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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-3042	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/18/2017 8:16 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/18/2017 Time: 8:16 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAFAYETTE REGIONAL REHABILITATION HO (15-3042) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-9,227	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-9,227	0	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2017 8:14 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 950 PARK EAST BLVD	PO Box:			1.00
2.00	City: LAFAYETTE	State: IN	Zip Code: 47905	County: TIPPECANOE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	LAFAYETTE REGIONAL REHABILITATION HO	153042	29200	5	04/18/2013	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	407	61	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2017 8:14 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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2017 8:14 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2017 8:14 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	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2017 8:14 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	329003	140.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/18/2017 8:14 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2017 8:14 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/23/2017	Y	03/23/2017
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/18/2017 8:14 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CATHERINE	CHRISTY	41.00
42.00	Enter the employer/company name of the cost report preparer.	ERNEST HEALTH INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	505-798-3191	CATHERINECHRISTY@ERNESTHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/18/2017 8:14 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/18/2017 8:14 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,640	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,640	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		40	14,640	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/18/2017 8:14 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,103	407	8,080			1.00
2.00	HMO and other (see instructions)	914	61				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,103	407	8,080			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	5,103	407	8,080	0.00	91.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	91.87	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: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/18/2017 8:14 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	397	32	604	1.00
2.00	HMO and other (see instructions)			61	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	397	32	604	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,204,487	2,204,487	173,664	2,378,151	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		298,952	298,952	40,115	339,067	2.00
3.00	00300	OTHER CAP REL COSTS		213,779	213,779	-213,779	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	463,761	627,557	1,091,318	0	1,091,318	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,156,512	1,686,335	2,842,847	0	2,842,847	5.00
7.00	00700	OPERATION OF PLANT	88,424	361,098	449,522	0	449,522	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,217	29,217	0	29,217	8.00
9.00	00900	HOUSEKEEPING	98,895	51,887	150,782	0	150,782	9.00
10.00	01000	DIETARY	239,410	175,067	414,477	0	414,477	10.00
13.00	01300	NURSING ADMINISTRATION	267,891	26,310	294,201	0	294,201	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,148	59,090	114,238	0	114,238	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,678,716	269,495	1,948,211	0	1,948,211	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,821	25,821	-9,223	16,598	54.00
57.00	05700	CT SCAN	0	0	0	6,203	6,203	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,020	3,020	58.00
60.00	06000	LABORATORY	0	86,293	86,293	0	86,293	60.00
65.00	06500	RESPIRATORY THERAPY	97,467	33,261	130,728	0	130,728	65.00
66.00	06600	PHYSICAL THERAPY	550,690	65,828	616,518	-31,104	585,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,309	37,868	474,177	24,487	498,664	67.00
68.00	06800	SPEECH PATHOLOGY	130,728	34,951	165,679	6,617	172,296	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,146	100,743	132,889	0	132,889	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,005	313,553	623,558	0	623,558	73.00
74.00	07400	RENAL DIALYSIS	0	121,109	121,109	0	121,109	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,606,102	6,822,701	12,428,803	0	12,428,803	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,606,102	6,822,701	12,428,803	0	12,428,803	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,821,784	556,367		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	93,522	432,589		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	435,647	1,526,965		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,388	2,903,235		5.00
7.00	00700	OPERATION OF PLANT	-5,801	443,721		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,217		8.00
9.00	00900	HOUSEKEEPING	0	150,782		9.00
10.00	01000	DIETARY	-16,976	397,501		10.00
13.00	01300	NURSING ADMINISTRATION	0	294,201		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,242	112,996		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,948,211		30.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,598		54.00
57.00	05700	CT SCAN	0	6,203		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,020		58.00
60.00	06000	LABORATORY	0	86,293		60.00
65.00	06500	RESPIRATORY THERAPY	0	130,728		65.00
66.00	06600	PHYSICAL THERAPY	0	585,414		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	498,664		67.00
68.00	06800	SPEECH PATHOLOGY	0	172,296		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-62	132,827		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	623,558		73.00
74.00	07400	RENAL DIALYSIS	0	121,109		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,256,308	11,172,495		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,256,308	11,172,495		200.00

RECLASSIFICATIONS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/18/2017 8:14 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RCLS PCT THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	22,208	2,279		1.00
2.00	SPEECH PATHOLOGY	68.00	6,001	616		2.00
	TOTALS		28,209	2,895		
	B - RCLS CT & MRI FROM RADIOLOGY					
1.00	CT SCAN	57.00	0	6,203		1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	3,020		2.00
	TOTALS		0	9,223		
500.00	Grand Total: Increases		28,209	12,118		500.00

RECLASSIFICATIONS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/18/2017 8:14 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RCLS PCT THERAPY						
1.00	PHYSICAL THERAPY	66.00	28,209	2,895	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		28,209	2,895			
	B - RCLS CT & MRI FROM RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,223	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	9,223			
500.00	Grand Total: Decreases		28,209	12,118			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 5/18/2017 8:14 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	800,183	0	0	0	0	1.00
2.00	Land Improvements	41,998	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,213,591	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,350	19,330	0	19,330	0	5.00
6.00	Movable Equipment	2,743,616	45,891	0	45,891	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,800,738	65,221	0	65,221	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,800,738	65,221	0	65,221	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	800,183	0	1.00
2.00	Land Improvements	41,998	0	2.00
3.00	Buildings and Fixtures	11,213,591	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	20,680	0	5.00
6.00	Movable Equipment	2,789,507	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,865,959	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,865,959	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/18/2017 8:14 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	319,775	2,975	1,881,737	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	279,238	19,714	0	0	0	2.00
3.00	Total (sum of lines 1-2)	599,013	22,689	1,881,737	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,204,487		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	298,952		2.00
3.00	Total (sum of lines 1-2)	0	2,503,439		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/18/2017 8:14 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	12,076,452	0	12,076,452	0.812356	12,848	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,789,507	0	2,789,507	0.187644	2,968	2.00
3.00	Total (sum of lines 1-2)	14,865,959	0	14,865,959	1.000000	15,816	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	160,816	0	173,664	341,843	2,975	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37,147	0	40,115	372,760	19,714	2.00
3.00	Total (sum of lines 1-2)	197,963	0	213,779	714,603	22,689	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	37,885	12,848	160,816	0	556,367	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,968	37,147	0	432,589	2.00
3.00	Total (sum of lines 1-2)	37,885	15,816	197,963	0	988,956	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/18/2017 8:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,010	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,799	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,635,422			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-15,850	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-642	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	-921	OPERATION OF PLANT	7.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INTEREST INCOME	B	-3,100	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PRE-OPENING AMORTIZATION - CAP	A	4,933	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/18/2017 8:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	PRE-OPENING AMORTIZATION - A&G	A	184,496	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER EXPENSE-ADVERTISING/MARKETING-	A	1,035	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-600	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-5,216	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-50,674	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-1,175	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER EXPENSE-ADVERTISING/MARKETING-	A	259	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-1,112	DIETARY	10.00	0	33.09
33.10	BAD DEBT EXPENSE-BAD DEBT--	A	55,089	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER EXPENSE-COMMUNITY EVENTS--FOOD	A	-14	DIETARY	10.00	0	33.11
33.12	OTHER EXPENSE-CONTRIBUTIONS / SPONSO	A	-350	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER EXPENSE-CONTRIBUTIONS / SPONSO	A	-6,750	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER EXPENSE-FLOWERS & GIFTS--HUMAN	A	-25	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER EXPENSE-FLOWERS & GIFTS--ADMIN	A	-1,398	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OTHER EXPENSE-FLOWERS & GIFTS--MARKE	A	-170	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	TAXES-FRANCHISE FEES/BUSINESS TAX--A	A	-1,595	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER EXPENSE-GIVEAWAYS--HUMAN RESOU	A	-183	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	OTHER EXPENSE-GIVEAWAYS--MARKETING	A	-70	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	OTHER EXPENSE-GIVEAWAYS--ADMIN - HOS	A	-253	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	OTHER EXPENSE-GIVEAWAYS--ADMISSIONS	A	-34	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	OTHER EXPENSE-GIVEAWAYS--CENTRAL SUP	A	-62	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.22
33.23	OTHER FEES-LATE FEES--PLANT OPERATIO	A	-81	OPERATION OF PLANT	7.00	0	33.23
33.24	OTHER FEES-LATE FEES--ADMIN - HOSPIT	A	-570	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	OTHER EXPENSE-MARKETING COLLATERAL--	A	-2,790	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	OTHER EXPENSE-MARKETING COLLATERAL--	A	-1,316	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	MARKETING EXPENSE	A	-6,546	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	MARKETING BENEFITS	A	-474	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.28
33.29	TELEPHONE OPERATOR EXPENSE	A	-6,364	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	TELEPHONE BENEFIT EXPENSE	A	-1,365	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31	TELEVISION DEPRECIATION	A	-9,843	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.31
33.32	UNALLOWABLE LOBBYING % OF ASSOC DUES	A	-1,195	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	ADJ HEALTH/DENTAL INS TO ACTUAL	A	437,486	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.33
33.34	ADJ LIABILITY INS TO ACTUAL	A	-2,923	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	PHYSICIAN CONTRACT	A	-174,714	ADMINISTRATIVE & GENERAL	5.00	0	33.35
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,256,308				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: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/18/2017 8:14 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO ALLOC CAP - BUILDING	16,057	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO ALLOC CAP - EQUIPMENT	103,365	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO ALLOC - A & G	900,366	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY INTEREST	0	1,843,852	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	248,270	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES - INTERCOMPA	0	584,688	4.02
4.03	0.00			0	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	PRE-OPENING AMORTIZATION - H	20,522	0	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	PRE-OPENING AMORTIZATION - H	1,078	0	4.05
5.00	0		0	1,041,388	2,676,810	5.00

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

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

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

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

6.00	B		0.00	ERNEST HEALTH	100.00	6.00
7.00	B		0.00	MPT	49.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/18/2017 8:14 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	16,057	9		1.00
2.00	103,365	9		2.00
3.00	900,366	0		3.00
4.00	-1,843,852	11		4.00
4.01	-248,270	0		4.01
4.02	-584,688	0		4.02
4.03	0	0		4.03
4.04	20,522	0		4.04
4.05	1,078	9		4.05
5.00	-1,635,422			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	RE INVEST TRUST		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	556,367	556,367				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	432,589		432,589			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,526,965	2,238	1,740	1,530,943		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,903,235	37,059	28,814	344,309	3,313,417	5.00
7.00	00700	OPERATION OF PLANT	443,721	127,953	99,487	26,325	697,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,217	0	0	0	29,217	8.00
9.00	00900	HOUSEKEEPING	150,782	3,625	2,819	29,442	186,668	9.00
10.00	01000	DIETARY	397,501	51,060	39,700	71,275	559,536	10.00
13.00	01300	NURSING ADMINISTRATION	294,201	5,840	4,541	79,755	384,337	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,996	6,062	4,713	16,418	140,189	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,948,211	227,043	176,532	499,778	2,851,564	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,598	0	0	0	16,598	54.00
57.00	05700	CT SCAN	6,203	0	0	0	6,203	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,020	0	0	0	3,020	58.00
60.00	06000	LABORATORY	86,293	0	0	0	86,293	60.00
65.00	06500	RESPIRATORY THERAPY	130,728	2,332	1,813	29,017	163,890	65.00
66.00	06600	PHYSICAL THERAPY	585,414	38,703	30,093	155,549	809,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	498,664	23,210	18,046	136,506	676,426	67.00
68.00	06800	SPEECH PATHOLOGY	172,296	2,565	1,994	40,706	217,561	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,827	5,362	4,169	9,570	151,928	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	623,558	6,528	5,076	92,293	727,455	73.00
74.00	07400	RENAL DIALYSIS	121,109	0	0	0	121,109	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,172,495	539,580	419,537	1,530,943	11,142,656	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,647	12,943	0	29,590	192.00
194.00	07950	MARKETING	0	140	109	0	249	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,172,495	556,367	432,589	1,530,943	11,172,495	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,313,417					5.00
7.00	00700	OPERATION OF PLANT	294,063	991,549				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,318	0	41,535			8.00
9.00	00900	HOUSEKEEPING	78,700	9,238	0	274,606		9.00
10.00	01000	DIETARY	235,903	130,111	0	36,373	961,923	10.00
13.00	01300	NURSING ADMINISTRATION	162,038	14,883	0	4,160	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,104	15,447	0	4,318	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,202,229	578,551	41,535	161,734	961,923	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,998	0	0	0	0	54.00
57.00	05700	CT SCAN	2,615	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,273	0	0	0	0	58.00
60.00	06000	LABORATORY	36,381	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	69,097	5,941	0	1,661	0	65.00
66.00	06600	PHYSICAL THERAPY	341,398	98,623	0	27,570	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	285,184	59,144	0	16,534	0	67.00
68.00	06800	SPEECH PATHOLOGY	91,725	6,535	0	1,827	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,053	13,665	0	3,820	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,698	16,635	0	4,650	0	73.00
74.00	07400	RENAL DIALYSIS	51,060	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,300,837	948,773	41,535	262,647	961,923	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,475	42,420	0	11,859	0	192.00
194.00	07950	MARKETING	105	356	0	100	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,313,417	991,549	41,535	274,606	961,923	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	565,418					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	219,058				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	565,418	95,003	6,457,957	0	6,457,957	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	937	24,533	0	24,533	54.00
57.00	05700	CT SCAN	0	350	9,168	0	9,168	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	171	4,464	0	4,464	58.00
60.00	06000	LABORATORY	0	5,255	127,929	0	127,929	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,945	248,534	0	248,534	65.00
66.00	06600	PHYSICAL THERAPY	0	34,741	1,312,091	0	1,312,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	30,470	1,067,758	0	1,067,758	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,234	325,882	0	325,882	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,524	235,990	0	235,990	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,679	1,086,117	0	1,086,117	73.00
74.00	07400	RENAL DIALYSIS	0	2,749	174,918	0	174,918	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	565,418	219,058	11,075,341	0	11,075,341	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	96,344	0	96,344	192.00
194.00	07950	MARKETING	0	0	810	0	810	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	565,418	219,058	11,172,495	0	11,172,495	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,238	1,740	3,978	3,978	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	37,059	28,814	65,873	895	5.00
7.00	00700	OPERATION OF PLANT	0	127,953	99,487	227,440	68	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	3,625	2,819	6,444	77	9.00
10.00	01000	DIETARY	0	51,060	39,700	90,760	185	10.00
13.00	01300	NURSING ADMINISTRATION	0	5,840	4,541	10,381	207	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,062	4,713	10,775	43	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	227,043	176,532	403,575	1,298	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,332	1,813	4,145	75	65.00
66.00	06600	PHYSICAL THERAPY	0	38,703	30,093	68,796	404	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	23,210	18,046	41,256	355	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,565	1,994	4,559	106	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,362	4,169	9,531	25	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,528	5,076	11,604	240	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	539,580	419,537	959,117	3,978	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,647	12,943	29,590	0	192.00
194.00	07950	MARKETING	0	140	109	249	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	556,367	432,589	988,956	3,978	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	66,768					5.00
7.00	00700	OPERATION OF PLANT	5,926	233,434				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	248	0	248			8.00
9.00	00900	HOUSEKEEPING	1,586	2,175	0	10,282		9.00
10.00	01000	DIETARY	4,754	30,631	0	1,362	127,692	10.00
13.00	01300	NURSING ADMINISTRATION	3,265	3,504	0	156	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,191	3,637	0	162	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,225	136,203	248	6,056	127,692	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	141	0	0	0	0	54.00
57.00	05700	CT SCAN	53	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26	0	0	0	0	58.00
60.00	06000	LABORATORY	733	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,392	1,399	0	62	0	65.00
66.00	06600	PHYSICAL THERAPY	6,880	23,218	0	1,032	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,747	13,924	0	619	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	1,539	0	68	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,291	3,217	0	143	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,180	3,916	0	174	0	73.00
74.00	07400	RENAL DIALYSIS	1,029	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,515	223,363	248	9,834	127,692	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	251	9,987	0	444	0	192.00
194.00	07950	MARKETING	2	84	0	4	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	66,768	233,434	248	10,282	127,692	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	17,513					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,808				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,513	6,859	723,669	0	723,669	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68	209	0	209	54.00
57.00	05700	CT SCAN	0	25	78	0	78	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12	38	0	38	58.00
60.00	06000	LABORATORY	0	379	1,112	0	1,112	60.00
65.00	06500	RESPIRATORY THERAPY	0	573	7,646	0	7,646	65.00
66.00	06600	PHYSICAL THERAPY	0	2,507	102,837	0	102,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,198	64,099	0	64,099	67.00
68.00	06800	SPEECH PATHOLOGY	0	594	8,714	0	8,714	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	182	14,389	0	14,389	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,213	24,327	0	24,327	73.00
74.00	07400	RENAL DIALYSIS	0	198	1,227	0	1,227	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,513	15,808	948,345	0	948,345	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	40,272	0	40,272	192.00
194.00	07950	MARKETING	0	0	339	0	339	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,513	15,808	988,956	0	988,956	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	47,726					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		47,726				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	192	192	5,142,342			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,179	3,179	1,156,512	-3,313,417	7,859,078	5.00
7.00	00700	OPERATION OF PLANT	10,976	10,976	88,424	0	697,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	29,217	8.00
9.00	00900	HOUSEKEEPING	311	311	98,895	0	186,668	9.00
10.00	01000	DIETARY	4,380	4,380	239,410	0	559,536	10.00
13.00	01300	NURSING ADMINISTRATION	501	501	267,891	0	384,337	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520	520	55,148	0	140,189	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,476	19,476	1,678,716	0	2,851,564	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	16,598	54.00
57.00	05700	CT SCAN	0	0	0	0	6,203	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	3,020	58.00
60.00	06000	LABORATORY	0	0	0	0	86,293	60.00
65.00	06500	RESPIRATORY THERAPY	200	200	97,467	0	163,890	65.00
66.00	06600	PHYSICAL THERAPY	3,320	3,320	522,481	0	809,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,991	1,991	458,517	0	676,426	67.00
68.00	06800	SPEECH PATHOLOGY	220	220	136,730	0	217,561	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	460	32,146	0	151,928	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560	560	310,005	0	727,455	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	121,109	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,286	46,286	5,142,342	-3,313,417	7,829,239	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	1,428	0	0	29,590	192.00
194.00	07950	MARKETING	12	12	0	0	249	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	556,367	432,589	1,530,943		3,313,417	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.657524	9.064011	0.297713		0.421604	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,978		66,768	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000774		0.008496	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (NURSING SALARIES)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	33,379					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,080				8.00
9.00	00900	HOUSEKEEPING	311	0	33,068			9.00
10.00	01000	DIETARY	4,380	0	4,380	8,080		10.00
13.00	01300	NURSING ADMINISTRATION	501	0	501	0	1,678,716	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520	0	520	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,476	8,080	19,476	8,080	1,678,716	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	200	0	200	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,320	0	3,320	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,991	0	1,991	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	220	0	220	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	0	460	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560	0	560	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,939	8,080	31,628	8,080	1,678,716	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	0	1,428	0	0	192.00
194.00	07950	MARKETING	12	0	12	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	991,549	41,535	274,606	961,923	565,418	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.705773	5.140470	8.304282	119.049876	0.336816	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	233,434	248	10,282	127,692	17,513	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.993439	0.030693	0.310935	15.803465	0.010432	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/18/2017 8:14 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,759,948		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,268,400		30.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,721		54.00
57.00	05700	CT SCAN	26,801		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,048		58.00
60.00	06000	LABORATORY	402,055		60.00
65.00	06500	RESPIRATORY THERAPY	607,876		65.00
66.00	06600	PHYSICAL THERAPY	2,658,051		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,331,319		67.00
68.00	06800	SPEECH PATHOLOGY	629,981		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,131		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,347,265		73.00
74.00	07400	RENAL DIALYSIS	210,300		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,759,948		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0		194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	219,058		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013070		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,808		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000943		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/18/2017 8:14 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,457,957		6,457,957	0	6,457,957	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,533		24,533	0	24,533	54.00
57.00	05700	CT SCAN	9,168		9,168	0	9,168	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,464		4,464	0	4,464	58.00
60.00	06000	LABORATORY	127,929		127,929	0	127,929	60.00
65.00	06500	RESPIRATORY THERAPY	248,534	0	248,534	0	248,534	65.00
66.00	06600	PHYSICAL THERAPY	1,312,091	0	1,312,091	0	1,312,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,067,758	0	1,067,758	0	1,067,758	67.00
68.00	06800	SPEECH PATHOLOGY	325,882	0	325,882	0	325,882	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	235,990		235,990	0	235,990	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,086,117		1,086,117	0	1,086,117	73.00
74.00	07400	RENAL DIALYSIS	174,918		174,918	0	174,918	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	11,075,341	0	11,075,341	0	11,075,341	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	11,075,341	0	11,075,341	0	11,075,341	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,268,400		7,268,400			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,721	0	71,721	0.342062	0.000000	54.00
57.00	05700	CT SCAN	26,801	0	26,801	0.342077	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,048	0	13,048	0.342121	0.000000	58.00
60.00	06000	LABORATORY	402,055	0	402,055	0.318188	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	607,876	0	607,876	0.408856	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,174,705	483,346	2,658,051	0.493629	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,112,265	219,054	2,331,319	0.458006	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	568,625	61,356	629,981	0.517289	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,131	0	193,131	1.221917	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,347,265	0	2,347,265	0.462716	0.000000	73.00
74.00	07400	RENAL DIALYSIS	210,300	0	210,300	0.831755	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	15,996,192	763,756	16,759,948			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,996,192	763,756	16,759,948			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/18/2017 8:14 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.342062	54.00
57.00	05700	CT SCAN	0.342077	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.342121	58.00
60.00	06000	LABORATORY	0.318188	60.00
65.00	06500	RESPIRATORY THERAPY	0.408856	65.00
66.00	06600	PHYSICAL THERAPY	0.493629	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.458006	67.00
68.00	06800	SPEECH PATHOLOGY	0.517289	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.221917	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462716	73.00
74.00	07400	RENAL DIALYSIS	0.831755	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,457,957		6,457,957	0	6,457,957	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,533		24,533	0	24,533	54.00
57.00	05700	CT SCAN	9,168		9,168	0	9,168	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,464		4,464	0	4,464	58.00
60.00	06000	LABORATORY	127,929		127,929	0	127,929	60.00
65.00	06500	RESPIRATORY THERAPY	248,534	0	248,534	0	248,534	65.00
66.00	06600	PHYSICAL THERAPY	1,312,091	0	1,312,091	0	1,312,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,067,758	0	1,067,758	0	1,067,758	67.00
68.00	06800	SPEECH PATHOLOGY	325,882	0	325,882	0	325,882	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	235,990		235,990	0	235,990	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,086,117		1,086,117	0	1,086,117	73.00
74.00	07400	RENAL DIALYSIS	174,918		174,918	0	174,918	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	11,075,341	0	11,075,341	0	11,075,341	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	11,075,341	0	11,075,341	0	11,075,341	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,268,400		7,268,400			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,721	0	71,721	0.342062	0.000000	54.00
57.00	05700	CT SCAN	26,801	0	26,801	0.342077	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,048	0	13,048	0.342121	0.000000	58.00
60.00	06000	LABORATORY	402,055	0	402,055	0.318188	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	607,876	0	607,876	0.408856	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,174,705	483,346	2,658,051	0.493629	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,112,265	219,054	2,331,319	0.458006	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	568,625	61,356	629,981	0.517289	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,131	0	193,131	1.221917	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,347,265	0	2,347,265	0.462716	0.000000	73.00
74.00	07400	RENAL DIALYSIS	210,300	0	210,300	0.831755	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	15,996,192	763,756	16,759,948			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,996,192	763,756	16,759,948			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.342062	54.00
57.00	05700	CT SCAN	0.342077	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.342121	58.00
60.00	06000	LABORATORY	0.318188	60.00
65.00	06500	RESPIRATORY THERAPY	0.408856	65.00
66.00	06600	PHYSICAL THERAPY	0.493629	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.458006	67.00
68.00	06800	SPEECH PATHOLOGY	0.517289	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.221917	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462716	73.00
74.00	07400	RENAL DIALYSIS	0.831755	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,533	209	24,324	0	0	54.00
57.00	05700	CT SCAN	9,168	78	9,090	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,464	38	4,426	0	0	58.00
60.00	06000	LABORATORY	127,929	1,112	126,817	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	248,534	7,646	240,888	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,312,091	102,837	1,209,254	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,067,758	64,099	1,003,659	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	325,882	8,714	317,168	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	235,990	14,389	221,601	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,086,117	24,327	1,061,790	0	0	73.00
74.00	07400	RENAL DIALYSIS	174,918	1,227	173,691	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
200.00		Subtotal (sum of lines 50 thru 199)	4,617,384	224,676	4,392,708	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	4,617,384	224,676	4,392,708	0	0	202.00

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

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,533	71,721	0.342062		54.00
57.00	05700	CT SCAN	9,168	26,801	0.342077		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,464	13,048	0.342121		58.00
60.00	06000	LABORATORY	127,929	402,055	0.318188		60.00
65.00	06500	RESPIRATORY THERAPY	248,534	607,876	0.408856		65.00
66.00	06600	PHYSICAL THERAPY	1,312,091	2,658,051	0.493629		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,067,758	2,331,319	0.458006		67.00
68.00	06800	SPEECH PATHOLOGY	325,882	629,981	0.517289		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	235,990	193,131	1.221917		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,086,117	2,347,265	0.462716		73.00
74.00	07400	RENAL DIALYSIS	174,918	210,300	0.831755		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000		117.00
200.00		Subtotal (sum of lines 50 thru 199)	4,617,384	9,491,548			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	4,617,384	9,491,548			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	723,669	0	723,669	8,080	89.56	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	723,669		723,669	8,080		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,103	457,025				30.00
40.00	SUBPROVIDER - IPF	0	0				40.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	5,103	457,025				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	209	71,721	0.002914	64,078	187	54.00
57.00	05700	CT SCAN	78	26,801	0.002910	16,314	47	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38	13,048	0.002912	1,825	5	58.00
60.00	06000	LABORATORY	1,112	402,055	0.002766	254,128	703	60.00
65.00	06500	RESPIRATORY THERAPY	7,646	607,876	0.012578	420,703	5,292	65.00
66.00	06600	PHYSICAL THERAPY	102,837	2,658,051	0.038689	1,374,035	53,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,099	2,331,319	0.027495	1,337,170	36,765	67.00
68.00	06800	SPEECH PATHOLOGY	8,714	629,981	0.013832	358,020	4,952	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,389	193,131	0.074504	105,423	7,854	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,327	2,347,265	0.010364	1,342,038	13,909	73.00
74.00	07400	RENAL DIALYSIS	1,227	210,300	0.005835	141,450	825	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	224,676	9,491,548		5,415,184	123,699	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,080	0.00	5,103	0		30.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	8,080		5,103	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,721	0.000000	0.000000	64,078	54.00
57.00	05700	CT SCAN	0	26,801	0.000000	0.000000	16,314	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,048	0.000000	0.000000	1,825	58.00
60.00	06000	LABORATORY	0	402,055	0.000000	0.000000	254,128	60.00
65.00	06500	RESPIRATORY THERAPY	0	607,876	0.000000	0.000000	420,703	65.00
66.00	06600	PHYSICAL THERAPY	0	2,658,051	0.000000	0.000000	1,374,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,331,319	0.000000	0.000000	1,337,170	67.00
68.00	06800	SPEECH PATHOLOGY	0	629,981	0.000000	0.000000	358,020	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	193,131	0.000000	0.000000	105,423	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,347,265	0.000000	0.000000	1,342,038	73.00
74.00	07400	RENAL DIALYSIS	0	210,300	0.000000	0.000000	141,450	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	9,491,548			5,415,184	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/18/2017 8:14 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		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	723,669	0	723,669	8,080	89.56	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	723,669		723,669	8,080		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	407	36,451		30.00
40.00	SUBPROVIDER - IPF	0	0		40.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	407	36,451		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	209	71,721	0.002914	0	0	54.00
57.00	05700	CT SCAN	78	26,801	0.002910	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38	13,048	0.002912	0	0	58.00
60.00	06000	LABORATORY	1,112	402,055	0.002766	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,646	607,876	0.012578	0	0	65.00
66.00	06600	PHYSICAL THERAPY	102,837	2,658,051	0.038689	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,099	2,331,319	0.027495	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,714	629,981	0.013832	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,389	193,131	0.074504	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,327	2,347,265	0.010364	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,227	210,300	0.005835	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	224,676	9,491,548		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,080	0.00	407	0		30.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	8,080		407	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,721	0.000000	0.000000	0	54.00
57.00	05700	CT SCAN	0	26,801	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,048	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	402,055	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	607,876	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,658,051	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,331,319	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	629,981	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	193,131	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,347,265	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	210,300	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	9,491,548			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,080	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,080	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)	8,080	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)	5,103	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,457,957	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)	6,457,957	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,457,957	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	799.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,078,573	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,078,573	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/18/2017 8:14 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)	2,624,339	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,702,912	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)	457,025	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	123,699	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	580,724	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,122,188	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: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	723,669	6,457,957	0.112059	0	0	90.00
91.00	Nursing School cost	0	6,457,957	0.000000	0	0	91.00
92.00	Allied health cost	0	6,457,957	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,457,957	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,080	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,080	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)	8,080	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)	407	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,457,957	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)	6,457,957	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,457,957	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	799.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	325,295	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)	325,295	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	325,295	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)	36,451	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)	36,451	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	288,844	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: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	723,669	6,457,957	0.112059	0	0	90.00
91.00	Nursing School cost	0	6,457,957	0.000000	0	0	91.00
92.00	Allied health cost	0	6,457,957	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,457,957	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/18/2017 8:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,591,800		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.342062	64,078	21,919	54.00
57.00	05700	CT SCAN	0.342077	16,314	5,581	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.342121	1,825	624	58.00
60.00	06000	LABORATORY	0.318188	254,128	80,860	60.00
65.00	06500	RESPIRATORY THERAPY	0.408856	420,703	172,007	65.00
66.00	06600	PHYSICAL THERAPY	0.493629	1,374,035	678,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.458006	1,337,170	612,432	67.00
68.00	06800	SPEECH PATHOLOGY	0.517289	358,020	185,200	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.221917	105,423	128,818	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462716	1,342,038	620,982	73.00
74.00	07400	RENAL DIALYSIS	0.831755	141,450	117,652	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,415,184	2,624,339	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,415,184		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/18/2017 8:14 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.342062	0	0	54.00
57.00	05700	CT SCAN	0.342077	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.342121	0	0	58.00
60.00	06000	LABORATORY	0.318188	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.408856	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.493629	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.458006	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.517289	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.221917	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462716	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.831755	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	91.00
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/18/2017 8:14 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		7,640,093		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,640,093		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		9,227		0	6.02
7.00	Total Medicare program liability (see instructions)		7,630,866		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: 15-3042	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 5/18/2017 8:14 am
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,748,936	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0197	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	185,974	3.00
4.00	Outlier Payments	26,458	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)	22.076503	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	7,961,368	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	7,961,368	17.00
18.00	Primary payer payments	712	18.00
19.00	Subtotal (line 17 less line 18).	7,960,656	19.00
20.00	Deductibles	162,176	20.00
21.00	Subtotal (line 19 minus line 20)	7,798,480	21.00
22.00	Coinsurance	31,878	22.00
23.00	Subtotal (line 21 minus line 22)	7,766,602	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,763	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	19,996	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,539	26.00
27.00	Subtotal (sum of lines 23 and 25)	7,786,598	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	7,786,598	32.00
32.01	Sequestration adjustment (see instructions)	155,732	32.01
33.00	Interim payments	7,640,093	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)	-9,227	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	26,458	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/18/2017 8:14 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	37,332	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	2,728,981	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,090,412	0	0	0	6.00
7.00	Inventory	110,212	0	0	0	7.00
8.00	Prepaid expenses	16,583	0	0	0	8.00
9.00	Other current assets	124,594	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,927,290	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	800,183	0	0	0	12.00
13.00	Land improvements	41,998	0	0	0	13.00
14.00	Accumulated depreciation	-15,986	0	0	0	14.00
15.00	Buildings	11,213,591	0	0	0	15.00
16.00	Accumulated depreciation	-1,188,681	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	20,680	0	0	0	19.00
20.00	Accumulated depreciation	-3,769	0	0	0	20.00
21.00	Automobiles and trucks	62,244	0	0	0	21.00
22.00	Accumulated depreciation	-57,848	0	0	0	22.00
23.00	Major movable equipment	2,727,263	0	0	0	23.00
24.00	Accumulated depreciation	-1,485,459	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,114,216	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	54,993,840	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	54,993,840	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	69,035,346	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	216,208	0	0	0	37.00
38.00	Salaries, wages, and fees payable	343,356	0	0	0	38.00
39.00	Payroll taxes payable	112,168	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	61,225,976	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	61,897,708	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,020,262	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	262,317	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,282,579	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	79,180,287	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-10,144,941				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-10,144,941	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	69,035,346	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/18/2017 8:14 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		-6,731,932		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,032,784				2.00
3.00	Total (sum of line 1 and line 2)		-7,764,716		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)		-7,764,716		0		11.00
12.00	INTERCOMPANY ADJ	2,380,225		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)		2,380,225		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-10,144,941		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	INTERCOMPANY ADJ		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: 15-3042 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/18/2017 8:14 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,268,400		7,268,400	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,268,400		7,268,400	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,268,400		7,268,400	17.00
18.00	Ancillary services	8,727,792	763,755	9,491,547	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,996,192	763,755	16,759,947	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,428,803		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)		12,428,803		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-3042	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/18/2017 8:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	16,759,947	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5,424,591	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,335,356	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,428,803	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,093,447	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,100	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	15,850	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	642	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	921	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INC, TRANSPORT, EMP PHYS SVCS	40,150	24.00
25.00	Total other income (sum of lines 6-24)	60,663	25.00
26.00	Total (line 5 plus line 25)	-1,032,784	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,032,784	29.00