

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/28/2016 1:05 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 9/28/2016 Time: 1:05 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	297,767	-31,391	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	215,889	0	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	513,656	-31,391	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 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 1:04 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: SECOND STREET	PO Box:	Zip Code: 61747-		County: TAZEWELL				1.00	
2.00	City: HOPEDALE	State: IL							2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HOPEDALE MEDICAL COMPLEX	141330	37900	1	10/01/2003	N	0	0	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	0	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:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2015	06/30/2016		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 §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 1:04 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		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.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N		N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N		N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.		N		N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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

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

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		V		XIX					
		1.00		2.00					
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00			
Rural Providers									
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	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	
								1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N		110.00	
								1.00	
								2.00	
								3.00	
Miscellaneous Cost Reporting Information									
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N						116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y						117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1						118.00	
		Premiums		Losses		Insurance			
		1.00		2.00		3.00			
118.01	List amounts of malpractice premiums and paid losses:	113,936		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	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N						122.00	
Transplant Center Information									
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N						125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 1:04 pm						
		1.00	2.00							
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00				
All Providers										
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y			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				
		1.00	2.00							
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		N			145.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N			146.00				
					1.00					
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00				
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00				
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00				
			Part A	Part B	Title V	Title XIX				
			1.00	2.00	3.00	4.00				
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				
Multi campus										
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N		165.00			
			Name	County	State	Zip Code	CBSA	FTE/Campus		
			0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	166.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				N				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 1:04 pm
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/28/2016 1:04 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	08/31/2016	Y	08/31/2016
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/28/2016 1:04 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		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.	RSM US 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@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/28/2016 1:04 pm
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		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 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	58,896.00	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	9,150	58,896.00	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	9,150	58,896.00	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	19,764		0	20.00
21.00 OTHER LONG TERM CARE	46.00	72	26,352			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 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	768	4	1,049			1.00
2.00 HMO and other (see instructions)	116	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	1,235	0	1,341			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	52			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,003	4	2,442			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)	2,003	4	2,442	0.00	215.91	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	17,930	0.00	34.79	20.00
21.00 OTHER LONG TERM CARE			18,880	0.00	13.08	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	263.78	27.00
28.00 Observation Bed Days		0	142			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 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	221	2	306	1.00
2.00 HMO and other (see instructions)			19	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	221	2	306	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				47	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 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 9/28/2016 1:04 pm
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			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)		0.451321	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		122,285	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		739,537	6.00	
7.00	Medicaid cost (line 1 times line 6)		333,769	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)		211,484	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)		211,484	19.00	
			1.00		
			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	164,345	513,110	677,455	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	74,172	231,577	305,749	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)	74,172	231,577	305,749	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)		41,093	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		155,944	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		-114,851	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		-51,835	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		253,914	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		465,398	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141330

Period: From 07/01/2015 To 06/30/2016

Worksheet A

Date/Time Prepared: 9/28/2016 1:04 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		218,780	218,780	184,907	403,687	1.00
1.01	00101		63,720	63,720	105,185	168,905	1.01
1.02	00102		0	0	711,806	711,806	1.02
2.00	00200		1,928,723	1,928,723	-722,682	1,206,041	2.00
2.01	00201		0	0	59,784	59,784	2.01
4.00	00400	150,022	1,887,022	2,037,044	19,054	2,056,098	4.00
5.01	00590	113,702	27,307	141,009	0	141,009	5.01
5.02	00591	418,224	170,690	588,914	0	588,914	5.02
5.03	00560	1,087,330	1,631,162	2,718,492	0	2,718,492	5.03
6.00	00600	541,678	362,319	903,997	0	903,997	6.00
7.01	00701	0	76,897	76,897	0	76,897	7.01
7.02	00702	0	304,045	304,045	14,706	318,751	7.02
8.00	00800	167,480	25,480	192,960	0	192,960	8.00
9.00	00900	145,657	50,550	196,207	0	196,207	9.00
10.00	01000	550,248	378,229	928,477	-173,088	755,389	10.00
11.00	01100	0	0	0	173,088	173,088	11.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	128,187	131,303	259,490	793	260,283	14.00
15.00	01500	202,778	22,746	225,524	-163	225,361	15.00
16.00	01600	81,609	362,077	443,686	0	443,686	16.00
17.00	01700	0	0	0	8,244	8,244	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,207,018	384,172	1,591,190	-74,214	1,516,976	30.00
45.00	04500	1,196,501	165,452	1,361,953	16,449	1,378,402	45.00
46.00	04600	350,354	189,273	539,627	20,979	560,606	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	447,980	629,599	1,077,579	-402,289	675,290	50.00
53.00	05300	16,253	442,033	458,286	-15,436	442,850	53.00
54.00	05400	344,204	282,694	626,898	3,882	630,780	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	76,230	76,230	0	76,230	58.00
60.00	06000	319,639	505,256	824,895	0	824,895	60.00
65.00	06500	316,029	55,616	371,645	1,433	373,078	65.00
65.01	06501	0	59,581	59,581	0	59,581	65.01
66.00	06600	536,630	64,850	601,480	-1,536	599,944	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	447,493	447,493	71.00
72.00	07200	0	141,893	141,893	0	141,893	72.00
73.00	07300	0	369,921	369,921	0	369,921	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	25,811	1,162,551	1,188,362	44,270	1,232,632	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		400,838	400,838	-400,838	0	113.00
118.00		8,347,334	12,571,009	20,918,343	21,827	20,940,170	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	11,982	11,982	0	11,982	190.00
192.00	19200	341,057	68,169	409,226	221	409,447	192.00
192.01	19201	243,910	34,530	278,440	0	278,440	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	319,625	1,304,738	1,624,363	0	1,624,363	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07957	74,950	27,752	102,702	0	102,702	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	328,698	125,596	454,294	-22,048	432,246	194.07
194.08	07958	21,363	3,479	24,842	0	24,842	194.08
194.09	07959	0	26	26	0	26	194.09
200.00		9,676,937	14,147,281	23,824,218	0	23,824,218	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet A
Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	0	403,687	1.00
1.01	00101	-3,923	164,982	1.01
1.02	00102	-70,111	641,695	1.02
2.00	00200	-92,885	1,113,156	2.00
2.01	00201	0	59,784	2.01
4.00	00400	-132,228	1,923,870	4.00
5.01	00590	0	141,009	5.01
5.02	00591	-3,601	585,313	5.02
5.03	00560	-607,236	2,111,256	5.03
6.00	00600	-800	903,197	6.00
7.01	00701	0	76,897	7.01
7.02	00702	-61,130	257,621	7.02
8.00	00800	0	192,960	8.00
9.00	00900	0	196,207	9.00
10.00	01000	-736	754,653	10.00
11.00	01100	-98,450	74,638	11.00
13.00	01300	0	0	13.00
14.00	01400	-173	260,110	14.00
15.00	01500	0	225,361	15.00
16.00	01600	-330	443,356	16.00
17.00	01700	0	8,244	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	0	1,516,976	30.00
45.00	04500	-51,687	1,326,715	45.00
46.00	04600	-24,440	536,166	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	675,290	50.00
53.00	05300	-263,400	179,450	53.00
54.00	05400	-848	629,932	54.00
57.00	05700	0	0	57.00
58.00	05800	0	76,230	58.00
60.00	06000	0	824,895	60.00
65.00	06500	-1,657	371,421	65.00
65.01	06501	0	59,581	65.01
66.00	06600	-155	599,789	66.00
69.00	06900	0	0	69.00
71.00	07100	0	447,493	71.00
72.00	07200	0	141,893	72.00
73.00	07300	0	369,921	73.00
76.00	03020	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	-267,781	964,851	91.00
92.00	09200			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	0	0	113.00
118.00		-1,681,571	19,258,599	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	11,982	190.00
192.00	19200	0	409,447	192.00
192.01	19201	0	278,440	192.01
194.00	07950	0	0	194.00
194.01	07951	0	0	194.01
194.02	07952	0	1,624,363	194.02
194.03	07953	0	0	194.03
194.04	07954	0	0	194.04
194.05	07957	0	102,702	194.05
194.06	07955	0	0	194.06
194.07	07956	0	432,246	194.07
194.08	07958	0	24,842	194.08
194.09	07959	0	26	194.09
200.00		-1,681,571	22,142,647	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	102,578	70,510	1.00	
	TOTALS		102,578	70,510		
B - INTEREST EXPENSE RECLASS						
1.00	2015 BUILDING RENOVATION & ADDITION	1.02	0	321,037	1.00	
2.00	WELLNESS CENTER B&F	1.01	0	17,963	2.00	
3.00	OPERATION OF PLANT ALL	7.02	0	14,706	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	793	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	
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,882	8.00	
9.00	RESPIRATORY THERAPY	65.00	0	1,666	9.00	
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	221	10.00	
	TOTALS		0	400,838		
C - ER NURSING RECLASS						
1.00	EMERGENCY	91.00	49,820	0	1.00	
	TOTALS		49,820	0		
D - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	662,898	1.00	
	TOTALS		0	662,898		
E - WELLNESS CENTER DEP						
1.00	WELLNESS CENTER B&F	1.01	0	87,222	1.00	
2.00	WELLNESS CENTER MME	2.01	0	59,784	2.00	
	TOTALS		0	147,006		
G - WELLNESS CENTER RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	12,440	6,614	1.00	
3.00	OTHER LONG TERM CARE	46.00	453	241	3.00	
4.00	RESPIRATORY THERAPY	65.00	664	353	4.00	
5.00	PHYSICAL THERAPY	66.00	838	445	5.00	
	TOTALS		14,395	7,653		
H - SOCIAL SERVICE RECLASS						
1.00	SOCIAL SERVICE	17.00	8,244	0	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		8,244	0		
I - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	447,493	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	447,493		
K - BUILDING RENOVATION DEPRE						
1.00	2015 BUILDING RENOVATION & ADDITION	1.02	0	390,769	1.00	
	TOTALS		0	390,769		
500.00	Grand Total: Increases		175,037	2,127,167	500.00	

		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	102,578	70,510	0		1.00
	TOTALS		102,578	70,510			
B - INTEREST EXPENSE RECLASS							
1.00	INTEREST EXPENSE	113.00	0	400,838	11		1.00
2.00		0.00	0	0	11		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
6.00		0.00	0	0	0		6.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		0	400,838			
C - ER NURSING RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	49,820	0	0		1.00
	TOTALS		49,820	0			
D - BUILDING DEPRECIATION							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	662,898	9		1.00
	TOTALS		0	662,898			
E - WELLNESS CENTER DEP							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	87,222	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	59,784	9		2.00
	TOTALS		0	147,006			
G - WELLNESS CENTER RECLASS							
1.00	WELLNESS CENTER	194.07	14,395	7,653	0		1.00
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		14,395	7,653			
H - SOCIAL SERVICE RECLASS							
1.00	NURSING FACILITY	45.00	3,770	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	4,474	0	0		2.00
	TOTALS		8,244	0			
I - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	19,920	0		1.00
2.00	OPERATING ROOM	50.00	0	402,289	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	15,436	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,250	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	2,819	0		5.00
6.00	EMERGENCY	91.00	0	5,550	0		6.00
7.00	PHARMACY	15.00	0	163	0		7.00
8.00	NURSING FACILITY	45.00	0	66	0		8.00
	TOTALS		0	447,493			
K - BUILDING RENOVATION DEPRE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	390,769	9		1.00
	TOTALS		0	390,769			
500.00	Grand Total: Decreases		175,037	2,127,167			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	922,672	83,827	0	83,827	0	1.00
2.00	Land Improvements	1,280,748	90,018	0	90,018	0	2.00
3.00	Buildings and Fixtures	31,692,376	379,584	0	379,584	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	15,406,804	363,857	0	363,857	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	49,302,600	917,286	0	917,286	0	8.00
9.00	Reconciling Items	-22,547	-134,678	0	-134,678	0	9.00
10.00	Total (line 8 minus line 9)	49,325,147	1,051,964	0	1,051,964	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,006,499	0				1.00
2.00	Land Improvements	1,370,766	0				2.00
3.00	Buildings and Fixtures	32,071,960	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	15,770,661	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	50,219,886	0				8.00
9.00	Reconciling Items	-157,225	0				9.00
10.00	Total (line 8 minus line 9)	50,377,111	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part II
Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	218,780	0	0	0	0	1.00
1.01	WELLNESS CENTER B&F	63,720	0	0	0	0	1.01
1.02	2015 BUILDING RENOVATION & ADDITION	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,928,723	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)	2,211,223	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	218,780				1.00
1.01	WELLNESS CENTER B&F	0	63,720				1.01
1.02	2015 BUILDING RENOVATION & ADDITION	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,928,723				2.00
2.01	WELLNESS CENTER MME	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,211,223				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part III
Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	34,449,225	0	34,449,225	0.685968	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	0.000000	0	1.01
1.02	2015 BUILDING RENOVATION & ADDITION	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	15,770,661	0	15,770,661	0.314032	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	50,219,886	0	50,219,886	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	403,687	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	150,942	0	1.01
1.02	2015 BUILDING RENOVATION & ADDITION	0	0	0	390,769	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,113,156	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	59,784	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,118,338	0	3.00
Cost Center Description		SUMMARY OF CAPITAL			Total (2)		
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	(sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	403,687	1.00
1.01	WELLNESS CENTER B&F	14,040	0	0	0	164,982	1.01
1.02	2015 BUILDING RENOVATION & ADDITION	250,926	0	0	0	641,695	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,113,156	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	59,784	2.01
3.00	Total (sum of lines 1-2)	264,966	0	0	0	2,383,304	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8

Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - WELLNESS CENTER B&F (chapter 2)			OWELLNESS CENTER B&F	1.01	0	1.01
1.02 Investment income - 2015 BUILDING RENOVATION & ADDITION (chapter 2)			O2015 BUILDING RENOVATION & ADDITION	1.02	0	1.02
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01 Investment income - WELLNESS CENTER MME (chapter 2)			OWELLNESS 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	-256,824			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	-10,957			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		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		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			O*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - WELLNESS CENTER B&F			OWELLNESS CENTER B&F	1.01	0	26.01
26.02 Depreciation - 2015 BUILDING RENOVATION & ADDITION			O2015 BUILDING RENOVATION & ADDITION	1.02	0	26.02

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		
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
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	-91,701		CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00 INVST INCOME-NEW BLDGS AND FIXTURES	B	-70,111		2015 BUILDING RENOVATION & ADDITION	1.02	11	33.00
33.01 INTEREST INCOME OFFSET	B	-3,923		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	-3,212		OPERATION OF PLANT ALL	7.02	0	33.04
33.05 INTEREST INCOME OFFSET	B	-173		CENTRAL SERVICES & SUPPLY	14.00	0	33.05
33.06 INTEREST INCOME OFFSET	B	-4,430		NURSING FACILITY	45.00	0	33.06
33.07 INTEREST INCOME OFFSET	B	-4,430		OTHER LONG TERM CARE	46.00	0	33.07
33.08		0			0.00	0	33.08
33.09		0			0.00	0	33.09
33.10 INTEREST INCOME OFFSET	B	-848		RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11 INTEREST INCOME OFFSET	B	-364		RESPIRATORY THERAPY	65.00	0	33.11
33.12 TRADE, QUANTITY AND TIME DISCOUNTS	B	-5,523		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13 CAFETERIA--EMPLOYEES AND GUESTS	B	-98,450		CAFETERIA	11.00	0	33.13
33.14 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-330		MEDICAL RECORDS & LIBRARY	16.00	0	33.14
33.15 EMPLOYEE CHILD CARE REV	B	-131,519		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16 MISC INCOME	B	-28,534		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.16
33.17 OTHER INCOME OLTC	B	-12,995		OTHER LONG TERM CARE	46.00	0	33.17
33.18		0			0.00	0	33.18
33.19 PROGRAM INCOME -DIETITIAN	B	-736		DIETARY	10.00	0	33.19
33.20		0			0.00	0	33.20
33.21		0			0.00	0	33.21
33.22 OTHER INCOME - MAINTENANCE	B	-800		MAINTENANCE & REPAIRS	6.00	0	33.22
33.23 BUYER'S GROUP REBATE	B	-22,306		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.23
33.24 FIT TESTING	B	-918		RESPIRATORY THERAPY	65.00	0	33.24
33.25 FLOOD ACTIVITY	B	-19,952		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.25
33.26 FLOOD ACTIVITY	B	-57,918		OPERATION OF PLANT ALL	7.02	0	33.26
33.27 FLOOD ACTIVITY	B	-47,257		NURSING FACILITY	45.00	0	33.27
33.28 TELEPHONE SERVICES	A	-3,601		HOSPITAL ADMIN & GENERAL	5.02	0	33.28
33.29 TELEPHONE EMP BENEFIT EXPENSE	A	-709		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.29
33.30 TELEPHONE DEPRECIATION	A	-1,184		CAP REL COSTS-MVBLE EQUIP	2.00	9	33.30
33.31 ALCOHOLIC BEVERAGES	A	-510		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.31
34.00 NON-ALLO ADVERTISING SALARIES	A	-39,800		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.00
34.01 ADVERTISING/MARKETING EXPENSE	A	-110,827		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.01
34.02 MARKETING OLTC	A	-7,015		OTHER LONG TERM CARE	46.00	0	34.02
34.04		0			0.00	0	34.04
34.07 MARKETING PT	A	-155		PHYSICAL THERAPY	66.00	0	34.07
34.09		0			0.00	0	34.09
34.11		0			0.00	0	34.11
34.12		0			0.00	0	34.12
34.13		0			0.00	0	34.13

Provider CCN: 141330
 Period: From 07/01/2015 To 06/30/2016
 Worksheet A-8
 Date/Time Prepared: 9/28/2016 1:04 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		
34.14	MARKETING MATERIALS	A	-375	RESPIRATORY THERAPY	65.00	0	34.14
34.15	CHARITABLE CONTRIBUTIONS	A	-13,012	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.15
36.00	ANESTHON-CALL TIME	A	-263,400	ANESTHESIOLOGY	53.00	0	36.00
36.01	MEDICAID ASSESSMENT	A	-352,572	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.01
38.02	GOODWILL	A	-226	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	38.02
38.04	PATIENT TELEVISION EXPENSE	A	-3,965	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	38.04
41.00	IHA LOBBYING DUES	A	-10,009	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	41.00
41.01			0		0.00	0	41.01
41.02			0		0.00	0	41.02
41.06			0		0.00	0	41.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,681,571				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 07/01/2015 To 06/30/2016
 Worksheet A-8-1
 Date/Time Prepared: 9/28/2016 1:04 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	91.00	EMERGENCY	ER PHYSICIAN	130,291	130,291 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MME	7,737	7,737 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMP BENEFITS	60,376	60,376 3.00
4.00	5.01	PHYSICIAN OFFICE BILLING	PHYS BILLING	141,843	141,843 4.00
4.01	5.03	OTHER ADMINISTRATIVE AND GEN	A&G ALL	19,463	19,463 4.01
4.02	6.00	MAINTENANCE & REPAIRS	MAINT AND REPAIRS	1,227	1,227 4.02
4.03	7.02	OPERATION OF PLANT ALL	PLANT OP ALL	19,299	19,299 4.03
4.04	192.00	PHYSICIANS' PRIVATE OFFICES	PHYS OFFICES	386,800	386,800 4.04
4.05	192.01	SATELLITE OFFICES	SATELLITE OFFICES	281,567	281,567 4.05
4.06	91.00	EMERGENCY	RENTAL DUPLEX	6,343	17,300 4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,054,946	1,065,903 5.00

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

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

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

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

6.00	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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-2

Date/Time Prepared:
9/28/2016 1:04 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	130,291	8,143	122,148	0	0	1.00
2.00	91.00	EMERGENCY	1,002,751	248,681	754,070	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			1,133,042	256,824	876,218	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	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	8,143		1.00
2.00	91.00	EMERGENCY	0	0	0	248,681		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	256,824		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	WELLNESS CENTER B&F	2015 BUILDING RENOVATION & ADDITION	MVBLE EQUIP	
		1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	403,687	403,687			1.00
1.01 00101	WELLNESS CENTER B&F	164,982	0	164,982		1.01
1.02 00102	2015 BUILDING RENOVATION & ADDITION	641,695	0	0	641,695	1.02
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,113,156				2.00
2.01 00201	WELLNESS CENTER MME	59,784				2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,923,870	6,887	23,766	0	4.00
5.01 00590	PHYSICIAN OFFICE BILLING	141,009	2,786	0	0	5.01
5.02 00591	HOSPITAL ADMIN & GENERAL	585,313	8,868	0	74,366	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	2,111,256	28,648	6,065	0	5.03
6.00 00600	MAINTENANCE & REPAIRS	903,197	3,821	0	0	6.00
7.01 00701	WELLNESS CENTER PLANT OP	76,897	0	0	0	7.01
7.02 00702	OPERATION OF PLANT ALL	257,621	2,400	0	0	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	192,960	6,985	0	0	8.00
9.00 00900	HOUSEKEEPING	196,207	1,053	0	0	9.00
10.00 01000	DIETARY	754,653	7,990	0	0	10.00
11.00 01100	CAFETERIA	74,638	12,387	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,126	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	260,110	7,881	0	0	14.00
15.00 01500	PHARMACY	225,361	1,633	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	443,356	10,697	701	0	16.00
17.00 01700	SOCIAL SERVICE	8,244	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,516,976	9,205	0	318,132	30.00
45.00 04500	NURSING FACILITY	1,326,715	90,048	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	536,166	166,079	866	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	675,290	16,950	0	45,552	50.00
53.00 05300	ANESTHESIOLOGY	179,450	455	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	629,932	9,505	0	71,503	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	76,230	0	0	0	58.00
60.00 06000	LABORATORY	824,895	5,504	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	371,421	1,658	9,519	0	65.00
65.01 06501	SLEEP LAB	59,581	0	0	0	65.01
66.00 06600	PHYSICAL THERAPY	599,789	1,121	34,536	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	447,493	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	141,893	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	369,921	0	0	0	73.00
76.00 03020	RENEWED HOPE	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	964,851	0	0	132,142	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)	19,258,599	403,687	75,453	641,695	1,097,395
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,982	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	409,447	0	0	0	192.00
192.01 19201	SATELLITE OFFICES	278,440	0	0	0	192.01
194.00 07950	ARC (HOPEDALE HALL)	0	0	0	0	194.00
194.01 07951	OUTSIDE PROPERTY	0	0	0	0	194.01
194.02 07952	RETAIL PHARMACY	1,624,363	0	0	0	194.02
194.03 07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	194.03
194.04 07954	TRIPLEXES	0	0	0	0	194.04
194.05 07957	WHITE FENCE ESTATES	102,702	0	0	0	194.05
194.06 07955	UNUSED SPACE	0	0	0	0	194.06
194.07 07956	WELLNESS CENTER	432,246	0	89,529	0	194.07
194.08 07958	ORTHO	24,842	0	0	0	194.08
194.09 07959	MEDICAL MASSAGE	26	0	0	0	194.09
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	22,142,647	403,687	164,982	641,695	1,113,156

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period: From 07/01/2015 To 06/30/2016

Worksheet B Part I Date/Time Prepared: 9/28/2016 1:04 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	PHYSICIAN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	
	WELLNESS CENTER MME						
	2.01	4.00					
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	WELLNESS CENTER B&F						1.01
1.02 00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00201	WELLNESS CENTER MME	59,784					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,909	1,961,432				4.00
5.01 00590	PHYSICIAN OFFICE BILLING	0	23,612	167,407	167,407		5.01
5.02 00591	HOSPITAL ADMIN & GENERAL	0	86,102	762,611	0	762,611	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	0	217,533	2,463,749	0	0	5.03
6.00 00600	MAINTENANCE & REPAIRS	0	112,486	1,038,480	0	0	6.00
7.01 00701	WELLNESS CENTER PLANT OP	0	0	76,897	0	0	7.01
7.02 00702	OPERATION OF PLANT ALL	0	0	381,200	0	0	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	0	34,779	237,141	0	0	8.00
9.00 00900	HOUSEKEEPING	0	30,248	227,508	0	0	9.00
10.00 01000	DIETARY	0	92,964	871,751	0	0	10.00
11.00 01100	CAFETERIA	0	21,302	108,327	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	1,126	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	26,620	329,535	0	0	14.00
15.00 01500	PHARMACY	0	42,109	278,436	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,947	483,760	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	1,712	9,956	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	239,378	2,350,007	0	79,468	30.00
45.00 04500	NURSING FACILITY	0	247,689	1,668,915	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	251	72,850	785,375	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	93,029	1,125,624	0	193,786	50.00
53.00 05300	ANESTHESIOLOGY	0	3,375	183,280	0	44,538	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	71,478	938,293	0	138,015	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	76,230	0	13,649	58.00
60.00 06000	LABORATORY	0	66,377	926,294	0	82,809	60.00
65.00 06500	RESPIRATORY THERAPY	11,017	65,765	471,813	0	39,325	65.00
65.01 06501	SLEEP LAB	0	0	59,581	0	6,027	65.01
66.00 06600	PHYSICAL THERAPY	15,581	111,612	762,639	0	34,309	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	447,493	0	30,549	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	141,893	0	7,505	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	369,921	0	61,143	73.00
76.00 03020	RENEWED HOPE	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	0	10,346	1,108,922	0	31,488	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)	33,758	1,688,313	18,854,164	0	762,611	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11,982	610	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	70,825	492,301	25,062	0	192.00
192.01 19201	SATELLITE OFFICES	0	50,651	329,091	16,753	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 PHARMACY	0	66,374	1,690,737	86,070	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	15,564	121,998	6,211	0	194.05
194.06 07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07 07956	WELLNESS CENTER	26,026	65,269	613,070	31,210	0	194.07
194.08 07958	ORTHO	0	4,436	29,278	1,490	0	194.08
194.09 07959	MEDICAL MASSAGE	0	0	26	1	0	194.09
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)	59,784	1,961,432	22,142,647	167,407	762,611	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

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Cost Center Description		Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	
		5A. 02	5. 03	6. 00	7. 01	7. 02	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00590						5.01
5.02	00591						5.02
5.03	00560	2,463,749	2,463,749				5.03
6.00	00600	1,038,480	130,016	1,168,496			6.00
7.01	00701	76,897	9,627	141,036	227,560		7.01
7.02	00702	381,200	47,725	462,412	0	891,337	7.02
8.00	00800	237,141	29,690	10,029	0	66,128	8.00
9.00	00900	227,508	28,484	0	0	9,970	9.00
10.00	01000	871,751	109,141	20,600	0	75,645	10.00
11.00	01100	108,327	13,562	2,891	0	117,269	11.00
13.00	01300	1,126	141	0	0	10,659	13.00
14.00	01400	329,535	41,257	29,544	0	74,612	14.00
15.00	01500	278,436	34,860	2,982	0	15,461	15.00
16.00	01600	483,760	60,566	4,337	1,180	101,270	16.00
17.00	01700	9,956	1,246	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,429,475	304,157	239,156	0	87,144	30.00
45.00	04500	1,668,915	208,945	0	0	0	45.00
46.00	04600	785,375	98,327	110,588	1,458	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,319,410	165,187	44,271	0	160,462	50.00
53.00	05300	227,818	28,522	0	0	4,307	53.00
54.00	05400	1,076,308	134,752	11,565	0	89,986	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	89,879	11,253	0	0	0	58.00
60.00	06000	1,009,103	126,338	10,481	0	52,110	60.00
65.00	06500	511,138	63,993	4,156	16,027	15,698	65.00
65.01	06501	65,608	8,214	0	0	0	65.01
66.00	06600	796,948	99,776	10,390	58,150	10,616	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	478,042	59,850	0	0	0	71.00
72.00	07200	149,398	18,704	0	0	0	72.00
73.00	07300	431,064	53,968	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,140,410	142,777	4,246	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		18,686,757	2,031,078	1,108,684	76,815	891,337	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	12,592	1,576	0	0	0	190.00
192.00	19200	517,363	64,773	14,637	0	0	192.00
192.01	19201	345,844	43,299	3,795	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	18,973	0	0	194.01
194.02	07952	1,776,807	222,453	3,072	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07957	128,209	16,052	19,335	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	644,280	80,663	0	150,745	0	194.07
194.08	07958	30,768	3,852	0	0	0	194.08
194.09	07959	27	3	0	0	0	194.09
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		22,142,647	2,463,749	1,168,496	227,560	891,337	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION					1.02
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	PHYSICIAN 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	342,988				8.00
9.00	00900	HOUSEKEEPING	0	265,962			9.00
10.00	01000	DIETARY	499	0	1,077,636		10.00
11.00	01100	CAFETERIA	0	0	0	242,049	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	11,926
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22	0	10,541	0
15.00	01500	PHARMACY	0	0	0	3,514	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	521	0	2,879	0
17.00	01700	SOCIAL SERVICE	0	0	0	280	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	53,917	50,989	63,442	40,538	5,055
45.00	04500	NURSING FACILITY	214,967	81,048	502,254	51,357	6,402
46.00	04600	OTHER LONG TERM CARE	2,920	65,173	511,940	19,310	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	28,834	0	0	24,226	0
53.00	05300	ANESTHESIOLOGY	0	0	0	428	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,743	7,873	0	13,449	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	0	10,432	0	12,224	0
65.00	06500	RESPIRATORY THERAPY	254	4,880	0	9,729	0
65.01	06501	SLEEP LAB	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	7,115	0	0	13,242	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	RENEWED HOPE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,426	0	0	3,764	469
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	323,675	220,938	1,077,636	205,481	11,926
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,233	41,142	0	14,335	0
192.01	19201	SATELLITE OFFICES	5,239	0	0	0	0
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	3,882	0	0	0
194.02	07952	RETAIL PHARMACY	0	0	0	7,455	0
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
194.04	07954	TRIPLEXES	0	0	0	0	0
194.05	07957	WHITE FENCE ESTATES	1,013	0	0	0	0
194.06	07955	UNUSED SPACE	0	0	0	0	0
194.07	07956	WELLNESS CENTER	5,828	0	0	14,689	0
194.08	07958	ORTHO	0	0	0	89	0
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	342,988	265,962	1,077,636	242,049	11,926

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

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Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
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	PHYSICIAN 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	485,511					14.00
15.00	01500	PHARMACY	2,629	337,882				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64	0	654,577			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	11,482		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,980	0	68,209	3,827	3,376,889	30.00
45.00	04500	NURSING FACILITY	12,119	0	0	7,655	2,753,662	45.00
46.00	04600	OTHER LONG TERM CARE	4,177	0	0	0	1,599,268	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	57,165	0	166,340	0	1,965,895	50.00
53.00	05300	ANESTHESIOLOGY	4,103	0	38,228	0	303,406	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,253	0	118,462	0	1,466,391	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	11,716	0	112,848	58.00
60.00	06000	LABORATORY	110,776	0	71,077	0	1,402,541	60.00
65.00	06500	RESPIRATORY THERAPY	13,831	0	33,754	0	673,460	65.00
65.01	06501	SLEEP LAB	1,583	0	5,173	0	80,578	65.01
66.00	06600	PHYSICAL THERAPY	1,651	0	29,448	0	1,027,336	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	162,243	0	26,221	0	726,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,438	0	6,441	0	225,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	337,882	52,481	0	875,395	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	6,538	0	27,027	0	1,334,657	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)	467,550	337,882	654,577	11,482	17,924,663	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,168	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,853	0	0	0	663,336	192.00
192.01	19201	SATELLITE OFFICES	2,721	0	0	0	400,898	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	22,855	194.01
194.02	07952	RETAIL PHARMACY	4,713	0	0	0	2,014,500	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	164,609	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	5,678	0	0	0	901,883	194.07
194.08	07958	ORTHO	996	0	0	0	35,705	194.08
194.09	07959	MEDICAL MASSAGE	0	0	0	0	30	194.09
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)	485,511	337,882	654,577	11,482	22,142,647	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
1.02	00102	2015 BUILDING RENOVATION & ADDITION		1.02
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	PHYSICIAN 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	0	3,376,889
45.00	04500	NURSING FACILITY	0	2,753,662
46.00	04600	OTHER LONG TERM CARE	0	1,599,268
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,965,895
53.00	05300	ANESTHESIOLOGY	0	303,406
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,466,391
57.00	05700	CT SCAN	0	0
58.00	05800	MRI	0	112,848
60.00	06000	LABORATORY	0	1,402,541
65.00	06500	RESPIRATORY THERAPY	0	673,460
65.01	06501	SLEEP LAB	0	80,578
66.00	06600	PHYSICAL THERAPY	0	1,027,336
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	726,356
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	225,981
73.00	07300	DRUGS CHARGED TO PATIENTS	0	875,395
76.00	03020	RENEWED HOPE	0	0
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	1,334,657
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	17,924,663
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,168
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	663,336
192.01	19201	SATELLITE OFFICES	0	400,898
194.00	07950	ARC (HOPEDALE HALL)	0	0
194.01	07951	OUTSIDE PROPERTY	0	22,855
194.02	07952	RETAIL PHARMACY	0	2,014,500
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0
194.04	07954	TRIPLEXES	0	0
194.05	07957	WHITE FENCE ESTATES	0	164,609
194.06	07955	UNUSED SPACE	0	0
194.07	07956	WELLNESS CENTER	0	901,883
194.08	07958	ORTHO	0	35,705
194.09	07959	MEDICAL MASSAGE	0	30
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	22,142,647

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 9/28/2016 1:04 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS						
		BLDG & FIXT	WELLNESS CENTER B&F	2015 BUILDING RENOVATION & ADDITION	MVBLE EQUIP			
		0	1.00	1.01	1.02		2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	WELLNESS CENTER B&F					1.01	
1.02	00102	2015 BUILDING RENOVATION & ADDITION					1.02	
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	6,887	23,766	0	0	4.00
5.01	00590	PHYSICIAN OFFICE BILLING	0	2,786	0	0	0	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	0	8,868	0	74,366	7,962	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	28,648	6,065	0	100,247	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	3,821	0	0	18,976	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	0	2,400	0	0	121,179	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,985	0	0	2,417	8.00
9.00	00900	HOUSEKEEPING	0	1,053	0	0	0	9.00
10.00	01000	DIETARY	0	7,990	0	0	16,144	10.00
11.00	01100	CAFETERIA	0	12,387	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,126	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,881	0	0	34,924	14.00
15.00	01500	PHARMACY	0	1,633	0	0	9,333	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,697	701	0	12,059	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	9,205	0	318,132	266,316	30.00
45.00	04500	NURSING FACILITY	0	90,048	0	0	4,463	45.00
46.00	04600	OTHER LONG TERM CARE	0	166,079	866	0	9,163	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,950	0	45,552	294,803	50.00
53.00	05300	ANESTHESIOLOGY	0	455	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,505	0	71,503	155,875	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	5,504	0	0	29,518	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,658	9,519	0	12,433	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,121	34,536	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	132,142	1,583	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	403,687	75,453	641,695	1,097,395	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	0	12,029	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	0	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 PHARMACY	0	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	0	0	0	0	3,732	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	89,529	0	0	194.07
194.08	07958	ORTHO	0	0	0	0	0	194.08
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		TOTAL (sum lines 118-201)	0	403,687	164,982	641,695	1,113,156	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

Period: From 07/01/2015 To 06/30/2016

Worksheet B Part II Date/Time Prepared: 9/28/2016 1:04 pm

Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PHYSICIAN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	
	WELLNESS CENTER MME						
	2.01	2A					
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	WELLNESS CENTER B&F						1.01
1.02 00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00201	WELLNESS CENTER MME						2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,909	37,562	37,562			4.00
5.01 00590	PHYSICIAN OFFICE BILLING	0	2,786	452	3,238		5.01
5.02 00591	HOSPITAL ADMIN & GENERAL	0	91,196	1,649	0	92,845	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	0	134,960	4,166	0	0	5.03
6.00 00600	MAINTENANCE & REPAIRS	0	22,797	2,154	0	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	123,579	0	0	0	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,402	666	0	0	8.00
9.00 00900	HOUSEKEEPING	0	1,053	579	0	0	9.00
10.00 01000	DIETARY	0	24,134	1,780	0	0	10.00
11.00 01100	CAFETERIA	0	12,387	408	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,126	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	42,805	510	0	0	14.00
15.00 01500	PHARMACY	0	10,966	806	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	23,457	325	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	33	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	593,653	4,584	0	9,674	30.00
45.00 04500	NURSING FACILITY	0	94,511	4,743	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	251	176,359	1,395	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	357,305	1,782	0	23,596	50.00
53.00 05300	ANESTHESIOLOGY	0	455	65	0	5,422	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	236,883	1,369	0	16,802	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	1,662	58.00
60.00 06000	LABORATORY	0	35,022	1,271	0	10,081	60.00
65.00 06500	RESPIRATORY THERAPY	11,017	34,627	1,259	0	4,787	65.00
65.01 06501	SLEEP LAB	0	0	0	0	734	65.01
66.00 06600	PHYSICAL THERAPY	15,581	51,238	2,138	0	4,177	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	3,719	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	914	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,444	73.00
76.00 03020	RENEWED HOPE	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	0	133,725	198	0	3,833	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)	33,758	2,251,988	32,332	0	92,845	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	12,029	1,356	485	0	192.00
192.01 19201	SATELLITE OFFICES	0	0	970	324	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 PHARMACY	0	0	1,271	1,664	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	3,732	298	120	0	194.05
194.06 07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07 07956	WELLNESS CENTER	26,026	115,555	1,250	604	0	194.07
194.08 07958	ORTHO	0	0	85	29	0	194.08
194.09 07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
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)	59,784	2,383,304	37,562	3,238	92,845	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141330		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 9/28/2016 1:04 pm	
Cost Center Description			OTHER ADMIN STRATIVE 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
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
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	PHYSICIAN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	139,126					5.03
6.00	00600	MAINTENANCE & REPAIRS	7,342	32,293				6.00
7.01	00701	WELLNESS CENTER PLANT OP	544	3,898	4,442			7.01
7.02	00702	OPERATION OF PLANT ALL	2,695	12,779	0	139,053		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,677	277	0	10,316	22,338	8.00
9.00	00900	HOUSEKEEPING	1,608	0	0	1,555	0	9.00
10.00	01000	DIETARY	6,163	569	0	11,801	33	10.00
11.00	01100	CAFETERIA	766	80	0	18,295	0	11.00
13.00	01300	NURSING ADMINISTRATION	8	0	0	1,663	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,330	817	0	11,640	0	14.00
15.00	01500	PHARMACY	1,969	82	0	2,412	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,420	120	23	15,799	0	16.00
17.00	01700	SOCIAL SERVICE	70	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,173	6,609	0	13,595	3,511	30.00
45.00	04500	NURSING FACILITY	11,799	0	0	0	14,000	45.00
46.00	04600	OTHER LONG TERM CARE	5,553	3,056	28	0	190	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,328	1,224	0	25,033	1,878	50.00
53.00	05300	ANESTHESIOLOGY	1,611	0	0	672	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,609	320	0	14,038	374	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	635	0	0	0	0	58.00
60.00	06000	LABORATORY	7,134	290	0	8,129	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,614	115	313	2,449	17	65.00
65.01	06501	SLEEP LAB	464	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	5,634	287	1,135	1,656	463	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,380	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,056	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,048	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	8,063	117	0	0	614	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)	114,693	30,640	1,499	139,053	21,080	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	89	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,658	405	0	0	471	192.00
192.01	19201	SATELLITE OFFICES	2,445	105	0	0	341	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	524	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	12,562	85	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	906	534	0	0	66	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	4,555	0	2,943	0	380	194.07
194.08	07958	ORTHO	218	0	0	0	0	194.08
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
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)	139,126	32,293	4,442	139,053	22,338	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 9/28/2016 1:04 pm			
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						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00590						5.01
5.02	00591						5.02
5.03	00560						5.03
6.00	00600						6.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900	4,795					9.00
10.00	01000	0	44,480				10.00
11.00	01100	0	0	31,936			11.00
13.00	01300	0	0	0	2,797		13.00
14.00	01400	0	0	1,391	0	59,493	14.00
15.00	01500	0	0	464	0	322	15.00
16.00	01600	9	0	380	0	8	16.00
17.00	01700	0	0	37	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	919	2,619	5,349	1,185	3,796	30.00
45.00	04500	1,462	20,731	6,775	1,502	1,485	45.00
46.00	04600	1,175	21,130	2,548	0	512	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	3,196	0	7,005	50.00
53.00	05300	0	0	56	0	503	53.00
54.00	05400	142	0	1,774	0	1,011	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	188	0	1,613	0	13,574	60.00
65.00	06500	88	0	1,284	0	1,695	65.00
65.01	06501	0	0	0	0	194	65.01
66.00	06600	0	0	1,747	0	202	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	19,882	71.00
72.00	07200	0	0	0	0	6,303	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	497	110	801	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,983	44,480	27,111	2,797	57,293	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	742	0	1,891	0	472	192.00
192.01	19201	0	0	0	0	333	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	70	0	0	0	0	194.01
194.02	07952	0	0	984	0	577	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07957	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	1,938	0	696	194.07
194.08	07958	0	0	12	0	122	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,795	44,480	31,936	2,797	59,493	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 9/28/2016 1:04 pm
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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
1.02	00102	2015 BUILDING RENOVATION & ADDITION					1.02
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	PHYSICIAN 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	17,021				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,541			16.00
17.00	01700	SOCIAL SERVICE	0	0	140		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,539	47	667,253	30.00
45.00	04500	NURSING FACILITY	0	0	93	157,101	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	211,946	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	11,051	0	441,398	50.00
53.00	05300	ANESTHESIOLOGY	0	2,544	0	11,328	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,883	0	288,205	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	780	0	3,077	58.00
60.00	06000	LABORATORY	0	4,730	0	82,032	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,246	0	52,494	65.00
65.01	06501	SLEEP LAB	0	344	0	1,736	65.01
66.00	06600	PHYSICAL THERAPY	0	1,960	0	70,637	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,745	0	28,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	429	0	8,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,021	3,492	0	31,005	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	1,798	0	149,756	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)	17,021	43,541	140	2,205,396	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	101	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	21,509	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	4,518	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	594	194.01
194.02	07952	RETAIL PHARMACY	0	0	0	17,143	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	5,656	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	0	127,921	194.07
194.08	07958	ORTHO	0	0	0	466	194.08
194.09	07959	MEDICAL MASSAGE	0	0	0	0	194.09
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,021	43,541	140	2,383,304	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 9/28/2016 1:04 pm
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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
1.02	00102	2015 BUILDING RENOVATION & ADDITION	1.02
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	PHYSICIAN 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	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	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	06501	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	RENEWED HOPE	76.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SATELLITE OFFICES	192.01
194.00	07950	ARC (HOPEDALE HALL)	194.00
194.01	07951	OUTSIDE PROPERTY	194.01
194.02	07952	RETAIL PHARMACY	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	194.03
194.04	07954	TRIPLEXES	194.04
194.05	07957	WHITE FENCE ESTATES	194.05
194.06	07955	UNUSED SPACE	194.06
194.07	07956	WELLNESS CENTER	194.07
194.08	07958	ORTHO	194.08
194.09	07959	MEDICAL MASSAGE	194.09
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	WELLNESS CENTER B&F (SQUARE FEET)	2015 BUILDING RENOVATION & ADDITION (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	WELLNESS CENTER MME (DOLLAR VALUE)	
		1.00	1.01	1.02	2.00	2.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	177,482				1.00
1.01	00101	WELLNESS CENTER B&F	0	35,064			1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION	0	0	17,482		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				1,027,122	2.00
2.01	00201	WELLNESS CENTER MME				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,028	5,051	0	0	4.00
5.01	00590	PHYSICIAN OFFICE BILLING	1,225	0	0	0	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	3,899	0	2,026	7,347	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	12,595	1,289	0	92,499	5.03
6.00	00600	MAINTENANCE & REPAIRS	1,680	0	0	17,509	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	1,055	0	0	111,813	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	3,071	0	0	2,230	8.00
9.00	00900	HOUSEKEEPING	463	0	0	0	9.00
10.00	01000	DIETARY	3,513	0	0	14,896	10.00
11.00	01100	CAFETERIA	5,446	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	495	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,465	0	0	32,225	14.00
15.00	01500	PHARMACY	718	0	0	8,612	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,703	149	0	11,127	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,047	0	8,667	245,733	30.00
45.00	04500	NURSING FACILITY	39,590	0	0	4,118	45.00
46.00	04600	OTHER LONG TERM CARE	73,016	184	0	8,455	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,452	0	1,241	272,017	50.00
53.00	05300	ANESTHESIOLOGY	200	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179	0	1,948	143,828	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,420	0	0	27,237	60.00
65.00	06500	RESPIRATORY THERAPY	729	2,023	0	11,472	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	493	7,340	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	3,600	1,461	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)	177,482	16,036	17,482	1,012,579	33,758
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	11,099	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	0	0	0	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	3,444	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	19,028	0	0	26,026
194.08	07958	ORTHO	0	0	0	0	194.08
194.09	07959	MEDICAL MASSAGE	0	0	0	0	194.09
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)	403,687	164,982	641,695	1,113,156	59,784
203.00		Unit cost multiplier (Wkst. B, Part I)	2.274524	4.705168	36.706040	1.083762	1.000000
204.00		Cost to be allocated (per Wkst. B, Part II)					
205.00		Unit cost multiplier (Wkst. B, Part II)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	PHYSICIAN OFFICE BILLING (ACCUM. COST)	HOSPITAL ADMIN & GENERAL (GROSS REV)	Reconciliation	
		4.00	5A.01	5.01	5.02	5A.03	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
2.01	00201						2.01
4.00	00400	9,445,263					4.00
5.01	00590	113,702	-167,407	3,288,483			5.01
5.02	00591	414,623	-762,611	0	34,707,339		5.02
5.03	00560	1,047,530	-2,463,749	0	0	-2,463,749	5.03
6.00	00600	541,678	-1,038,480	0	0	0	6.00
7.01	00701	0	-76,897	0	0	0	7.01
7.02	00702	0	-381,200	0	0	0	7.02
8.00	00800	167,480	-237,141	0	0	0	8.00
9.00	00900	145,657	-227,508	0	0	0	9.00
10.00	01000	447,670	-871,751	0	0	0	10.00
11.00	01100	102,578	-108,327	0	0	0	11.00
13.00	01300	0	-1,126	0	0	0	13.00
14.00	01400	128,187	-329,535	0	0	0	14.00
15.00	01500	202,778	-278,436	0	0	0	15.00
16.00	01600	81,609	-483,760	0	0	0	16.00
17.00	01700	8,244	-9,956	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,152,724	-2,350,007	0	3,616,620	0	30.00
45.00	04500	1,192,731	-1,668,915	0	0	0	45.00
46.00	04600	350,807	-785,375	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	447,980	-1,125,624	0	8,819,918	0	50.00
53.00	05300	16,253	-183,280	0	2,026,929	0	53.00
54.00	05400	344,204	-938,293	0	6,281,113	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	-76,230	0	621,193	0	58.00
60.00	06000	319,639	-926,294	0	3,768,664	0	60.00
65.00	06500	316,693	-471,813	0	1,789,708	0	65.00
65.01	06501	0	-59,581	0	274,309	0	65.01
66.00	06600	537,468	-762,639	0	1,561,394	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	-447,493	0	1,390,289	0	71.00
72.00	07200	0	-141,893	0	341,533	0	72.00
73.00	07300	0	-369,921	0	2,782,639	0	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	49,820	-1,108,922	0	1,433,030	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		8,130,055	-18,854,164	0	34,707,339	-2,463,749	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	11,982	0	0	190.00
192.00	19200	341,057	0	492,301	0	0	192.00
192.01	19201	243,910	0	329,091	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	319,625	0	1,690,737	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07957	74,950	0	121,998	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	314,303	0	613,070	0	0	194.07
194.08	07958	21,363	0	29,278	0	0	194.08
194.09	07959	0	0	26	0	0	194.09
200.00							200.00
201.00							201.00
202.00		1,961,432		167,407	762,611		202.00
203.00		0.207663		0.050907	0.021973		203.00
204.00		37,562		3,238	92,845		204.00
205.00		0.003977		0.000985	0.002675		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (MAINT TIME)	WELLNESS CENTER PLANT OP (SQUARE FEET)	OPERATION OF PLANT ALL (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)		
		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	
1.02	00102	2015 BUILDING RENOVATION & ADDITION					1.02	
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	PHYSICIAN OFFICE BILLING					5.01	
5.02	00591	HOSPITAL ADMIN & GENERAL					5.02	
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	19,678,898				5.03	
6.00	00600	MAINTENANCE & REPAIRS	1,038,480	12,933			6.00	
7.01	00701	WELLNESS CENTER PLANT OP	76,897	1,561	28,724		7.01	
7.02	00702	OPERATION OF PLANT ALL	381,200	5,118	0	41,394	7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	237,141	111	0	3,071	330,980	8.00
9.00	00900	HOUSEKEEPING	227,508	0	0	463	0	9.00
10.00	01000	DIETARY	871,751	228	0	3,513	482	10.00
11.00	01100	CAFETERIA	108,327	32	0	5,446	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,126	0	0	495	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	329,535	327	0	3,465	0	14.00
15.00	01500	PHARMACY	278,436	33	0	718	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	483,760	48	149	4,703	0	16.00
17.00	01700	SOCIAL SERVICE	9,956	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,429,475	2,647	0	4,047	52,029	30.00
45.00	04500	NURSING FACILITY	1,668,915	0	0	0	207,439	45.00
46.00	04600	OTHER LONG TERM CARE	785,375	1,224	184	0	2,818	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,319,410	490	0	7,452	27,825	50.00
53.00	05300	ANESTHESIOLOGY	227,818	0	0	200	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,076,308	128	0	4,179	5,542	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	89,879	0	0	0	0	58.00
60.00	06000	LABORATORY	1,009,103	116	0	2,420	0	60.00
65.00	06500	RESPIRATORY THERAPY	511,138	46	2,023	729	245	65.00
65.01	06501	SLEEP LAB	65,608	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	796,948	115	7,340	493	6,866	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	478,042	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,398	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	431,064	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	1,140,410	47	0	0	9,096	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)	16,223,008	12,271	9,696	41,394	312,342	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,592	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	517,363	162	0	0	6,980	192.00
192.01	19201	SATELLITE OFFICES	345,844	42	0	0	5,056	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	210	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	1,776,807	34	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	128,209	214	0	0	978	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	644,280	0	19,028	0	5,624	194.07
194.08	07958	ORTHO	30,768	0	0	0	0	194.08
194.09	07959	MEDICAL MASSAGE	27	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,463,749	1,168,496	227,560	891,337	342,988	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.125198	90.349957	7.922295	21.533000	1.036280	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	139,126	32,293	4,442	139,053	22,338	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007070	2.496946	0.154644	3.359255	0.067490	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS G HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00590						5.01
5.02	00591						5.02
5.03	00560						5.03
6.00	00600						6.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900	12,263					9.00
10.00	01000	0	116,152				10.00
11.00	01100	0	0	16,396			11.00
13.00	01300	0	0	0	134,780		13.00
14.00	01400	1	0	714	0	1,339,283	14.00
15.00	01500	0	0	238	0	7,252	15.00
16.00	01600	24	0	195	0	177	16.00
17.00	01700	0	0	19	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,351	6,838	2,746	57,123	85,458	30.00
45.00	04500	3,737	54,135	3,479	72,359	33,431	45.00
46.00	04600	3,005	55,179	1,308	0	11,523	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	1,641	0	157,689	50.00
53.00	05300	0	0	29	0	11,318	53.00
54.00	05400	363	0	911	0	22,767	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	481	0	828	0	305,575	60.00
65.00	06500	225	0	659	0	38,153	65.00
65.01	06501	0	0	0	0	4,366	65.01
66.00	06600	0	0	897	0	4,553	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	447,546	71.00
72.00	07200	0	0	0	0	141,893	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	255	5,298	18,035	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		10,187	116,152	13,919	134,780	1,289,736	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	1,897	0	971	0	10,629	192.00
192.01	19201	0	0	0	0	7,507	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	179	0	0	0	0	194.01
194.02	07952	0	0	505	0	13,000	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07957	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	995	0	15,664	194.07
194.08	07958	0	0	6	0	2,747	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00							201.00
202.00		265,962	1,077,636	242,049	11,926	485,511	202.00
203.00		21.688168	9.277808	14.762686	0.088485	0.362516	203.00
204.00		4,795	44,480	31,936	2,797	59,493	204.00
205.00		0.391014	0.382946	1.947792	0.020752	0.044422	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1
Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)	
		15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
1.02	00102				1.02
2.00	00200				2.00
2.01	00201				2.01
4.00	00400				4.00
5.01	00590				5.01
5.02	00591				5.02
5.03	00560				5.03
6.00	00600				6.00
7.01	00701				7.01
7.02	00702				7.02
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500	100			15.00
16.00	01600	0	34,707,339		16.00
17.00	01700	0	0	390	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	3,616,620	130	30.00
45.00	04500	0	0	260	45.00
46.00	04600	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	8,819,918	0	50.00
53.00	05300	0	2,026,929	0	53.00
54.00	05400	0	6,281,113	0	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	621,193	0	58.00
60.00	06000	0	3,768,664	0	60.00
65.00	06500	0	1,789,708	0	65.00
65.01	06501	0	274,309	0	65.01
66.00	06600	0	1,561,394	0	66.00
69.00	06900	0	0	0	69.00
71.00	07100	0	1,390,289	0	71.00
72.00	07200	0	341,533	0	72.00
73.00	07300	100	2,782,639	0	73.00
76.00	03020	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	0	1,433,030	0	91.00
92.00	09200				92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		100	34,707,339	390	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	0	0	194.04
194.05	07957	0	0	0	194.05
194.06	07955	0	0	0	194.06
194.07	07956	0	0	0	194.07
194.08	07958	0	0	0	194.08
194.09	07959	0	0	0	194.09
200.00					200.00
201.00					201.00
202.00		337,882	654,577	11,482	202.00
203.00		3,378.820000	0.018860	29.441026	203.00
204.00		17,021	43,541	140	204.00
205.00		170.210000	0.001255	0.358974	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 9/28/2016 1:04 pm		
		Title XVIII		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,376,889		3,376,889	0	0	30.00
45.00	04500	NURSING FACILITY	2,753,662		2,753,662	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	1,599,268		1,599,268	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,965,895		1,965,895	0	0	50.00
53.00	05300	ANESTHESIOLOGY	303,406		303,406	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,466,391		1,466,391	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	112,848		112,848	0	0	58.00
60.00	06000	LABORATORY	1,402,541		1,402,541	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	673,460	0	673,460	0	0	65.00
65.01	06501	SLEEP LAB	80,578	0	80,578	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,027,336	0	1,027,336	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	726,356		726,356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	225,981		225,981	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	875,395		875,395	0	0	73.00
76.00	03020	RENEWED HOPE	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,334,657		1,334,657	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	188,958		188,958	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,113,621	0	18,113,621	0	0	200.00
201.00		Less Observation Beds	188,958		188,958			201.00
202.00		Total (see instructions)	17,924,663	0	17,924,663	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 9/28/2016 1:04 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,455,776		3,455,776			30.00
45.00 04500 NURSING FACILITY	3,428,927		3,428,927			45.00
46.00 04600 OTHER LONG TERM CARE	1,579,698		1,579,698			46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3,539,957	5,279,961	8,819,918	0.222893	0.000000	50.00
53.00 05300 ANESTHESIOLOGY	1,079,629	947,300	2,026,929	0.149688	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	830,174	5,450,939	6,281,113	0.233460	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 05800 MRI	18,194	602,999	621,193	0.181663	0.000000	58.00
60.00 06000 LABORATORY	677,119	3,091,545	3,768,664	0.372159	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	1,168,579	621,129	1,789,708	0.376296	0.000000	65.00
65.01 06501 SLEEP LAB	4,000	270,309	274,309	0.293749	0.000000	65.01
66.00 06600 PHYSICAL THERAPY	344,915	1,216,479	1,561,394	0.657961	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	820,017	570,272	1,390,289	0.522450	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	215,047	126,486	341,533	0.661667	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,003,869	778,770	2,782,639	0.314592	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	58,269	1,374,761	1,433,030	0.931353	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11,526	149,319	160,845	1.174783	0.000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	19,235,696	20,480,269	39,715,965		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	19,235,696	20,480,269	39,715,965		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 9/28/2016 1:04 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		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
65.01	06501 SLEEP LAB	0.000000		65.01
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 07/01/2015
To 06/30/2016

Worksheet C
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		3,376,889	0	3,376,889	30.00
45.00	04500	NURSING FACILITY		2,753,662	0	2,753,662	45.00
46.00	04600	OTHER LONG TERM CARE		1,599,268	0	1,599,268	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		1,965,895	0	1,965,895	50.00
53.00	05300	ANESTHESIOLOGY		303,406	0	303,406	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,466,391	0	1,466,391	54.00
57.00	05700	CT SCAN		0	0	0	57.00
58.00	05800	MRI		112,848	0	112,848	58.00
60.00	06000	LABORATORY		1,402,541	0	1,402,541	60.00
65.00	06500	RESPIRATORY THERAPY	0	673,460	0	673,460	65.00
65.01	06501	SLEEP LAB	0	80,578	0	80,578	65.01
66.00	06600	PHYSICAL THERAPY	0	1,027,336	0	1,027,336	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		726,356	0	726,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		225,981	0	225,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		875,395	0	875,395	73.00
76.00	03020	RENEWED HOPE		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY		1,334,657	0	1,334,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		188,958		188,958	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	0	18,113,621	0	18,113,621	200.00
201.00		Less Observation Beds		188,958		188,958	201.00
202.00		Total (see instructions)	0	17,924,663	0	17,924,663	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet C
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,455,776		3,455,776		30.00
45.00	04500	NURSING FACILITY	3,428,927		3,428,927		45.00
46.00	04600	OTHER LONG TERM CARE	1,579,698		1,579,698		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,539,957	5,279,961	8,819,918	0.222893	50.00
53.00	05300	ANESTHESIOLOGY	1,079,629	947,300	2,026,929	0.149688	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	830,174	5,450,939	6,281,113	0.233460	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	18,194	602,999	621,193	0.181663	58.00
60.00	06000	LABORATORY	677,119	3,091,545	3,768,664	0.372159	60.00
65.00	06500	RESPIRATORY THERAPY	1,168,579	621,129	1,789,708	0.376296	65.00
65.01	06501	SLEEP LAB	4,000	270,309	274,309	0.293749	65.01
66.00	06600	PHYSICAL THERAPY	344,915	1,216,479	1,561,394	0.657961	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	820,017	570,272	1,390,289	0.522450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,047	126,486	341,533	0.661667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,003,869	778,770	2,782,639	0.314592	73.00
76.00	03020	RENEWED HOPE	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	58,269	1,374,761	1,433,030	0.931353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,526	149,319	160,845	1.174783	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	19,235,696	20,480,269	39,715,965		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,235,696	20,480,269	39,715,965		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 9/28/2016 1:04 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		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
65.01	06501 SLEEP LAB	0.000000		65.01
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 07/01/2015 To 06/30/2016		Worksheet D Part II Date/Time Prepared: 9/28/2016 1:04 pm	
Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	441,398	8,819,918	0.050046	2,166,381	108,419	50.00
53.00	05300 ANESTHESIOLOGY	11,328	2,026,929	0.005589	721,160	4,031	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	288,205	6,281,113	0.045884	705,233	32,359	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	3,077	621,193	0.004953	14,877	74	58.00
60.00	06000 LABORATORY	82,032	3,768,664	0.021767	363,314	7,908	60.00
65.00	06500 RESPIRATORY THERAPY	52,494	1,789,708	0.029331	492,723	14,452	65.00
65.01	06501 SLEEP LAB	1,736	274,309	0.006329	3,744	24	65.01
66.00	06600 PHYSICAL THERAPY	70,637	1,561,394	0.045240	49,613	2,244	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28,726	1,390,289	0.020662	472,387	9,760	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8,702	341,533	0.025479	167,320	4,263	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	31,005	2,782,639	0.011142	871,970	9,715	73.00
76.00	03020 RENEWED HOPE	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	149,756	1,433,030	0.104503	5,324	556	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	37,337	160,845	0.232130	0	0	92.00
200.00	Total (lines 50-199)	1,206,433	31,251,564		6,034,046	193,805	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 9/28/2016 1:04 pm
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Cost Center Description	Title XVIII				Hospital	Cost	
	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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 9/28/2016 1:04 pm
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Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Cost		
				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	8,819,918	0.000000	0.000000	2,166,381	50.00
53.00 05300 ANESTHESIOLOGY	0	2,026,929	0.000000	0.000000	721,160	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	6,281,113	0.000000	0.000000	705,233	54.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MRI	0	621,193	0.000000	0.000000	14,877	58.00
60.00 06000 LABORATORY	0	3,768,664	0.000000	0.000000	363,314	60.00
65.00 06500 RESPIRATORY THERAPY	0	1,789,708	0.000000	0.000000	492,723	65.00
65.01 06501 SLEEP LAB	0	274,309	0.000000	0.000000	3,744	65.01
66.00 06600 PHYSICAL THERAPY	0	1,561,394	0.000000	0.000000	49,613	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,390,289	0.000000	0.000000	472,387	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	341,533	0.000000	0.000000	167,320	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,782,639	0.000000	0.000000	871,970	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	1,433,030	0.000000	0.000000	5,324	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	160,845	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	31,251,564			6,034,046	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 9/28/2016 1:04 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		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
65.01	06501 SLEEP LAB	0	0	0		65.01
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 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 9/28/2016 1:04 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.222893	0	2,010,547	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.149688	0	451,883	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.233460	0	3,805,003	0	0	54.00
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MRI	0.181663	0	289,355	0	0	58.00
60.00 06000 LABORATORY	0.372159	0	1,623,334	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.376296	0	352,058	0	0	65.00
65.01 06501 SLEEP LAB	0.293749	0	117,331	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0.657961	0	540,274	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.522450	0	257,913	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.661667	0	95,929	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.314592	0	501,106	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	0.931353	0	664,725	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.174783	0	88,038	0	0	92.00
200.00 Subtotal (see instructions)		0	10,797,496	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	10,797,496	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 9/28/2016 1:04 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	448,137	0	50.00
53.00	05300 ANESTHESIOLOGY	67,641	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	888,316	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	52,565	0	58.00
60.00	06000 LABORATORY	604,138	0	60.00
65.00	06500 RESPIRATORY THERAPY	132,478	0	65.00
65.01	06501 SLEEP LAB	34,466	0	65.01
66.00	06600 PHYSICAL THERAPY	355,479	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	134,747	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	63,473	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	157,644	0	73.00
76.00	03020 RENEWED HOPE	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	619,094	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	103,426	0	92.00
200.00	Subtotal (see instructions)	3,661,604	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,661,604	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330 Component CCN: 14Z330	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 9/28/2016 1:04 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.222893	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.149688	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.233460	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MRI	0.181663	0	0	0	0
60.00 06000 LABORATORY	0.372159	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.376296	0	0	0	0
65.01 06501 SLEEP LAB	0.293749	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.657961	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.522450	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.661667	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.314592	0	0	0	0
76.00 03020 RENEWED HOPE	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0.931353	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.174783	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330 Component CCN: 14Z330	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 9/28/2016 1:04 pm
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
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
65.01	06501	SLEEP LAB	0	0	65.01
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	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 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 9/28/2016 1:04 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,584 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,191 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)			1,049 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			671 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)			670 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			26 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)			26 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			768 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)			618 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)			617 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			144.67 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			147.50 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,376,889 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)			3,761 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)			3,835 25.00
26.00	Total swing-bed cost (see instructions)			1,792,038 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,584,851 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)			1,584,851 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)			1,330.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,021,962 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,021,962 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 9/28/2016 1:04 pm
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)					1,749,314 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,771,276 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)					822,360 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					821,030 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,643,390 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					142 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,330.69 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					188,958 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141330		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 9/28/2016 1:04 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	667,253	3,376,889	0.197594	188,958	37,337	90.00
91.00	Nursing School cost	0	3,376,889	0.000000	188,958	0	91.00
92.00	Allied health cost	0	3,376,889	0.000000	188,958	0	92.00
93.00	All other Medical Education	0	3,376,889	0.000000	188,958	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 9/28/2016 1:04 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		997,608		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.222893	2,166,381	482,871	50.00
53.00	05300 ANESTHESIOLOGY	0.149688	721,160	107,949	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.233460	705,233	164,644	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.181663	14,877	2,703	58.00
60.00	06000 LABORATORY	0.372159	363,314	135,211	60.00
65.00	06500 RESPIRATORY THERAPY	0.376296	492,723	185,410	65.00
65.01	06501 SLEEP LAB	0.293749	3,744	1,100	65.01
66.00	06600 PHYSICAL THERAPY	0.657961	49,613	32,643	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.522450	472,387	246,799	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.661667	167,320	110,710	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.314592	871,970	274,315	73.00
76.00	03020 RENEWED HOPE	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.931353	5,324	4,959	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.174783	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		6,034,046	1,749,314	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		6,034,046		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141330 Component CCN: 14Z330	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 9/28/2016 1:04 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.222893	0	50.00
53.00	05300 ANESTHESIOLOGY	0.149688	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.233460	75,243	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.181663	0	58.00
60.00	06000 LABORATORY	0.372159	168,263	60.00
65.00	06500 RESPIRATORY THERAPY	0.376296	454,559	65.00
65.01	06501 SLEEP LAB	0.293749	0	65.01
66.00	06600 PHYSICAL THERAPY	0.657961	266,113	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.522450	80,560	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.661667	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.314592	517,201	73.00
76.00	03020 RENEWED HOPE	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.931353	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.174783	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,561,939	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)		1,561,939	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 9/28/2016 1:04 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,661,604 1.00
2.00	Medical and other services reimbursed under OPPIs (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)			3,661,604 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,698,220 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)			37,120 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,840,861 26.00
27.00	Subtotal [(Lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,820,239 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)			1,820,239 30.00
31.00	Primary payer payments			445 31.00
32.00	Subtotal (line 30 minus line 31)			1,819,794 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)			224,349 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			145,827 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			110,677 36.00
37.00	Subtotal (see instructions)			1,965,621 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)			1,965,621 40.00
40.01	Sequestration adjustment (see instructions)			39,312 40.01
41.00	Interim payments			1,957,700 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-31,391 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 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

		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		2,058,942		1,756,465	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	01/19/2016	36,910	01/19/2016	22,486		3.01
3.02		06/16/2016	135,380	06/16/2016	178,749		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)		172,290		201,235		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,231,232		1,957,700		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		297,767		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		31,391		6.02
7.00	Total Medicare program liability (see instructions)		2,528,999		1,926,309		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 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
9/28/2016 1:04 pm

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		1,746,816		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	01/19/2016	80,451		0	3.01
3.02		06/16/2016	157,102		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)		237,553		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)		1,984,369		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		215,889		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,200,258		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 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 9/28/2016 1:04 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD 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			306 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			768 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			116 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,049 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			39,715,965 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			677,455 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 THE IPPS & 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	Period:	Worksheet E-2
		Component CCN: 14Z330	From 07/01/2015 To 06/30/2016	Date/Time Prepared: 9/28/2016 1:04 pm
		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)		1,659,824	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		637,435	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		1,235	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,297,259	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		2,297,259	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		2,297,259	0
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		52,098	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		2,245,161	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
16.55	410A RURAL DEMONSTRATION PROJECT		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		2,245,161	0
19.01	Sequestration adjustment (see instructions)		44,903	0
20.00	Interim payments		1,984,369	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		215,889	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141330	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 9/28/2016 1:04 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,771,276 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)			2,771,276 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,789,566 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)			2,789,566 19.00
20.00	Deductibles (exclude professional component)			219,072 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,570,494 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,570,494 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			15,565 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			10,117 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,580,611 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)			2,580,611 30.00
30.01	Sequestration adjustment (see instructions)			51,612 30.01
31.00	Interim payments			2,231,232 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)			297,767 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 07/01/2015
To 06/30/2016

Worksheet G

Date/Time Prepared:
9/28/2016 1:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,275,016	0	0	0	1.00
2.00	Temporary investments	2,988,949	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,430,797	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	794,997	0	0	0	7.00
8.00	Prepaid expenses	231,427	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	695,059	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,416,245	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	22,819,242	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)	22,819,242	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	542,350	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	584,140	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,126,490	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,361,977	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	521,352	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,141,882	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	859,651	0	0	0	40.00
41.00	Deferred income	423,503	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,634,622	0	0	0	43.00
44.00	Other current liabilities	416,060	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,997,070	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,936,708	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	609,517	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,546,225	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,543,295	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	19,818,682	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	19,818,682	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,361,977	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-1

Date/Time Prepared:
9/28/2016 1:04 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		18,676,774		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		727,565				2.00
3.00	Total (sum of line 1 and line 2)		19,404,339		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00	ROUNDING	2,359		0		0	6.00
7.00	PRIOR PERIOD ADJUSTMENT	411,984		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)		414,343		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,818,682		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,818,682		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			0				4.00
5.00			0				5.00
6.00	ROUNDING		0				6.00
7.00	PRIOR PERIOD ADJUSTMENT		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			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 07/01/2015
To 06/30/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/28/2016 1:04 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,700,956		3,700,956	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	3,428,927		3,428,927	8.00
9.00	OTHER LONG TERM CARE	1,579,698		1,579,698	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,709,581		8,709,581	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)	8,709,581		8,709,581	17.00
18.00	Ancillary services	10,651,382	18,913,912	29,565,294	18.00
19.00	Outpatient services	63,417	2,004,781	2,068,198	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	1,763,843	1,763,843	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,424,380	22,682,536	42,106,916	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,824,218		29.00
30.00	GAIN ON ASSET	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,824,218		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141330

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-3

Date/Time Prepared:
9/28/2016 1:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	42,106,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,559,847	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,547,069	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,824,218	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-277,149	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	5,785	6.00
7.00	Income from investments	87,490	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	1,193,530	24.00
24.01	UNREALIZED GAIN	19,504	24.01
24.02	NET ASSETS RELEASED	0	24.02
24.03	ORTHO REVENUE	30,073	24.03
25.00	Total other income (sum of lines 6-24)	1,336,382	25.00
26.00	Total (line 5 plus line 25)	1,059,233	26.00
27.00	FAIR VALUE OF INTEREST	275,080	27.00
27.01	UNREALIZED LOSS	0	27.01
27.02	PROVISION FOR UNCOLLECTIBLE ACCTS	41,093	27.02
27.03	EQUITY IN NET LOSS OF HRES	9,354	27.03
27.04	ROUNDING	6,141	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	331,668	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	727,565	29.00