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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141330	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/3/2015 3:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/3/2015 Time: 3:19 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOPEDALE MEDICAL COMPLEX (141330) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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	48,395	160,370	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	180,785	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	229,180	160,370	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/3/2015 11:50 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SECOND STREET	PO Box:			1.00
2.00	City: HOPEDALE	State: IL	Zip Code: 61747-	County: TAZEWELL	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	HOPEDALE MEDICAL COMPLEX	141330	37900	1	10/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HOPEDALE SWING BED	14Z330	37900		10/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/3/2015 11:50 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.	2		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.	2		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 in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for 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, § 2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/3/2015 11:50 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	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: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/3/2015 11:50 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, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/3/2015 11:50 am

		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.	Y	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/MR 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
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)?	Y		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)	Y		106.00
107.00	Column 1: 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 would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	121,939	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.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/3/2015 11:50 am

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	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		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
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 Section §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
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: 141330	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/3/2015 11:50 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	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/3/2015 11:50 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.		Y		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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	09/01/2015	Y 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N 19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N 20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/3/2015 11:50 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	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.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/3/2015 11:50 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	09/01/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		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: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/3/2015 11:50 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	25	9,125	25,619.00	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)		25	9,125	25,619.00	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)		25	9,125	25,619.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	45.00	54	19,710		0	20.00
21.00	OTHER LONG TERM CARE	46.00	72	26,280			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		151				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: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/3/2015 11:50 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)	648	24	1,093			1.00
2.00	HMO and other (see instructions)	50	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,275	0	1,356			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	77			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,923	24	2,526			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)	1,923	24	2,526	0.00	220.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	17,952	0.00	36.17	20.00
21.00	OTHER LONG TERM CARE			17,127	0.00	11.37	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	268.12	27.00
28.00	Observation Bed Days		0	240			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: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/3/2015 11:50 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	196	6	448	1.00
2.00	HMO and other (see instructions)			16	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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	196	6	448	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE	0.00				45	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141330	Period: From 07/01/2014 To 06/30/2015	Worksheet S-10 Date/Time Prepared: 11/3/2015 11:50 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.449364	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	164,719	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	1,064,289	6.00
7.00	Medicaid cost (line 1 times line 6)	478,253	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	313,534	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	313,534	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	605,482	1	605,483	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	272,082	0	272,082	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	272,082	0	272,082	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	366,932	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	201,824	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	165,108	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	74,194	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	346,276	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	659,810	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/3/2015 11:50 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		321,150	321,150	429,508	750,658	1.00
1.01	00101	WELLNESS CENTER B&F		63,720	63,720	108,554	172,274	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,218,516	1,218,516	-435,443	783,073	2.00
2.01	00201	WELLNESS CENTER MME		0	0	29,815	29,815	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	142,338	2,517,552	2,659,890	11,868	2,671,758	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	115,584	32,201	147,785	0	147,785	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	322,685	137,759	460,444	0	460,444	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	1,139,988	1,548,392	2,688,380	0	2,688,380	5.03
6.00	00600	MAINTENANCE & REPAIRS	455,337	322,715	778,052	0	778,052	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	70,518	70,518	0	70,518	7.01
7.02	00702	OPERATION OF PLANT ALL	0	301,447	301,447	11,925	313,372	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	157,197	18,174	175,371	0	175,371	8.00
9.00	00900	HOUSEKEEPING	132,301	55,452	187,753	0	187,753	9.00
10.00	01000	DIETARY	553,892	384,413	938,305	-181,634	756,671	10.00
11.00	01100	CAFETERIA	0	0	0	181,634	181,634	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	142,906	73,189	216,095	1,796	217,891	14.00
15.00	01500	PHARMACY	219,367	21,422	240,789	-72	240,717	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	134,295	387,700	521,995	0	521,995	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,392	7,392	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,236,059	403,829	1,639,888	-79,397	1,560,491	30.00
45.00	04500	NURSING FACILITY	1,180,851	332,318	1,513,169	16,779	1,529,948	45.00
46.00	04600	OTHER LONG TERM CARE	320,759	195,469	516,228	20,578	536,806	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	485,399	503,999	989,398	-306,730	682,668	50.00
53.00	05300	ANESTHESIOLOGY	6,049	436,017	442,066	-14,661	427,405	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	366,568	289,354	655,922	208	656,130	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	86,488	86,488	0	86,488	58.00
60.00	06000	LABORATORY	301,224	589,852	891,076	0	891,076	60.00
65.00	06500	RESPIRATORY THERAPY	297,139	52,320	349,459	737	350,196	65.00
66.00	06600	PHYSICAL THERAPY	534,402	80,291	614,693	-3,343	611,350	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	349,516	349,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	121,015	121,015	0	121,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	288,623	288,623	0	288,623	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	26,153	1,160,022	1,186,175	52,107	1,238,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		187,796	187,796	-187,796	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,270,493	12,201,713	20,472,206	13,341	20,485,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314,276	81,605	395,881	0	395,881	192.00
192.01	19201	SATELLITE OFFICES	223,534	78,413	301,947	0	301,947	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	323,301	1,291,430	1,614,731	0	1,614,731	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	70,854	63,203	134,057	0	134,057	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	323,212	128,070	451,282	-13,341	437,941	194.07
200.00		TOTAL (SUM OF LINES 118-199)	9,525,670	13,844,434	23,370,104	0	23,370,104	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/3/2015 11:50 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	-55,902	694,756		1.00
1.01	00101	WELLNESS CENTER B&F	-8,772	163,502		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	25,037	808,110		2.00
2.01	00201	WELLNESS CENTER MME	0	29,815		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-91,969	2,579,789		4.00
5.01	00590	PHYSICAIN OFFICE BILLING	0	147,785		5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	-3,381	457,063		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-557,226	2,131,154		5.03
6.00	00600	MAINTENANCE & REPAIRS	-6,538	771,514		6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	70,518		7.01
7.02	00702	OPERATION OF PLANT ALL	-5,824	307,548		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	175,371		8.00
9.00	00900	HOUSEKEEPING	0	187,753		9.00
10.00	01000	DIETARY	-228	756,443		10.00
11.00	01100	CAFETERIA	-100,070	81,564		11.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-877	217,014		14.00
15.00	01500	PHARMACY	0	240,717		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,910	519,085		16.00
17.00	01700	SOCIAL SERVICE	0	7,392		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,335	1,557,156		30.00
45.00	04500	NURSING FACILITY	-9,906	1,520,042		45.00
46.00	04600	OTHER LONG TERM CARE	-40,516	496,290		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	682,668		50.00
53.00	05300	ANESTHESIOLOGY	-263,419	163,986		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-526	655,604		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	86,488		58.00
60.00	06000	LABORATORY	-120	890,956		60.00
65.00	06500	RESPIRATORY THERAPY	-402	349,794		65.00
66.00	06600	PHYSICAL THERAPY	-8,418	602,932		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	349,516		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	121,015		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	288,623		73.00
76.00	03020	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-287,344	950,938		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,422,646	19,062,901		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	395,881		192.00
192.01	19201	SATELLITE OFFICES	0	301,947		192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0		194.00
194.01	07951	OUTSIDE PROPERTY	0	0		194.01
194.02	07952	RETAIL PHAMACY	0	1,614,731		194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0		194.03
194.04	07954	TRIPLEXES	0	0		194.04
194.05	07957	WHITE FENCE ESTATES	0	134,057		194.05
194.06	07955	UNUSED SPACE	0	0		194.06
194.07	07956	WELLNESS CENTER	0	437,941		194.07
200.00		TOTAL (SUM OF LINES 118-199)	-1,422,646	21,947,458		200.00

RECLASSIFICATIONS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/3/2015 11:50 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	107,221	74,413	1.00
	TOTALS		107,221	74,413	
	B - INTEREST EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	114,471	1.00
2.00	WELLNESS CENTER B&F	1.01	0	17,963	2.00
3.00	OPERATION OF PLANT ALL	7.02	0	11,925	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,796	4.00
5.00	NURSING FACILITY	45.00	0	20,285	5.00
6.00	OTHER LONG TERM CARE	46.00	0	20,285	6.00
7.00	ANESTHESIOLOGY	53.00	0	39	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	208	8.00
9.00	RESPIRATORY THERAPY	65.00	0	824	9.00
	TOTALS		0	187,796	
	C - ER NURSING RECLASS				
1.00	EMERGENCY	91.00	56,210	0	1.00
	TOTALS		56,210	0	
	D - BUILDING DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	405,628	1.00
	TOTALS		0	405,628	
	E - WELLNESS CENTER DEP				
1.00	WELLNESS CENTER B&F	1.01	0	90,591	1.00
2.00	WELLNESS CENTER MME	2.01	0	29,815	2.00
	TOTALS		0	120,406	
	G - WELLNESS CENTER RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7,811	4,057	1.00
2.00	NURSING FACILITY	45.00	17	9	2.00
3.00	OTHER LONG TERM CARE	46.00	193	100	3.00
4.00	RESPIRATORY THERAPY	65.00	627	326	4.00
5.00	PHYSICAL THERAPY	66.00	132	69	5.00
	TOTALS		8,780	4,561	
	H - SOCIAL SERVICE RECLASS				
1.00	SOCIAL SERVICE	17.00	7,392	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		7,392	0	
	I - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	349,516	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	349,516	
500.00	Grand Total: Increases		179,603	1,142,320	500.00

RECLASSIFICATIONS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/3/2015 11:50 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	107,221	74,413	0		1.00
	TOTALS		107,221	74,413			
	B - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	187,796	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	187,796			
	C - ER NURSING RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	56,210	0	0		1.00
	TOTALS		56,210	0			
	D - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	405,628	9		1.00
	TOTALS		0	405,628			
	E - WELLNESS CENTER DEP						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,591	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29,815	9		2.00
	TOTALS		0	120,406			
	G - WELLNESS CENTER RECLASS						
1.00	WELLNESS CENTER	194.07	8,780	4,561	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		8,780	4,561			
	H - SOCIAL SERVICE RECLASS						
1.00	NURSING FACILITY	45.00	3,514	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	3,878	0	0		2.00
	TOTALS		7,392	0			
	I - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	19,309	0		1.00
2.00	OPERATING ROOM	50.00	0	306,730	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	14,700	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,040	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	3,544	0		5.00
6.00	EMERGENCY	91.00	0	4,103	0		6.00
7.00	PHARMACY	15.00	0	72	0		7.00
8.00	NURSING FACILITY	45.00	0	18	0		8.00
	TOTALS		0	349,516			
500.00	Grand Total: Decreases		179,603	1,142,320			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/3/2015 11:50 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	790,265	132,407	0	132,407	0	1.00
2.00	Land Improvements	600,064	680,684	0	680,684	0	2.00
3.00	Buildings and Fixtures	19,518,357	12,174,019	0	12,174,019	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,363,652	2,043,152	0	2,043,152	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,272,338	15,030,262	0	15,030,262	0	8.00
9.00	Reconciling Items	-4,912,190	0	4,889,643	4,889,643	0	9.00
10.00	Total (line 8 minus line 9)	39,184,528	15,030,262	-4,889,643	10,140,619	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	922,672	0	1.00
2.00	Land Improvements	1,280,748	0	2.00
3.00	Buildings and Fixtures	31,692,376	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	15,406,804	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	49,302,600	0	8.00
9.00	Reconciling Items	-22,547	0	9.00
10.00	Total (line 8 minus line 9)	49,325,147	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/3/2015 11:50 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	321,150	0	0	0	0	1.00
1.01	WELLNESS CENTER B&F	63,720	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	1,218,516	0	0	0	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,603,386	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	321,150	1.00
1.01	WELLNESS CENTER B&F	0	63,720	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,218,516	2.00
2.01	WELLNESS CENTER MME	0	0	2.01
3.00	Total (sum of lines 1-2)	0	1,603,386	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/3/2015 11:50 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	33,895,796	0	33,895,796	0.687505	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	15,406,804	0	15,406,804	0.312495	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	49,302,600	0	49,302,600	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	636,187	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	154,311	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	772,110	36,000	2.00
2.01	WELLNESS CENTER MME	0	0	0	29,815	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,592,423	36,000	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	58,569	0	0	0	694,756	1.00
1.01	WELLNESS CENTER B&F	9,191	0	0	0	163,502	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	808,110	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	29,815	2.01
3.00	Total (sum of lines 1-2)	67,760	0	0	0	1,696,183	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/3/2015 11:50 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
1.01	Investment income - WELLNESS CENTER B&F (chapter 2)		0	WELLNESS CENTER B&F	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - WELLNESS CENTER MME (chapter 2)		0	WELLNESS CENTER MME	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-273,665			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	-13,679			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to 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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - WELLNESS CENTER B&F		0	WELLNESS CENTER B&F	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - WELLNESS CENTER MME		0	WELLNESS CENTER MME	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/3/2015 11:50 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-9,718	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	B	-55,902	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	INTEREST INCOME OFFSET	B	-8,772	WELLNESS CENTER B&F	1.01	11	33.01
33.02			0		0.00	0	33.02
33.03			0		0.00	0	33.03
33.04	INTEREST INCOME OFFSET	B	-5,824	OPERATION OF PLANT ALL	7.02	0	33.04
33.05	INTEREST INCOME OFFSET	B	-877	CENTRAL SERVICES & SUPPLY	14.00	0	33.05
33.06	INTEREST INCOME OFFSET	B	-9,906	NURSING FACILITY	45.00	0	33.06
33.07	INTEREST INCOME OFFSET	B	-9,906	OTHER LONG TERM CARE	46.00	0	33.07
33.08			0		0.00	0	33.08
33.09	INTEREST INCOME OFFSET	B	-19	ANESTHESIOLOGY	53.00	0	33.09
33.10	INTEREST INCOME OFFSET	B	-102	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	INTEREST INCOME OFFSET	B	-402	RESPIRATORY THERAPY	65.00	0	33.11
33.12	TRADE, QUANTITY AND TIME DISCOUNTS	B	-6,945	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	CAFETERIA--EMPLOYEES AND GUESTS	B	-100,070	CAFETERIA	11.00	0	33.13
33.14	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-2,910	MEDICAL RECORDS & LIBRARY	16.00	0	33.14
33.15	EMPLOYEE CHILD CARE REV	B	-91,057	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	MISC INCOME	B	-28,906	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.16
33.17	OTHER INCOME OLTC	B	-17,438	OTHER LONG TERM CARE	46.00	0	33.17
33.18	MISC REVENUE - RAD.	B	-424	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	PROGRAM INCOME -DIETITIAN	B	-228	DIETARY	10.00	0	33.19
33.20	MISC REVENUE - HOSPITAL	B	-3,335	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	OTHER INCOME - LAB	B	-120	LABORATORY	60.00	0	33.21
33.22	OTHER INCOME - MAINTENANCE	B	-3,779	MAINTENANCE & REPAIRS	6.00	0	33.22
33.23	TELEPHONE SERVICES	A	-3,381	HOSPITAL ADMIN & GENERAL	5.02	0	33.23
34.00	TELEPHONE EMP BENEFIT EXPENSE	A	-912	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	TELEPHONE DEPRECIATION	A	-1,245	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02	ALCOHOLIC BEVERAGES	A	-448	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.02
34.04	NON-ALLO ADVERTISING SALARIES	A	-43,626	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.04
34.07	ADVERTISING/MARKETING EXPENSE	A	-163,856	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.07
34.09	MARKETING OLTC	A	-13,172	OTHER LONG TERM CARE	46.00	0	34.09
34.10			0		0.00	0	34.10
34.11	MARKETING PT	A	-8,418	PHYSICAL THERAPY	66.00	0	34.11
34.12	MARKETING - WHITE FENCE	A	-2,759	MAINTENANCE & REPAIRS	6.00	0	34.12
34.13	CHARITABLE CONTRIBUTIONS	A	-14,822	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.13
34.14	ANESTH ON-CALL TIME	A	-263,400	ANESTHESIOLOGY	53.00	0	34.14
34.15	PATIENT TELEVISION EXPENSE	A	-3,816	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.15
36.00	MEDICAID ASSESSMENT	A	-278,118	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.00
38.02	IHA LOBBYING DUES	A	-10,009	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	38.02
38.04	LEASE ADJUSTMENTS - CSK-3	A	36,000	CAP REL COSTS-MVBLE EQUIP	2.00	10	38.04
41.03			0		0.00	0	41.03
41.04			0		0.00	0	41.04
41.06	EHR FY15 EXPENSES	A	-6,680	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	41.06
44.00			0		0.00	0	44.00
44.01			0		0.00	0	44.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/3/2015 11:50 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	
44.02			0		0.00	0	44.02
44.04			0		0.00	0	44.04
44.06			0		0.00	0	44.06
44.08			0		0.00	0	44.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,422,646				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: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/3/2015 11:50 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	91.00	EMERGENCY	ER PHYSICIAN	130,553	130,553	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MME	4,884	4,884	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMP BENEFITS	54,135	54,135	3.00
4.00	5.01	PHYSICAIN OFFICE BILLING	PHYS BILLING	148,489	148,489	4.00
4.01	5.03	OTHER ADMINISTRATIVE AND GEN	A&G ALL	20,354	20,354	4.01
4.02	6.00	MAINTENANCE & REPAIRS	MAINT AND REPAIRS	4,712	4,712	4.02
4.03	7.02	OPERATION OF PLANT ALL	PLANT OP ALL	17,792	17,792	4.03
4.04	192.00	PHYSICIANS' PRIVATE OFFICES	PHYS OFFICES	393,968	393,968	4.04
4.06	91.00	EMERGENCY	RENTAL DUPLEX	4,921	18,600	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			779,808	793,487	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	G		0.00	ROSSI PHYSICIANS	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141330	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/3/2015 11:50 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	0	0		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.06	-13,679	0		4.06
5.00	-13,679			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	PHYSCIANS		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/3/2015 11:50 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	130,553	8,160	122,393	0	0	1.00
2.00	91.00	EMERGENCY	988,336	265,505	722,831	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,118,889	273,665	845,224		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	8,160		1.00
2.00	91.00	EMERGENCY	0	0	0	265,505		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	273,665		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	WELLNESS CENTER B&F	MVBLE EQUIP	WELLNESS CENTER MME	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	694,756	694,756				1.00
1.01	00101	WELLNESS CENTER B&F	163,502	0	163,502			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	808,110			808,110		2.00
2.01	00201	WELLNESS CENTER MME	29,815			0	29,815	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,579,789	10,809	29,782	2,474	6,022	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	147,785	3,198	0	0	0	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	457,063	21,149	0	6,962	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	2,131,154	44,958	6,011	121,723	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	771,514	5,997	0	7,700	0	6.00
7.01	00701	WELLNESS CENTER PLANT OP	70,518	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	307,548	3,766	0	66,836	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	175,371	10,962	0	2,210	0	8.00
9.00	00900	HOUSEKEEPING	187,753	1,653	0	0	0	9.00
10.00	01000	DIETARY	756,443	12,540	0	11,837	0	10.00
11.00	01100	CAFETERIA	81,564	19,440	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,767	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	217,014	12,368	0	31,604	0	14.00
15.00	01500	PHARMACY	240,717	2,563	0	11,997	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	519,085	16,788	695	3,101	0	16.00
17.00	01700	SOCIAL SERVICE	7,392	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,557,156	45,383	0	75,210	0	30.00
45.00	04500	NURSING FACILITY	1,520,042	141,318	65	4,174	13	45.00
46.00	04600	OTHER LONG TERM CARE	496,290	260,632	737	11,014	148	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	682,668	31,030	0	225,315	0	50.00
53.00	05300	ANESTHESIOLOGY	163,986	714	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	655,604	21,871	0	154,385	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	86,488	0	0	0	0	58.00
60.00	06000	LABORATORY	890,956	8,638	0	20,845	0	60.00
65.00	06500	RESPIRATORY THERAPY	349,794	2,602	10,566	13,707	1,736	65.00
66.00	06600	PHYSICAL THERAPY	602,932	1,760	33,144	5,404	5,116	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	349,516	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,015	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	288,623	12,850	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	950,938	0	0	803	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,062,901	694,756	81,000	777,301	13,035	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	395,881	0	0	1,732	0	192.00
192.01	19201	SATELLITE OFFICES	301,947	0	0	2,158	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	1,614,731	0	0	93	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	134,057	0	0	1,402	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	437,941	0	82,502	25,424	16,780	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,947,458	694,756	163,502	808,110	29,815	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	PHYSICAIN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	Subtotal	
			4.00	4A	5.01	5.02	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,628,876					4.00
5.01	00590	PHYSICAIN OFFICE BILLING	32,664	183,647	183,647			5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	90,236	575,410	0	575,410		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	309,833	2,613,679	0	0	2,613,679	5.03
6.00	00600	MAINTENANCE & REPAIRS	128,679	913,890	0	0	913,890	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	70,518	0	0	70,518	7.01
7.02	00702	OPERATION OF PLANT ALL	0	378,150	0	0	378,150	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	44,424	232,967	0	0	232,967	8.00
9.00	00900	HOUSEKEEPING	37,388	226,794	0	0	226,794	9.00
10.00	01000	DIETARY	126,230	907,050	0	0	907,050	10.00
11.00	01100	CAFETERIA	30,301	131,305	0	0	131,305	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,767	0	0	1,767	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,385	301,371	0	0	301,371	14.00
15.00	01500	PHARMACY	61,993	317,270	0	0	317,270	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,952	577,621	0	0	577,621	16.00
17.00	01700	SOCIAL SERVICE	2,089	9,481	0	0	9,481	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	332,379	2,010,128	0	65,872	2,076,000	30.00
45.00	04500	NURSING FACILITY	333,713	1,999,325	0	0	1,999,325	45.00
46.00	04600	OTHER LONG TERM CARE	89,661	858,482	0	0	858,482	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	137,174	1,076,187	0	143,927	1,220,114	50.00
53.00	05300	ANESTHESIOLOGY	1,709	166,409	0	31,141	197,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,592	935,452	0	108,948	1,044,400	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	86,488	0	11,792	98,280	58.00
60.00	06000	LABORATORY	85,126	1,005,565	0	64,026	1,069,591	60.00
65.00	06500	RESPIRATORY THERAPY	84,149	462,554	0	27,448	490,002	65.00
66.00	06600	PHYSICAL THERAPY	151,060	799,416	0	29,033	828,449	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	349,516	0	20,387	369,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	121,015	0	5,292	126,307	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	301,473	0	40,686	342,159	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,906	967,647	0	26,858	994,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,276,643	18,580,577	0	575,410	18,396,930	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,815	486,428	26,532	0	512,960	192.00
192.01	19201	SATELLITE OFFICES	63,171	367,276	20,033	0	387,309	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	91,365	1,706,189	93,065	0	1,799,254	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	20,023	155,482	8,481	0	163,963	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	88,859	651,506	35,536	0	687,042	194.07
200.00		Cross Foot Adjustments		0			0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,628,876	21,947,458	183,647	575,410	21,947,458	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	LAUNDRY & LINEN SERVICE	
			5.03	6.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	2,613,679					5.03
6.00	00600	MAINTENANCE & REPAIRS	123,546	1,037,436				6.00
7.01	00701	WELLNESS CENTER PLANT OP	9,533	124,596	204,647			7.01
7.02	00702	OPERATION OF PLANT ALL	51,121	372,807	0	802,078		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	31,494	8,205	0	43,328	315,994	8.00
9.00	00900	HOUSEKEEPING	30,660	0	0	6,532	0	9.00
10.00	01000	DIETARY	122,621	18,640	0	49,564	204	10.00
11.00	01100	CAFETERIA	17,751	3,568	0	76,836	0	11.00
13.00	01300	NURSING ADMINISTRATION	239	0	0	6,984	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,741	9,989	0	48,887	0	14.00
15.00	01500	PHARMACY	42,891	2,854	0	10,130	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,087	4,103	1,113	66,353	0	16.00
17.00	01700	SOCIAL SERVICE	1,282	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	280,650	144,841	0	179,376	48,216	30.00
45.00	04500	NURSING FACILITY	270,283	0	105	0	195,143	45.00
46.00	04600	OTHER LONG TERM CARE	116,056	149,301	1,181	0	1,478	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164,944	61,094	0	122,647	26,626	50.00
53.00	05300	ANESTHESIOLOGY	26,706	0	0	2,822	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,189	15,340	0	86,444	6,697	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	13,286	0	0	0	0	58.00
60.00	06000	LABORATORY	144,595	19,978	0	34,143	0	60.00
65.00	06500	RESPIRATORY THERAPY	66,242	4,727	16,932	10,285	326	65.00
66.00	06600	PHYSICAL THERAPY	111,996	5,262	53,112	6,956	7,684	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,006	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,075	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,255	0	0	50,791	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	134,444	2,676	0	0	9,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,133,693	947,981	72,443	802,078	296,071	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,346	9,276	0	0	6,818	192.00
192.01	19201	SATELLITE OFFICES	52,359	7,313	0	0	5,549	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	13,824	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	243,236	4,013	0	0	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	22,166	55,029	0	0	1,704	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	92,879	0	132,204	0	5,852	194.07
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)	2,613,679	1,037,436	204,647	802,078	315,994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.01	00701	WELLNESS CENTER PLANT OP						7.01
7.02	00702	OPERATION OF PLANT ALL						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	263,986					9.00
10.00	01000	DIETARY	0	1,098,079				10.00
11.00	01100	CAFETERIA	0	0	229,460			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	8,990		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68	0	11,000	0	412,056	14.00
15.00	01500	PHARMACY	0	0	3,336	0	1,708	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	980	0	4,216	0	46	16.00
17.00	01700	SOCIAL SERVICE	0	0	237	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,075	77,107	37,648	3,675	28,884	30.00
45.00	04500	NURSING FACILITY	83,590	561,210	50,489	4,928	10,425	45.00
46.00	04600	OTHER LONG TERM CARE	65,541	459,762	15,872	0	2,802	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	17,421	0	42,011	50.00
53.00	05300	ANESTHESIOLOGY	0	0	140	0	2,595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,933	0	13,764	0	7,460	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	87	58.00
60.00	06000	LABORATORY	9,913	0	11,865	0	119,002	60.00
65.00	06500	RESPIRATORY THERAPY	4,649	0	9,506	0	10,737	65.00
66.00	06600	PHYSICAL THERAPY	0	0	13,373	0	1,506	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	122,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	42,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	3,964	387	5,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	226,749	1,098,079	192,831	8,990	396,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,340	0	12,996	0	3,340	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	0	2,675	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	3,897	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	7,803	0	3,820	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	15,830	0	5,640	194.07
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)	263,986	1,098,079	229,460	8,990	412,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.01	00701	WELLNESS CENTER PLANT OP						7.01
7.02	00702	OPERATION OF PLANT ALL						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	378,189					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	732,519				16.00
17.00	01700	SOCIAL SERVICE	0	0	11,000			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	83,858	3,348	3,016,678	0	30.00
45.00	04500	NURSING FACILITY	0	0	7,652	3,183,150	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	1,670,475	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	183,217	0	1,838,074	0	50.00
53.00	05300	ANESTHESIOLOGY	0	39,644	0	269,457	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	138,697	0	1,462,924	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	15,012	0	126,665	0	58.00
60.00	06000	LABORATORY	0	81,509	0	1,490,596	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	34,943	0	648,349	0	65.00
66.00	06600	PHYSICAL THERAPY	0	36,960	0	1,065,298	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,954	0	567,921	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,737	0	192,379	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	378,189	51,796	0	869,190	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	34,192	0	1,184,865	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	378,189	732,519	11,000	17,586,021	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	648,076	0	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	455,205	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	17,721	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	0	2,058,126	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	242,862	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	0	939,447	0	194.07
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	378,189	732,519	11,000	21,947,458	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	WELLNESS CENTER B&F			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	WELLNESS CENTER MME			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	PHYSICAIN OFFICE BILLING			5.01
5.02	00591	HOSPITAL ADMIN & GENERAL			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.01	00701	WELLNESS CENTER PLANT OP			7.01
7.02	00702	OPERATION OF PLANT ALL			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,016,678		30.00
45.00	04500	NURSING FACILITY	3,183,150		45.00
46.00	04600	OTHER LONG TERM CARE	1,670,475		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,838,074		50.00
53.00	05300	ANESTHESIOLOGY	269,457		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,924		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	126,665		58.00
60.00	06000	LABORATORY	1,490,596		60.00
65.00	06500	RESPIRATORY THERAPY	648,349		65.00
66.00	06600	PHYSICAL THERAPY	1,065,298		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	567,921		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	192,379		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	869,190		73.00
76.00	03020	RENEWED HOPE	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	1,184,865		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,586,021		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	648,076		192.00
192.01	19201	SATELLITE OFFICES	455,205		192.01
194.00	07950	ARC (HOPEDALE HALL)	0		194.00
194.01	07951	OUTSIDE PROPERTY	17,721		194.01
194.02	07952	RETAIL PHAMACY	2,058,126		194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0		194.03
194.04	07954	TRIPLEXES	0		194.04
194.05	07957	WHITE FENCE ESTATES	242,862		194.05
194.06	07955	UNUSED SPACE	0		194.06
194.07	07956	WELLNESS CENTER	939,447		194.07
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	21,947,458		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	WELLNESS CENTER B&F	MVBLE EQUIP	WELLNESS CENTER MME	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,809	29,782	2,474	6,022	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	0	3,198	0	0	0	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	0	21,149	0	6,962	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	44,958	6,011	121,723	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	5,997	0	7,700	0	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	0	3,766	0	66,836	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,962	0	2,210	0	8.00
9.00	00900	HOUSEKEEPING	0	1,653	0	0	0	9.00
10.00	01000	DIETARY	0	12,540	0	11,837	0	10.00
11.00	01100	CAFETERIA	0	19,440	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,767	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,368	0	31,604	0	14.00
15.00	01500	PHARMACY	0	2,563	0	11,997	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,788	695	3,101	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	45,383	0	75,210	0	30.00
45.00	04500	NURSING FACILITY	0	141,318	65	4,174	13	45.00
46.00	04600	OTHER LONG TERM CARE	0	260,632	737	11,014	148	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,030	0	225,315	0	50.00
53.00	05300	ANESTHESIOLOGY	0	714	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,871	0	154,385	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	8,638	0	20,845	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,602	10,566	13,707	1,736	65.00
66.00	06600	PHYSICAL THERAPY	0	1,760	33,144	5,404	5,116	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,850	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	803	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	694,756	81,000	777,301	13,035	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,732	0	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	2,158	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	0	93	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	1,402	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	82,502	25,424	16,780	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	694,756	163,502	808,110	29,815	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PHYSICAIN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	OTHER ADMINISTRATIVE AND GENERAL	
			2A	4.00	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	49,087	49,087				4.00
5.01	00590	PHYSICAIN OFFICE BILLING	3,198	610	3,808			5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	28,111	1,685	0	29,796		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	172,692	5,786	0	0	178,478	5.03
6.00	00600	MAINTENANCE & REPAIRS	13,697	2,403	0	0	8,436	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	651	7.01
7.02	00702	OPERATION OF PLANT ALL	70,602	0	0	0	3,491	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	13,172	830	0	0	2,151	8.00
9.00	00900	HOUSEKEEPING	1,653	698	0	0	2,094	9.00
10.00	01000	DIETARY	24,377	2,357	0	0	8,373	10.00
11.00	01100	CAFETERIA	19,440	566	0	0	1,212	11.00
13.00	01300	NURSING ADMINISTRATION	1,767	0	0	0	16	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,972	754	0	0	2,782	14.00
15.00	01500	PHARMACY	14,560	1,158	0	0	2,929	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,584	709	0	0	5,332	16.00
17.00	01700	SOCIAL SERVICE	0	39	0	0	88	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	120,593	6,207	0	3,411	19,170	30.00
45.00	04500	NURSING FACILITY	145,570	6,228	0	0	18,456	45.00
46.00	04600	OTHER LONG TERM CARE	272,531	1,674	0	0	7,925	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,345	2,561	0	7,454	11,263	50.00
53.00	05300	ANESTHESIOLOGY	714	32	0	1,612	1,824	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,256	1,934	0	5,641	9,641	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	611	907	58.00
60.00	06000	LABORATORY	29,483	1,590	0	3,315	9,873	60.00
65.00	06500	RESPIRATORY THERAPY	28,611	1,571	0	1,421	4,523	65.00
66.00	06600	PHYSICAL THERAPY	45,424	2,821	0	1,503	7,647	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,056	3,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	274	1,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,850	0	0	2,107	3,158	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	803	297	0	1,391	9,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,566,092	42,510	0	29,796	145,703	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,732	1,658	550	0	4,735	192.00
192.01	19201	SATELLITE OFFICES	2,158	1,180	415	0	3,575	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	93	1,706	1,930	0	16,609	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	1,402	374	176	0	1,514	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	124,706	1,659	737	0	6,342	194.07
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,696,183	49,087	3,808	29,796	178,478	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.00	7.01	7.02	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS	24,536					6.00
7.01	00701	WELLNESS CENTER PLANT OP	2,947	3,598				7.01
7.02	00702	OPERATION OF PLANT ALL	8,819	0	82,912			7.02
8.00	00800	LAUNDRY & LINEN SERVICE	194	0	4,479	20,826		8.00
9.00	00900	HOUSEKEEPING	0	0	675	0	5,120	9.00
10.00	01000	DIETARY	441	0	5,123	13	0	10.00
11.00	01100	CAFETERIA	84	0	7,943	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	722	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	236	0	5,053	0	1	14.00
15.00	01500	PHARMACY	67	0	1,047	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97	20	6,859	0	19	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,426	0	18,544	3,178	1,029	30.00
45.00	04500	NURSING FACILITY	0	2	0	12,863	1,622	45.00
46.00	04600	OTHER LONG TERM CARE	3,531	21	0	97	1,271	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,445	0	12,678	1,755	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	292	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	363	0	8,936	441	173	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	472	0	3,529	0	192	60.00
65.00	06500	RESPIRATORY THERAPY	112	298	1,063	21	90	65.00
66.00	06600	PHYSICAL THERAPY	124	934	719	506	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,250	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	63	0	0	639	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,421	1,275	82,912	19,513	4,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	219	0	0	449	647	192.00
192.01	19201	SATELLITE OFFICES	173	0	0	366	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	327	0	0	0	76	194.01
194.02	07952	RETAIL PHAMACY	95	0	0	0	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	1,301	0	0	112	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	2,323	0	386	0	194.07
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)	24,536	3,598	82,912	20,826	5,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.01	00701	WELLNESS CENTER PLANT OP						7.01
7.02	00702	OPERATION OF PLANT ALL						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	40,684					10.00
11.00	01100	CAFETERIA	0	29,245				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,505			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,402	0	54,200		14.00
15.00	01500	PHARMACY	0	425	0	225	20,411	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	537	0	6	0	16.00
17.00	01700	SOCIAL SERVICE	0	30	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,857	4,798	1,024	3,799	0	30.00
45.00	04500	NURSING FACILITY	20,793	6,436	1,373	1,371	0	45.00
46.00	04600	OTHER LONG TERM CARE	17,034	2,023	0	369	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,220	0	5,526	0	50.00
53.00	05300	ANESTHESIOLOGY	0	18	0	341	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,754	0	981	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	11	0	58.00
60.00	06000	LABORATORY	0	1,512	0	15,653	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,212	0	1,412	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,704	0	198	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,055	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,559	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	20,411	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	505	108	658	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,684	24,576	2,505	52,164	20,411	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,656	0	439	0	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	352	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	995	0	503	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	2,018	0	742	0	194.07
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)	40,684	29,245	2,505	54,200	20,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.01	00701	WELLNESS CENTER PLANT OP						7.01
7.02	00702	OPERATION OF PLANT ALL						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,163					16.00
17.00	01700	SOCIAL SERVICE	0	157				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,913	48	191,997	0	191,997	30.00
45.00	04500	NURSING FACILITY	0	109	214,823	0	214,823	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	306,476	0	306,476	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,533	0	309,780	0	309,780	50.00
53.00	05300	ANESTHESIOLOGY	1,850	0	6,683	0	6,683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,472	0	212,592	0	212,592	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	700	0	2,229	0	2,229	58.00
60.00	06000	LABORATORY	3,803	0	69,422	0	69,422	60.00
65.00	06500	RESPIRATORY THERAPY	1,630	0	41,964	0	41,964	65.00
66.00	06600	PHYSICAL THERAPY	1,725	0	63,305	0	63,305	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,211	0	21,737	0	21,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	314	0	7,313	0	7,313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,417	0	46,193	0	46,193	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,595	0	15,239	0	15,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,163	157	1,509,753	0	1,509,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	12,085	0	12,085	192.00
192.01	19201	SATELLITE OFFICES	0	0	8,219	0	8,219	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	403	0	403	194.01
194.02	07952	RETAIL PHAMACY	0	0	21,931	0	21,931	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	4,879	0	4,879	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	138,913	0	138,913	194.07
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)	34,163	157	1,696,183	0	1,696,183	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	WELLNESS CENTER B&F (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	WELLNESS CENTER MME (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	194,635					1.00
1.01	00101	WELLNESS CENTER B&F	0	35,064				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			839,168			2.00
2.01	00201	WELLNESS CENTER MME			0	29,916		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,028	6,387	2,569	6,042	9,302,441	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	896	0	0	0	115,584	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	5,925	0	7,230	0	319,304	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	12,595	1,289	126,401	0	1,096,362	5.03
6.00	00600	MAINTENANCE & REPAIRS	1,680	0	7,996	0	455,337	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	1,055	0	69,405	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	3,071	0	2,295	0	157,197	8.00
9.00	00900	HOUSEKEEPING	463	0	0	0	132,301	9.00
10.00	01000	DIETARY	3,513	0	12,292	0	446,671	10.00
11.00	01100	CAFETERIA	5,446	0	0	0	107,221	11.00
13.00	01300	NURSING ADMINISTRATION	495	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,465	0	32,819	0	142,906	14.00
15.00	01500	PHARMACY	718	0	12,458	0	219,367	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,703	149	3,220	0	134,295	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	7,391	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,714	0	78,100	0	1,176,144	30.00
45.00	04500	NURSING FACILITY	39,590	14	4,334	13	1,180,868	45.00
46.00	04600	OTHER LONG TERM CARE	73,016	158	11,437	149	317,271	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,693	0	233,974	0	485,399	50.00
53.00	05300	ANESTHESIOLOGY	200	0	0	0	6,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,127	0	160,318	0	366,568	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,420	0	21,646	0	301,224	60.00
65.00	06500	RESPIRATORY THERAPY	729	2,266	14,234	1,742	297,766	65.00
66.00	06600	PHYSICAL THERAPY	493	7,108	5,612	5,133	534,534	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,600	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	834	0	56,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	194,635	17,371	807,174	13,079	8,056,045	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,799	0	314,276	192.00
192.01	19201	SATELLITE OFFICES	0	0	2,241	0	223,534	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	97	0	323,301	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	1,456	0	70,854	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	17,693	26,401	16,837	314,431	194.07
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)	694,756	163,502	808,110	29,815	2,628,876	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.569533	4.662959	0.962990	0.996624	0.282601	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					49,087	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.005277	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	Reconciliation	PHYSICAIN OFFICE BILLING (ACCUM. COST)	HOSPITAL ADMIN & GENERAL (GROSS REV)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5A.01	5.01	5.02	5A.03	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING	-183,647	3,366,881				5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	-575,410	0	34,282,769			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-2,613,679	0	0	-2,613,679	19,333,779	5.03
6.00	00600	MAINTENANCE & REPAIRS	-913,890	0	0	0	913,890	6.00
7.01	00701	WELLNESS CENTER PLANT OP	-70,518	0	0	0	70,518	7.01
7.02	00702	OPERATION OF PLANT ALL	-378,150	0	0	0	378,150	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	-232,967	0	0	0	232,967	8.00
9.00	00900	HOUSEKEEPING	-226,794	0	0	0	226,794	9.00
10.00	01000	DIETARY	-907,050	0	0	0	907,050	10.00
11.00	01100	CAFETERIA	-131,305	0	0	0	131,305	11.00
13.00	01300	NURSING ADMINISTRATION	-1,767	0	0	0	1,767	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-301,371	0	0	0	301,371	14.00
15.00	01500	PHARMACY	-317,270	0	0	0	317,270	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-577,621	0	0	0	577,621	16.00
17.00	01700	SOCIAL SERVICE	-9,481	0	0	0	9,481	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	-2,010,128	0	3,924,663	0	2,076,000	30.00
45.00	04500	NURSING FACILITY	-1,999,325	0	0	0	1,999,325	45.00
46.00	04600	OTHER LONG TERM CARE	-858,482	0	0	0	858,482	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	-1,076,187	0	8,574,812	0	1,220,114	50.00
53.00	05300	ANESTHESIOLOGY	-166,409	0	1,855,398	0	197,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-935,452	0	6,491,160	0	1,044,400	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	-86,488	0	702,594	0	98,280	58.00
60.00	06000	LABORATORY	-1,005,565	0	3,814,700	0	1,069,591	60.00
65.00	06500	RESPIRATORY THERAPY	-462,554	0	1,635,356	0	490,002	65.00
66.00	06600	PHYSICAL THERAPY	-799,416	0	1,729,773	0	828,449	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-349,516	0	1,214,656	0	369,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-121,015	0	315,311	0	126,307	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-301,473	0	2,424,119	0	342,159	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	-967,647	0	1,600,227	0	994,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-18,580,577	0	34,282,769	-2,613,679	15,783,251	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	486,428	0	0	512,960	192.00
192.01	19201	SATELLITE OFFICES	0	367,276	0	0	387,309	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	1,706,189	0	0	1,799,254	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	155,482	0	0	163,963	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	651,506	0	0	687,042	194.07
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)		183,647	575,410		2,613,679	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.054545	0.016784		0.135187	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		3,808	29,796		178,478	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001131	0.000869		0.009231	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	MAINTENANCE & REPAIRS (MAINT TIME)	WELLNESS CENTER PLANT OP (SQUARE FEET)	OPERATION OF PLANT ALL (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.00	7.01	7.02	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS	11,632					6.00
7.01	00701	WELLNESS CENTER PLANT OP	1,397	27,388				7.01
7.02	00702	OPERATION OF PLANT ALL	4,180	0	56,850			7.02
8.00	00800	LAUNDRY & LINEN SERVICE	92	0	3,071	326,077		8.00
9.00	00900	HOUSEKEEPING	0	0	463	0	11,584	9.00
10.00	01000	DIETARY	209	0	3,513	210	0	10.00
11.00	01100	CAFETERIA	40	0	5,446	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	495	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112	0	3,465	0	3	14.00
15.00	01500	PHARMACY	32	0	718	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46	149	4,703	0	43	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,624	0	12,714	49,754	2,329	30.00
45.00	04500	NURSING FACILITY	0	14	0	201,371	3,668	45.00
46.00	04600	OTHER LONG TERM CARE	1,674	158	0	1,525	2,876	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	685	0	8,693	27,476	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	200	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172	0	6,127	6,911	392	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	224	0	2,420	0	435	60.00
65.00	06500	RESPIRATORY THERAPY	53	2,266	729	336	204	65.00
66.00	06600	PHYSICAL THERAPY	59	7,108	493	7,929	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,600	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	30	0	0	10,006	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,629	9,695	56,850	305,518	9,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104	0	0	7,036	1,463	192.00
192.01	19201	SATELLITE OFFICES	82	0	0	5,726	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	155	0	0	0	171	194.01
194.02	07952	RETAIL PHAMACY	45	0	0	0	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	617	0	0	1,758	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	17,693	0	6,039	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,037,436	204,647	802,078	315,994	263,986	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	89.188102	7.472141	14.108672	0.969078	22.788847	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,536	3,598	82,912	20,826	5,120	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.109354	0.131371	1.458434	0.063868	0.441989	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS G HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.01	00701	WELLNESS CENTER PLANT OP						7.01
7.02	00702	OPERATION OF PLANT ALL						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	105,967					10.00
11.00	01100	CAFETERIA	0	16,438				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	137,242			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	788	0	1,179,943		14.00
15.00	01500	PHARMACY	0	239	0	4,892	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	302	0	133	0	16.00
17.00	01700	SOCIAL SERVICE	0	17	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,441	2,697	56,100	82,711	0	30.00
45.00	04500	NURSING FACILITY	54,158	3,617	75,233	29,852	0	45.00
46.00	04600	OTHER LONG TERM CARE	44,368	1,137	0	8,025	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,248	0	120,300	0	50.00
53.00	05300	ANESTHESIOLOGY	0	10	0	7,430	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	986	0	21,363	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	248	0	58.00
60.00	06000	LABORATORY	0	850	0	340,768	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	681	0	30,746	0	65.00
66.00	06600	PHYSICAL THERAPY	0	958	0	4,312	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	349,516	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	121,015	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	284	5,909	14,318	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	105,967	13,814	137,242	1,135,629	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	931	0	9,564	0	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	7,660	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	559	0	10,940	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	1,134	0	16,150	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,098,079	229,460	8,990	412,056	378,189	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.362462	13.959119	0.065505	0.349217	3,781.890000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,684	29,245	2,505	54,200	20,411	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.383931	1.779109	0.018252	0.045934	204.110000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/3/2015 11:50 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLNESS CENTER B&F				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	WELLNESS CENTER MME				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	PHYSICAIN OFFICE BILLING				5.01
5.02	00591	HOSPITAL ADMIN & GENERAL				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.01	00701	WELLNESS CENTER PLANT OP				7.01
7.02	00702	OPERATION OF PLANT ALL				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,282,769			16.00
17.00	01700	SOCIAL SERVICE	0	345		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,924,663	105		30.00
45.00	04500	NURSING FACILITY	0	240		45.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,574,812	0		50.00
53.00	05300	ANESTHESIOLOGY	1,855,398	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,491,160	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	702,594	0		58.00
60.00	06000	LABORATORY	3,814,700	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,635,356	0		65.00
66.00	06600	PHYSICAL THERAPY	1,729,773	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,214,656	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	315,311	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,424,119	0		73.00
76.00	03020	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,600,227	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,282,769	345		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	SATELLITE OFFICES	0	0		192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0		194.00
194.01	07951	OUTSIDE PROPERTY	0	0		194.01
194.02	07952	RETAIL PHAMACY	0	0		194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0		194.03
194.04	07954	TRIPLEXES	0	0		194.04
194.05	07957	WHITE FENCE ESTATES	0	0		194.05
194.06	07955	UNUSED SPACE	0	0		194.06
194.07	07956	WELLNESS CENTER	0	0		194.07
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)	732,519	11,000		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.021367	31.884058		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,163	157		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000997	0.455072		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,016,678		3,016,678	0	0	30.00
45.00	04500	NURSING FACILITY	3,183,150		3,183,150	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	1,670,475		1,670,475	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,838,074		1,838,074	0	0	50.00
53.00	05300	ANESTHESIOLOGY	269,457		269,457	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,924		1,462,924	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	126,665		126,665	0	0	58.00
60.00	06000	LABORATORY	1,490,596		1,490,596	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	648,349	0	648,349	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,065,298	0	1,065,298	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	567,921		567,921	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	192,379		192,379	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	869,190		869,190	0	0	73.00
76.00	03020	RENEWED HOPE	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,184,865		1,184,865	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	268,320		268,320		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,854,341	0	17,854,341	0	0	200.00
201.00		Less Observation Beds	268,320		268,320		0	201.00
202.00		Total (see instructions)	17,586,021	0	17,586,021	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		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	3,663,207		3,663,207			30.00
45.00	04500	NURSING FACILITY	3,387,447		3,387,447			45.00
46.00	04600	OTHER LONG TERM CARE	1,465,109		1,465,109			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,909,797	5,638,540	8,548,337	0.215021	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	852,937	1,002,461	1,855,398	0.145229	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	924,454	5,566,706	6,491,160	0.225372	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	12,304	690,290	702,594	0.180282	0.000000	58.00
60.00	06000	LABORATORY	650,110	3,164,590	3,814,700	0.390751	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,063,095	572,261	1,635,356	0.396457	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	274,754	1,455,019	1,729,773	0.615860	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	684,726	556,406	1,241,132	0.457583	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,031	165,280	315,311	0.610125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,633,101	791,018	2,424,119	0.358559	0.000000	73.00
76.00	03020	RENEWED HOPE	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	105,971	1,494,256	1,600,227	0.740436	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,967	239,489	261,456	1.026253	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,799,010	21,336,316	39,135,326			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,799,010	21,336,316	39,135,326			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	RENEWED HOPE	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/3/2015 11:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,016,678		3,016,678	0	3,016,678	30.00
45.00	04500	NURSING FACILITY	3,183,150		3,183,150	0	3,183,150	45.00
46.00	04600	OTHER LONG TERM CARE	1,670,475		1,670,475	0	1,670,475	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,838,074		1,838,074	0	1,838,074	50.00
53.00	05300	ANESTHESIOLOGY	269,457		269,457	0	269,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,924		1,462,924	0	1,462,924	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	126,665		126,665	0	126,665	58.00
60.00	06000	LABORATORY	1,490,596		1,490,596	0	1,490,596	60.00
65.00	06500	RESPIRATORY THERAPY	648,349	0	648,349	0	648,349	65.00
66.00	06600	PHYSICAL THERAPY	1,065,298	0	1,065,298	0	1,065,298	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	567,921		567,921	0	567,921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	192,379		192,379	0	192,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	869,190		869,190	0	869,190	73.00
76.00	03020	RENEWED HOPE	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,184,865		1,184,865	0	1,184,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	268,320		268,320		268,320	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,854,341	0	17,854,341	0	17,854,341	200.00
201.00		Less Observation Beds	268,320		268,320		268,320	201.00
202.00		Total (see instructions)	17,586,021	0	17,586,021	0	17,586,021	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/3/2015 11:50 am

Title XIX | Hospital | Cost

		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	3,663,207		3,663,207			30.00
45.00	04500	NURSING FACILITY	3,387,447		3,387,447			45.00
46.00	04600	OTHER LONG TERM CARE	1,465,109		1,465,109			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,909,797	5,638,540	8,548,337	0.215021	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	852,937	1,002,461	1,855,398	0.145229	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	924,454	5,566,706	6,491,160	0.225372	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	12,304	690,290	702,594	0.180282	0.000000	58.00
60.00	06000	LABORATORY	650,110	3,164,590	3,814,700	0.390751	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,063,095	572,261	1,635,356	0.396457	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	274,754	1,455,019	1,729,773	0.615860	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	684,726	556,406	1,241,132	0.457583	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,031	165,280	315,311	0.610125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,633,101	791,018	2,424,119	0.358559	0.000000	73.00
76.00	03020	RENEWED HOPE	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	105,971	1,494,256	1,600,227	0.740436	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,967	239,489	261,456	1.026253	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,799,010	21,336,316	39,135,326			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,799,010	21,336,316	39,135,326			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/3/2015 11:50 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	RENEWED HOPE	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		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						
50.00	05000	OPERATING ROOM	309,780	8,548,337	0.036239	1,493,401	54,119	50.00
53.00	05300	ANESTHESIOLOGY	6,683	1,855,398	0.003602	507,775	1,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,592	6,491,160	0.032751	712,083	23,321	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	2,229	702,594	0.003173	9,327	30	58.00
60.00	06000	LABORATORY	69,422	3,814,700	0.018199	286,425	5,213	60.00
65.00	06500	RESPIRATORY THERAPY	41,964	1,635,356	0.025660	374,606	9,612	65.00
66.00	06600	PHYSICAL THERAPY	63,305	1,729,773	0.036597	42,189	1,544	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,737	1,241,132	0.017514	308,592	5,405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,313	315,311	0.023193	76,690	1,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,193	2,424,119	0.019056	527,825	10,058	73.00
76.00	03020	RENEWED HOPE	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,239	1,600,227	0.009523	11,840	113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,568	261,456	0.132213	0	0	92.00
200.00		Total (lines 50-199)	831,025	30,619,563		4,350,753	113,023	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		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						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
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	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		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						
50.00	05000	OPERATING ROOM	0	8,548,337	0.000000	0.000000	1,493,401	50.00
53.00	05300	ANESTHESIOLOGY	0	1,855,398	0.000000	0.000000	507,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,491,160	0.000000	0.000000	712,083	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	702,594	0.000000	0.000000	9,327	58.00
60.00	06000	LABORATORY	0	3,814,700	0.000000	0.000000	286,425	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,635,356	0.000000	0.000000	374,606	65.00
66.00	06600	PHYSICAL THERAPY	0	1,729,773	0.000000	0.000000	42,189	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,241,132	0.000000	0.000000	308,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	315,311	0.000000	0.000000	76,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,424,119	0.000000	0.000000	527,825	73.00
76.00	03020	RENEWED HOPE	0	0	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,600,227	0.000000	0.000000	11,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	261,456	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	30,619,563			4,350,753	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		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					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	RENEWED HOPE	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.215021	0	2,077,249	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.145229	0	432,037	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225372	0	3,587,916	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.180282	0	341,227	0	0	58.00
60.00	06000	LABORATORY	0.390751	0	1,639,030	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.396457	0	336,492	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.615860	0	580,506	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.457583	0	195,384	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.610125	0	107,432	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.358559	0	479,036	0	0	73.00
76.00	03020	RENEWED HOPE	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.740436	0	793,544	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.026253	0	107,379	0	0	92.00
200.00		Subtotal (see instructions)		0	10,677,232	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,677,232	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	446,652	0		50.00
53.00	05300	ANESTHESIOLOGY	62,744	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	808,616	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	61,517	0		58.00
60.00	06000	LABORATORY	640,453	0		60.00
65.00	06500	RESPIRATORY THERAPY	133,405	0		65.00
66.00	06600	PHYSICAL THERAPY	357,510	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,404	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,547	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	171,763	0		73.00
76.00	03020	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	587,569	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	110,198	0		92.00
200.00		Subtotal (see instructions)	3,535,378	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,535,378	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141330 | Component CCN: 14Z330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.215021	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.145229	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225372	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.180282	0	0	0	0	58.00
60.00	06000	LABORATORY	0.390751	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.396457	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.615860	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.457583	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.610125	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.358559	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.740436	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.026253	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141330 | Component CCN: 14Z330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

	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)	2,766	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,333	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)	1,093	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	678	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)	678	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	39	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)	38	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	648	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)	638	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)	637	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,016,678	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)	5,247	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)	5,113	25.00
26.00	Total swing-bed cost (see instructions)	1,526,382	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,490,296	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)	1,490,296	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)	1,118.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	724,470	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)	724,470	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,229,460	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,953,930	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	713,290	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	712,172	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,425,462	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/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)	240	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,118.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	268,320	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	191,997	1,490,296	0.128831	268,320	34,568	90.00
91.00	Nursing School cost	0	1,490,296	0.000000	268,320	0	91.00
92.00	Allied health cost	0	1,490,296	0.000000	268,320	0	92.00
93.00	All other Medical Education	0	1,490,296	0.000000	268,320	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		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		840,561		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.215021	1,493,401	321,113	50.00
53.00	05300	ANESTHESIOLOGY	0.145229	507,775	73,744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225372	712,083	160,484	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.180282	9,327	1,681	58.00
60.00	06000	LABORATORY	0.390751	286,425	111,921	60.00
65.00	06500	RESPIRATORY THERAPY	0.396457	374,606	148,515	65.00
66.00	06600	PHYSICAL THERAPY	0.615860	42,189	25,983	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.457583	308,592	141,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.610125	76,690	46,790	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.358559	527,825	189,256	73.00
76.00	03020	RENEWED HOPE	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.740436	11,840	8,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.026253	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,350,753	1,229,460	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)		4,350,753		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141330 | Component CCN: 14Z330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.215021	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.145229	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225372	93,656	21,107	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.180282	0	0	58.00
60.00	06000	LABORATORY	0.390751	151,673	59,266	60.00
65.00	06500	RESPIRATORY THERAPY	0.396457	435,850	172,796	65.00
66.00	06600	PHYSICAL THERAPY	0.615860	198,132	122,022	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.457583	74,389	34,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.610125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.358559	452,808	162,358	73.00
76.00	03020	RENEWED HOPE	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.740436	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.026253	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,406,508	571,588	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,406,508		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141330	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/3/2015 11:50 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,535,378	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,535,378	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,570,732	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	29,493	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,812,082	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,729,157	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,729,157	30.00
31.00	Primary payer payments	138	31.00
32.00	Subtotal (line 30 minus line 31)	1,729,019	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	236,094	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	179,431	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	121,504	36.00
37.00	Subtotal (see instructions)	1,908,450	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,908,450	40.00
40.01	Sequestration adjustment (see instructions)	38,169	40.01
41.00	Interim payments	1,709,911	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	160,370	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,678,395		1,789,054	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/25/2015	32,739		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	06/25/2015	79,143	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)		32,739		-79,143	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)		1,711,134		1,709,911	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		48,395		160,370	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,759,529		1,870,281	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141330 | Component CCN: 14Z330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,751,419		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	06/25/2015	11,091		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)		11,091		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)		1,762,510		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		180,785		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,943,295		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 FOR HIT	Provider CCN: 141330	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/3/2015 11:50 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	448	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	648	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	50	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,093	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	39,135,326	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	605,483	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141330 | Component CCN: 14Z330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-2 | Date/Time Prepared: 11/3/2015 11:50 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,439,717	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	577,304	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,275	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,017,021	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,017,021	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,017,021	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	34,067	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,982,954	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,982,954	0	19.00
19.01	Sequestration adjustment (see instructions)	39,659	0	19.01
20.00	Interim payments	1,762,510	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	180,785	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141330	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/3/2015 11:50 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,953,930	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,953,930	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,973,469	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,973,469	19.00
20.00	Deductibles (exclude professional component)	200,424	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,773,045	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,773,045	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,465	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,393	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,568	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,795,438	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,795,438	30.00
30.01	Sequestration adjustment (see instructions)	35,909	30.01
31.00	Interim payments	1,711,134	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	48,395	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/3/2015 11:50 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	5,838,251	0	0	0	1.00
2.00	Temporary investments	1,849,605	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,583,729	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	918,784	0	0	0	7.00
8.00	Prepaid expenses	104,147	0	0	0	8.00
9.00	Other current assets	3,642	0	0	0	9.00
10.00	Due from other funds	1,286,826	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,584,984	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	23,682,854	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	23,682,854	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	576,208	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	533,706	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,109,914	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,377,752	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,933,282	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,078,250	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	659,087	0	0	0	40.00
41.00	Deferred income	414,634	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,574,789	0	0	0	43.00
44.00	Other current liabilities	385,984	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,046,026	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,320,515	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	334,437	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	12,654,952	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	18,700,978	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,676,774				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)	18,676,774	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,377,752	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/3/2015 11:50 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		16,980,879		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,387,410				2.00
3.00	Total (sum of line 1 and line 2)		19,368,289		0		3.00
4.00	CONTRIBUTIONS	59,568		0		0	4.00
5.00	INTEREST INCOME	565		0		0	5.00
6.00	ROUNDING	1,127		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)		61,260		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,429,549		0		11.00
12.00	NET ASSETS RELEASED	752,775		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)		752,775		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,676,774		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	CONTRIBUTIONS		0		4.00
5.00	INTEREST INCOME		0		5.00
6.00	ROUNDING		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	NET ASSETS RELEASED		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: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/3/2015 11:50 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,998,399		3,998,399	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	3,387,447		3,387,447	8.00
9.00	OTHER LONG TERM CARE	1,465,109		1,465,109	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,850,955		8,850,955	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)	8,850,955		8,850,955	17.00
18.00	Ancillary services	9,106,577	19,566,636	28,673,213	18.00
19.00	Outpatient services	113,713	2,163,116	2,276,829	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	RETAIL PHARMACY	0	1,799,779	1,799,779	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,071,245	23,529,531	41,600,776	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,370,104		29.00
30.00	GAIN ON ASSET	39,365			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)		39,365		36.00
37.00		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)		23,409,469		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141330 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 11/3/2015 11:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	41,600,776	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,057,625	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,543,151	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,409,469	4.00
5.00	Net income from service to patients (line 3 minus line 4)	133,682	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,411	6.00
7.00	Income from investments	92,216	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OP REV	1,911,393	24.00
24.01	UNREALIZED GAIN	0	24.01
24.02	NET ASSETS RELEASED	752,775	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	2,757,795	25.00
26.00	Total (line 5 plus line 25)	2,891,477	26.00
27.00	FAIR VALUE OF INTEREST	65,071	27.00
27.01	UNREALIZED LOSS	51,964	27.01
27.02	PROVISION FOR UNCOLLECTIBLE ACCTS	366,932	27.02
27.03	EQUITY IN NET LOSS OF HRES	10,984	27.03
27.04	ROUNDING	9,116	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	504,067	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,387,410	29.00