	71.00	MEDICAL SUPPLIES CHARGED TO	MEDICAL SUPPLIES	145,065	132,969	4.08
4.09	73.00	DRUGS CHARGED TO PATIENTS	DRUGS CHARGED TO PATIENTS	484,055	486,651	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,875,940	2,488,349	5.00

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

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

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	KENTUCKYONE	33.34	6.00
7.00	B	0.00	CLARK MEMORIAL	33.33	7.00
8.00	B	0.00	FLOYD MEMORIAL	33.33	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8-1

Date/Time Prepared:  
5/18/2016 8:11 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	64,424	9		1.00
2.00	-725,490	0		2.00
3.00	0	0		3.00
4.00	-14,310	0		4.00
4.01	-3,153	0		4.01
4.02	1	0		4.02
4.03	5,913	0		4.03
4.04	13,781	0		4.04
4.05	37,003	0		4.05
4.06	0	0		4.06
4.07	-78	0		4.07
4.08	12,096	0		4.08
4.09	-2,596	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	-612,409			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	SHARED SVCS JV		7.00
8.00	SHARED SVCS JV		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8-2  
Date/Time Prepared:  
5/18/2016 8:11 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	27,225	27,225	0	179,000	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	18,612	18,612	0	179,000	0	2.00
3.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	168,903	168,903	0	179,000	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			214,740	214,740	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	27,225		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	18,612		2.00
3.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	168,903		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	214,740		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	525,492	525,492			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	380,588		380,588		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,957,779	0	0	1,957,779	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,419,295	171,133	123,943	58,802	1,773,173 5.00
6.00 00600	MAINTENANCE & REPAIRS	640,810	0	0	47,389	688,199 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	10,347	0	0	2,105	12,452 8.00
9.00 00900	HOUSEKEEPING	248,357	0	0	45,302	293,659 9.00
10.00 01000	DIETARY	702,905	33,369	24,167	54,020	814,461 10.00
14.00 01400	CENTRAL SERVICE & SUPPLY	36,986	0	0	6,501	43,487 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	140,330	0	0	24,339	164,669 16.00
17.00 01700	SOCIAL SERVICE	844,470	0	0	160,862	1,005,332 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,154,921	55,615	40,279	404,768	2,655,583 30.00
44.00 04400	SKILLED NURSING FACILITY	1,250,210	62,633	45,362	236,865	1,595,070 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,859	0	0	0	3,859 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	50,519	1,881	1,362	0	53,762 54.00
60.00 06000	LABORATORY	177,441	1,389	1,006	0	179,836 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	502,409	784	568	9,398	513,159 65.00
66.00 06600	PHYSICAL THERAPY	2,429,432	114,642	83,030	477,881	3,104,985 66.00
67.00 06700	OCCUPATIONAL THERAPY	1,264,991	74,939	54,275	249,061	1,643,266 67.00
68.00 06800	SPEECH PATHOLOGY	705,650	4,781	3,463	142,115	856,009 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	231,635	0	0	0	231,635 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	735,633	1,283	929	0	737,845 73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	195,947	3,043	2,204	38,371	239,565 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	0 99.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,610,006	525,492	380,588	1,957,779	16,610,006 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	OTHER NRCC	105,306	0	0	0	105,306 194.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	16,715,312	525,492	380,588	1,957,779	16,715,312 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	1,773,173					5.00
6.00	00600	81,668	769,867				6.00
8.00	00800	1,478	0	13,930			8.00
9.00	00900	34,848	0	328	328,835		9.00
10.00	01000	96,651	72,496	328	30,536	1,014,472	10.00
14.00	01400	5,161	0	0	0	0	14.00
16.00	01600	19,541	0	0	1,285	0	16.00
17.00	01700	119,302	0	0	2,754	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	315,135	120,826	7,768	221,562	494,644	30.00
44.00	04400	189,285	136,075	3,420	0	519,828	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	458	0	0	0	0	50.00
54.00	05400	6,380	4,087	0	673	0	54.00
60.00	06000	21,341	3,019	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	60,896	1,703	0	1,754	0	65.00
66.00	06600	368,469	249,066	903	48,629	0	66.00
67.00	06700	195,005	162,810	1,183	14,115	0	67.00
68.00	06800	101,582	10,388	0	2,427	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	27,488	0	0	0	0	71.00
73.00	07300	87,559	2,787	0	449	0	73.00
76.00	03550	28,429	6,610	0	4,651	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		1,760,676	769,867	13,930	328,835	1,014,472	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	12,497	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,773,173	769,867	13,930	328,835	1,014,472	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
14.00	01400	48,648					14.00
16.00	01600	0	185,495				16.00
17.00	01700	0	0	1,127,388			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	90,063	547,380	4,452,961	0	30.00
44.00	04400	0	95,432	580,008	3,119,118	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	4,317	0	50.00
54.00	05400	0	0	0	64,902	0	54.00
60.00	06000	0	0	0	204,196	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	577,512	0	65.00
66.00	06600	0	0	0	3,772,052	0	66.00
67.00	06700	0	0	0	2,016,379	0	67.00
68.00	06800	0	0	0	970,406	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	48,648	0	0	307,771	0	71.00
73.00	07300	0	0	0	828,640	0	73.00
76.00	03550	0	0	0	279,255	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		48,648	185,495	1,127,388	16,597,509	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	117,803	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		48,648	185,495	1,127,388	16,715,312	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	09900	CMHC	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
194.00	07950	OTHER NRCC	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	171,133	123,943	295,076	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	33,369	24,167	57,536	10.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	55,615	40,279	95,894	30.00
44.00 04400	SKILLED NURSING FACILITY	0	62,633	45,362	107,995	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,881	1,362	3,243	54.00
60.00 06000	LABORATORY	0	1,389	1,006	2,395	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	784	568	1,352	65.00
66.00 06600	PHYSICAL THERAPY	0	114,642	83,030	197,672	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	74,939	54,275	129,214	67.00
68.00 06800	SPEECH PATHOLOGY	0	4,781	3,463	8,244	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,283	929	2,212	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,043	2,204	5,247	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	525,492	380,588	906,080	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	OTHER NRCC	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	525,492	380,588	906,080	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	295,076					5.00
6.00	00600	13,591	13,591				6.00
8.00	00800	246	0	246			8.00
9.00	00900	5,799	0	0	5,805		9.00
10.00	01000	16,084	1,280	6	539	75,445	10.00
14.00	01400	859	0	0	0	0	14.00
16.00	01600	3,252	0	0	23	0	16.00
17.00	01700	19,853	0	0	49	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	52,442	2,133	137	3,911	36,786	30.00
44.00	04400	31,499	2,402	60	0	38,659	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	76	0	0	0	0	50.00
54.00	05400	1,062	72	0	12	0	54.00
60.00	06000	3,551	53	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	10,134	30	0	31	0	65.00
66.00	06600	61,317	4,398	16	858	0	66.00
67.00	06700	32,451	2,874	21	249	0	67.00
68.00	06800	16,904	183	0	43	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	4,574	0	0	0	0	71.00
73.00	07300	14,571	49	0	8	0	73.00
76.00	03550	4,731	117	0	82	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		292,996	13,591	246	5,805	75,445	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	2,080	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		295,076	13,591	246	5,805	75,445	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
14.00	01400	859					14.00
16.00	01600	0	3,275				16.00
17.00	01700	0	0	19,902			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	1,590	9,663	202,556	0	30.00
44.00	04400	0	1,685	10,239	192,539	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	76	0	50.00
54.00	05400	0	0	0	4,389	0	54.00
60.00	06000	0	0	0	5,999	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	11,547	0	65.00
66.00	06600	0	0	0	264,261	0	66.00
67.00	06700	0	0	0	164,809	0	67.00
68.00	06800	0	0	0	25,374	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	859	0	0	5,433	0	71.00
73.00	07300	0	0	0	16,840	0	73.00
76.00	03550	0	0	0	10,177	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		859	3,275	19,902	904,000	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	2,080	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		859	3,275	19,902	906,080	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	09900	CMHC	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
194.00	07950	OTHER NRCC	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	73,748				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		73,748			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,621,902		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	24,017	24,017	288,995	-1,773,173	14,942,139
6.00 00600	MAINTENANCE & REPAIRS	0	0	232,902	0	688,199
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	10,347	0	12,452
9.00 00900	HOUSEKEEPING	0	0	222,644	0	293,659
10.00 01000	DIETARY	4,683	4,683	265,490	0	814,461
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	31,951	0	43,487
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	119,619	0	164,669
17.00 01700	SOCIAL SERVICE	0	0	790,589	0	1,005,332
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,805	7,805	1,989,317	0	2,655,583
44.00 04400	SKILLED NURSING FACILITY	8,790	8,790	1,164,123	0	1,595,070
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	3,859
54.00 05400	RADIOLOGY-DIAGNOSTIC	264	264	0	0	53,762
60.00 06000	LABORATORY	195	195	0	0	179,836
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	110	110	46,190	0	513,159
66.00 06600	PHYSICAL THERAPY	16,089	16,089	2,348,639	0	3,104,985
67.00 06700	OCCUPATIONAL THERAPY	10,517	10,517	1,224,061	0	1,643,266
68.00 06800	SPEECH PATHOLOGY	671	671	698,455	0	856,009
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	231,635
73.00 07300	DRUGS CHARGED TO PATIENTS	180	180	0	0	737,845
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	427	427	188,580	0	239,565
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	73,748	73,748	9,621,902	-1,773,173	14,836,833
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	OTHER NRCC	0	0	0	0	105,306
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)	525,492	380,588	1,957,779		1,773,173
203.00	Unit cost multiplier (Wkst. B, Part I)	7.125508	5.160655	0.203471		0.118669
204.00	Cost to be allocated (per Wkst. B, Part II)			0		295,076
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019748

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
		6.00	8.00	9.00	10.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800	49,731					8.00
9.00	00900	0	46,092				9.00
10.00	01000	0	1,086	80,605			10.00
14.00	01400	4,683	1,086	7,485	50,110		14.00
16.00	01600	0	0	0	0	100	16.00
17.00	01700	0	0	315	0	0	17.00
		0	0	675	0	0	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	7,805	25,702	54,310	24,433	0	30.00
44.00	04400	8,790	11,316	0	25,677	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	264	0	165	0	0	54.00
60.00	06000	195	0	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	110	0	430	0	0	65.00
66.00	06600	16,089	2,987	11,920	0	0	66.00
67.00	06700	10,517	3,915	3,460	0	0	67.00
68.00	06800	671	0	595	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	100	71.00
73.00	07300	180	0	110	0	0	73.00
76.00	03550	427	0	1,140	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		49,731	46,092	80,605	50,110	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		769,867	13,930	328,835	1,014,472	48,648	202.00
203.00		15.480626	0.302222	4.079586	20.244901	486.480000	203.00
204.00		13,591	246	5,805	75,445	859	204.00
205.00		0.273290	0.005337	0.072018	1.505588	8.590000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
6.00	00600			6.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
14.00	01400			14.00
16.00	01600	14,996		16.00
17.00	01700	0	14,996	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	7,281	7,281	30.00
44.00	04400	7,715	7,715	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	0	0	50.00
54.00	05400	0	0	54.00
60.00	06000	0	0	60.00
64.00	06400	0	0	64.00
65.00	06500	0	0	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
70.00	07000	0	0	70.00
71.00	07100	0	0	71.00
73.00	07300	0	0	73.00
76.00	03550	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	0	0	88.00
91.00	09100	0	0	91.00
92.00	09200			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	09900	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		14,996	14,996	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
194.00	07950	0	0	194.00
200.00				200.00
201.00				201.00
202.00		185,495	1,127,388	202.00
203.00		12.369632	75.179248	203.00
204.00		3,275	19,902	204.00
205.00		0.218392	1.327154	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,452,961		4,452,961	0	4,452,961	30.00
44.00	04400 SKILLED NURSING FACILITY	3,119,118		3,119,118	0	3,119,118	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,317		4,317	0	4,317	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	64,902		64,902	0	64,902	54.00
60.00	06000 LABORATORY	204,196		204,196	0	204,196	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	577,512	0	577,512	0	577,512	65.00
66.00	06600 PHYSICAL THERAPY	3,772,052	0	3,772,052	0	3,772,052	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,016,379	0	2,016,379	0	2,016,379	67.00
68.00	06800 SPEECH PATHOLOGY	970,406	0	970,406	0	970,406	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	307,771		307,771	0	307,771	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	828,640		828,640	0	828,640	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	279,255		279,255	0	279,255	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0		0	0	0	99.00
200.00	Subtotal (see instructions)	16,597,509	0	16,597,509	0	16,597,509	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	16,597,509	0	16,597,509	0	16,597,509	202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,947,530		12,947,530		30.00
44.00	04400	SKILLED NURSING FACILITY	2,978,693		2,978,693		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	124,148	0	124,148	0.034773	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,462	0	183,462	0.353763	54.00
60.00	06000	LABORATORY	1,102,597	64	1,102,661	0.185185	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,353,180	476,310	2,829,490	0.204105	65.00
66.00	06600	PHYSICAL THERAPY	8,783,254	10,520,434	19,303,688	0.195406	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,016,492	2,037,549	9,054,041	0.222705	67.00
68.00	06800	SPEECH PATHOLOGY	2,623,900	2,227,360	4,851,260	0.200032	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	759,820	81	759,901	0.405015	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,305,570	0	2,305,570	0.359408	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	332,457	1,588,879	1,921,336	0.145344	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0	0	0		99.00
200.00		Subtotal (see instructions)	41,511,103	16,850,677	58,361,780		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	41,511,103	16,850,677	58,361,780		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/18/2016 8:11 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.034773		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.353763		54.00
60.00	06000 LABORATORY	0.185185		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.204105		65.00
66.00	06600 PHYSICAL THERAPY	0.195406		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.222705		67.00
68.00	06800 SPEECH PATHOLOGY	0.200032		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405015		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359408		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.145344		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	09900 CMHC			99.00
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: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,452,961		4,452,961	0	4,452,961	30.00
44.00	04400 SKILLED NURSING FACILITY	3,119,118		3,119,118	0	3,119,118	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,317		4,317	0	4,317	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	64,902		64,902	0	64,902	54.00
60.00	06000 LABORATORY	204,196		204,196	0	204,196	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	577,512	0	577,512	0	577,512	65.00
66.00	06600 PHYSICAL THERAPY	3,772,052	0	3,772,052	0	3,772,052	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,016,379	0	2,016,379	0	2,016,379	67.00
68.00	06800 SPEECH PATHOLOGY	970,406	0	970,406	0	970,406	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	307,771		307,771	0	307,771	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	828,640		828,640	0	828,640	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	279,255		279,255	0	279,255	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0		0	0	0	99.00
200.00	Subtotal (see instructions)	16,597,509	0	16,597,509	0	16,597,509	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	16,597,509	0	16,597,509	0	16,597,509	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,947,530		12,947,530		30.00
44.00	04400	SKILLED NURSING FACILITY	2,978,693		2,978,693		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	124,148	0	124,148	0.034773	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,462	0	183,462	0.353763	54.00
60.00	06000	LABORATORY	1,102,597	64	1,102,661	0.185185	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,353,180	476,310	2,829,490	0.204105	65.00
66.00	06600	PHYSICAL THERAPY	8,783,254	10,520,434	19,303,688	0.195406	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,016,492	2,037,549	9,054,041	0.222705	67.00
68.00	06800	SPEECH PATHOLOGY	2,623,900	2,227,360	4,851,260	0.200032	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	759,820	81	759,901	0.405015	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,305,570	0	2,305,570	0.359408	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	332,457	1,588,879	1,921,336	0.145344	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0	0	0		99.00
200.00		Subtotal (see instructions)	41,511,103	16,850,677	58,361,780		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	41,511,103	16,850,677	58,361,780		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/18/2016 8:11 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	09900 CMHC			99.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153037		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/18/2016 8:11 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	202,556	0	202,556	7,281	27.82	30.00
44.00	SKILLED NURSING FACILITY	192,539		192,539	7,715	24.96	44.00
200.00	Total (lines 30-199)	395,095		395,095	14,996		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,963	138,071				
44.00	SKILLED NURSING FACILITY	5,247	130,965				
200.00	Total (lines 30-199)	10,210	269,036				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 153037		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part II Date/Time Prepared: 5/18/2016 8:11 am	
Cost Center Description			Capital Related Cost (from Wkst. C, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	76	124,148	0.000612	49,934	31	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,389	183,462	0.023923	71,264	1,705	54.00
60.00	06000	LABORATORY	5,999	1,102,661	0.005440	528,020	2,872	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,547	2,829,490	0.004081	792,787	3,235	65.00
66.00	06600	PHYSICAL THERAPY	264,261	19,303,688	0.013690	3,258,047	44,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,809	9,054,041	0.018203	2,407,770	43,829	67.00
68.00	06800	SPEECH PATHOLOGY	25,374	4,851,260	0.005230	1,244,040	6,506	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,433	759,901	0.007150	297,975	2,131	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,840	2,305,570	0.007304	857,997	6,267	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,177	1,921,336	0.005297	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	508,905	42,435,557		9,507,834	111,179	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153037		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/18/2016 8:11 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS 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
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	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	7,281	0.00	4,963	0		30.00
44.00	04400	SKILLED NURSING FACILITY	7,715	0.00	5,247	0		44.00
200.00		Total (lines 30-199)	14,996		10,210	0		200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/18/2016 8:11 am
--	----------------------	---------------------------------------	---

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	124,148	0.000000	0.000000	49,934	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	183,462	0.000000	0.000000	71,264	54.00
60.00	06000 LABORATORY	0	1,102,661	0.000000	0.000000	528,020	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,829,490	0.000000	0.000000	792,787	65.00
66.00	06600 PHYSICAL THERAPY	0	19,303,688	0.000000	0.000000	3,258,047	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	9,054,041	0.000000	0.000000	2,407,770	67.00
68.00	06800 SPEECH PATHOLOGY	0	4,851,260	0.000000	0.000000	1,244,040	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	759,901	0.000000	0.000000	297,975	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,305,570	0.000000	0.000000	857,997	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,921,336	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	42,435,557			9,507,834	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/18/2016 8:11 am
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	119,966	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,944	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
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
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	326,014	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	448,924	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/18/2016 8:11 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.034773	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.353763	0	0	0	54.00
60.00	06000 LABORATORY	0.185185	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.204105	119,966	0	24,486	65.00
66.00	06600 PHYSICAL THERAPY	0.195406	2,944	0	575	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.222705	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.200032	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405015	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359408	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.145344	326,014	0	47,384	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000			0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
200.00	Subtotal (see instructions)		448,924	0	72,445	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		448,924	0	72,445	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/18/2016 8:11 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153037 Component CCN: 155765	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/18/2016 8:11 am
	Title XVIII	Skilled Nursing Facility	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153037 Component CCN: 155765	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/18/2016 8:11 am
Title XVIII		Skilled Nursing Facility	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	124,148	0.000000	0.000000	19,043	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	183,462	0.000000	0.000000	52,565	54.00
60.00 06000 LABORATORY	0	1,102,661	0.000000	0.000000	391,109	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	2,829,490	0.000000	0.000000	675,455	65.00
66.00 06600 PHYSICAL THERAPY	0	19,303,688	0.000000	0.000000	2,815,633	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	9,054,041	0.000000	0.000000	2,169,417	67.00
68.00 06800 SPEECH PATHOLOGY	0	4,851,260	0.000000	0.000000	419,623	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	759,901	0.000000	0.000000	202,210	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,305,570	0.000000	0.000000	808,148	73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,921,336	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00 09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	42,435,557			7,553,203	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153037 Component CCN: 155765	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/18/2016 8:11 am
Title XVIII		Skilled Nursing Facility	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	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
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
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/18/2016 8:11 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.034773	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.353763	0	0	0	54.00
60.00	06000 LABORATORY	0.185185	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.204105	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.195406	0	467,278	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.222705	0	294,637	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.200032	0	369,882	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405015	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359408	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.145344	0	46,926	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
200.00	Subtotal (see instructions)			1,178,723	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	1,178,723	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/18/2016 8:11 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	91,309	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	65,617	0	67.00
68.00	06800 SPEECH PATHOLOGY	73,988	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,820	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	237,734	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	237,734	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/18/2016 8:11 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,281	1.00
2.00	Total inpatient days (including private room days, excluding swing-bed and newborn days)		7,281	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)		7,281	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)		4,963	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
<b>SWING BED ADJUSTMENT</b>				
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)		4,452,961	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)		4,452,961	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		4,452,961	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		611.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,035,321	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)		3,035,321	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 8:11 am
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)					2,137,307 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,172,628 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)					138,071 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					111,179 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					249,250 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,923,378 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: 153037		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/18/2016 8:11 am	
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	202,556	4,452,961	0.045488	0	0	90.00
91.00	Nursing School cost	0	4,452,961	0.000000	0	0	91.00
92.00	Allied health cost	0	4,452,961	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,452,961	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Component CCN: 155765		Date/Time Prepared: 5/18/2016 8:11 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,715	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,715	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)		7,715	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)		5,247	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
<b>SWING BED ADJUSTMENT</b>				
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)		3,119,118	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)		3,119,118	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,119,118	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1	
		Component CCN: 155765		Date/Time Prepared: 5/18/2016 8:11 am	
		Title XVIII	Skilled Nursing Facility	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)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				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)				3,119,118 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				404.29 71.00
72.00	Program routine service cost (line 9 x line 71)				2,121,310 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				2,121,310 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				2,121,310 83.00
84.00	Program inpatient ancillary services (see instructions)				1,719,173 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				3,840,483 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: 153037 Component CCN: 155765		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/18/2016 8:11 am	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/18/2016 8:11 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,281	1.00
2.00	Total inpatient days (including private room days, excluding swing-bed and newborn days)		7,281	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)		7,281	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)		118	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
<b>SWING BED ADJUSTMENT</b>				
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)		4,452,961	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)		4,452,961	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		4,452,961	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		611.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		72,168	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)		72,168	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/18/2016 8:11 am
Title XIX			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					63,333 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					135,501 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					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: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet D-1  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Title XIX Hospital Cost		
				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	202,556	4,452,961	0.045488	0	0	90.00
91.00 Nursing School cost	0	4,452,961	0.000000	0	0	91.00
92.00 Allied health cost	0	4,452,961	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,452,961	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/18/2016 8:11 am	
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		8,570,603		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.034773	49,934	1,736	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.353763	71,264	25,211	54.00
60.00	06000 LABORATORY	0.185185	528,020	97,781	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.204105	792,787	161,812	65.00
66.00	06600 PHYSICAL THERAPY	0.195406	3,258,047	636,642	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.222705	2,407,770	536,222	67.00
68.00	06800 SPEECH PATHOLOGY	0.200032	1,244,040	248,848	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405015	297,975	120,684	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359408	857,997	308,371	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.145344	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		9,507,834	2,137,307	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		9,507,834		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153037 Component CCN: 155765	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/18/2016 8:11 am	
		Title XVIII	Skilled Nursing Facility	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.034773	19,043	662	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.353763	52,565	18,596	54.00
60.00	06000 LABORATORY	0.185185	391,109	72,428	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.204105	675,455	137,864	65.00
66.00	06600 PHYSICAL THERAPY	0.195406	2,815,633	550,192	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.222705	2,169,417	483,140	67.00
68.00	06800 SPEECH PATHOLOGY	0.200032	419,623	83,938	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405015	202,210	81,898	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359408	808,148	290,455	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.145344	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,553,203	1,719,173	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)		7,553,203		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/18/2016 8:11 am	
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		252,110		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.034773	4,608	160	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.353763	1,549	548	54.00
60.00	06000 LABORATORY	0.185185	13,580	2,515	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.204105	16,806	3,430	65.00
66.00	06600 PHYSICAL THERAPY	0.195406	75,822	14,816	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.222705	73,475	16,363	67.00
68.00	06800 SPEECH PATHOLOGY	0.200032	57,104	11,423	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.405015	16,968	6,872	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359408	18,878	6,785	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.145344	2,895	421	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		281,685	63,333	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		281,685		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/18/2016 8:11 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		72,445	2.00
3.00	PPS payments		73,895	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		73,895	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		15,131	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		58,764	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		58,764	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		58,764	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		12,157	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		7,902	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,157	36.00
37.00	Subtotal (see instructions)		66,666	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		66,666	40.00
40.01	Sequestration adjustment (see instructions)		1,333	40.01
41.00	Interim payments		58,298	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		7,035	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 153037		Period: From 01/01/2015 To 12/31/2015		Worksheet E-1 Part I Date/Time Prepared: 5/18/2016 8:11 am	
		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		6,619,095		58,298	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	06/25/2015	13,235		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)		13,235		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)		6,632,330		58,298	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		59,490		7,035	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		6,691,820		65,333	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153037  
Component CCN: 155765

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/18/2016 8:11 am

Title XVIII

Skilled Nursing  
Facility

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					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		2,233,241		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)		2,233,241		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,233,241		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: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Prepared: 5/18/2016 8:11 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		6,650,662	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0396	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		242,749	3.00
4.00	Outlier Payments		885	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)		19.947945	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)		6,894,296	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)		6,894,296	17.00
18.00	Primary payer payments		19,064	18.00
19.00	Subtotal (line 17 less line 18).		6,875,232	19.00
20.00	Deductibles		46,532	20.00
21.00	Subtotal (line 19 minus line 20)		6,828,700	21.00
22.00	Coinsurance		3,780	22.00
23.00	Subtotal (line 21 minus line 22)		6,824,920	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		5,336	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		3,468	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,336	26.00
27.00	Subtotal (sum of lines 23 and 25)		6,828,388	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)		6,828,388	32.00
32.01	Sequestration adjustment (see instructions)		136,568	32.01
33.00	Interim payments		6,632,330	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)		59,490	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		885	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153037 Component CCN: 155765	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 5/18/2016 8:11 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,415,295	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,415,295	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		134,978	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		2,280,317	12.00
13.00	Inpatient primary payer payments		1,500	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		2,278,817	15.00
15.01	Sequestration adjustment (see instructions)		45,576	15.01
16.00	Interim payments		2,233,241	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		0	18.00
19.00	Protected amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153037	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/18/2016 8:11 am
		Title XIX	Hospital	Cost
		Inpatient	Outpatient	
		1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	135,501		1.00
2.00	Medical and other services		237,734	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	135,501	237,734	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	135,501	237,734	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	281,685	1,178,723	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	281,685	1,178,723	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	281,685	1,178,723	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	146,184	940,989	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	135,501	237,734	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	135,501	237,734	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	135,501	237,734	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	135,501	237,734	36.00
37.00	ZERO OUT MEDICAID SETTLEMENT	-135,501	-237,734	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G

Date/Time Prepared:  
5/18/2016 8:11 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,641,499	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	14,385,853	0	0	0	4.00
5.00	Other receivable	-60,543	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,697,602	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	133,241	0	0	0	8.00
9.00	Other current assets	-58,660	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)	6,343,788	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	425,000	0	0	0	12.00
13.00	Land improvements	151,544	0	0	0	13.00
14.00	Accumulated depreciation	-129,760	0	0	0	14.00
15.00	Buildings	14,986,559	0	0	0	15.00
16.00	Accumulated depreciation	-12,352,469	0	0	0	16.00
17.00	Leasehold improvements	441,587	0	0	0	17.00
18.00	Accumulated depreciation	-376,706	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,264,219	0	0	0	23.00
24.00	Accumulated depreciation	-4,658,439	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)	3,751,535	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,095,323	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	338,225	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,016,648	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	104,006	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	479,691	0	0	0	43.00
44.00	Other current liabilities	463,131	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,401,701	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,528,765	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,528,765	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,930,466	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	5,164,857	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,164,857	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,095,323	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-1

Date/Time Prepared:  
5/18/2016 8:11 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,871,989			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		292,868				2.00
3.00	Total (sum of line 1 and line 2)		5,164,857			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		5,164,857			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)		5,164,857			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/18/2016 8:11 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	12,947,530		12,947,530	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,978,693		2,978,693	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)	15,926,223		15,926,223	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
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)	15,926,223		15,926,223	17.00
18.00	Ancillary services	25,584,898	15,261,780	40,846,678	18.00
19.00	Outpatient services	0	1,588,879	1,588,879	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	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)	41,511,121	16,850,659	58,361,780	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,995,428		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)		17,995,428		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153037

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-3

Date/Time Prepared:  
5/18/2016 8:11 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	58,361,780	1.00
2.00	Less contractual allowances and discounts on patients' accounts	40,178,015	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,183,765	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,995,428	4.00
5.00	Net income from service to patients (line 3 minus line 4)	188,337	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-19,592	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	0	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	0	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	7,809	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	116,314	24.00
25.00	Total other income (sum of lines 6-24)	104,531	25.00
26.00	Total (line 5 plus line 25)	292,868	26.00
27.00	OTHER EXPENSES	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)	292,868	29.00