

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 10/5/2017 12:07 pm
--	-----------------------	---	---

<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 10/5/2017	Time: 12:07 pm
	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.		
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 ( 14-1330 ) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	50,457	77,006	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	56,855	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	107,312	77,006	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: 14-1330		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 10/5/2017 12:04 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: SECOND STREET	PO Box:							1.00	
2.00	City: HOPEDALE	State: IL		Zip Code: 61747-		County: TAZEWELL			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
							V	XVIII	XIX	
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)					07/01/2016	06/30/2017		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: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 10/5/2017 12:04 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		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N		N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N		N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.		N		N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1330		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 10/5/2017 12:04 pm		
	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		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01	
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00	
		Unweighted FTEs Nonprovi der Site		Unweighted FTEs in Hospi tal	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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 10/5/2017 12:04 pm		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		
		1.00	2.00	3.00		
		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	4.00	5.00
		1.00	2.00	3.00	4.00	5.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		0
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
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		0
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
		1.00	2.00	3.00	4.00	5.00
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		
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		
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		
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.			N		
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		
		1.00	2.00	3.00	4.00	5.00
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			Y		N
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
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
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
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 10/5/2017 12:04 pm		
		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	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		
<b>Rural Providers</b>						
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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
						1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.	N				110.00
						1.00 2.00 3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	159,854	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
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 10/5/2017 12:04 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		
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	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
							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
168.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 10/5/2017 12:04 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	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1330		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 10/5/2017 12:04 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				
		1.00	2.00				
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				
		1.00	2.00				
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					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	08/24/2017	Y	08/24/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 10/5/2017 12:04 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		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
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		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		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN		LI NHART	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.LI NHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 10/5/2017 12:04 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 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	9,125	30,792.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	30,792.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	30,792.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	54	19,710		0	20.00
21.00 OTHER LONG TERM CARE	46.00	72	26,280			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	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: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	834	8	1,157			1.00
2.00 HMO and other (see instructions)	139	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	991	0	1,095			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	53			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,825	8	2,305			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,825	8	2,305	0.00	226.89	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	17,731	0.00	36.42	20.00
21.00 OTHER LONG TERM CARE			19,692	0.00	13.23	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	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	276.54	27.00
28.00 Observation Bed Days		0	149			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: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 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	237	2	336	1.00
2.00 HMO and other (see instructions)				33	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	237		2	336	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					55	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	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 10/5/2017 12:04 pm
---	-----------------------	---	---

			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.432833	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		75,375	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid		44,491	5.00
6.00	Medicaid charges		695,224	6.00
7.00	Medicaid cost (line 1 times line 6)		300,916	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)		181,050	8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>				
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, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		181,050	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
<b>Uncompensated Care (see instructions for each line)</b>				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	133,765	423,225	556,990
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	57,898	423,225	481,123
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	57,898	423,225	481,123
			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, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		388,878	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		248,700	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		382,614	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)		6,264	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		136,625	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		617,748	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		798,798	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-1330		Period: From 07/01/2016 To 06/30/2017		Worksheet A			
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
<b>GENERAL SERVICE COST CENTERS</b>									
1.00	00100	CAP REL COSTS-BLDG & FIXT		260,260		260,260	161,171	421,431	1.00
1.01	00101	WELLNESS CENTER B&F		73,269		73,269	118,056	191,325	1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION		0		0	721,032	721,032	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,079,348		2,079,348	-723,690	1,355,658	2.00
2.01	00201	WELLNESS CENTER MME		0		0	51,834	51,834	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	163,656	2,202,468	2,366,124	10,974		2,377,098	4.00
5.01	00590	PHYSICIAN OFFICE BILLING	144,908	49,094	194,002	0		194,002	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	413,895	150,844	564,739	0		564,739	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	1,003,032	1,831,967	2,834,999	0		2,834,999	5.03
6.00	00600	MAINTENANCE & REPAIRS	534,619	322,151	856,770	0		856,770	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	86,046	86,046	0		86,046	7.01
7.02	00702	OPERATION OF PLANT ALL	0	344,074	344,074	18,423		362,497	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	171,719	19,127	190,846	0		190,846	8.00
9.00	00900	HOUSEKEEPING	153,882	51,299	205,181	0		205,181	9.00
10.00	01000	DIETARY	584,847	390,398	975,245	-152,858		822,387	10.00
11.00	01100	CAFETERIA	0	0	0	152,858		152,858	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0		0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	163,923	94,719	258,642	98		258,740	14.00
15.00	01500	PHARMACY	210,524	27,118	237,642	-118		237,524	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,870	388,533	455,403	0		455,403	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	8,104		8,104	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	1,187,059	239,527	1,426,586	-76,357		1,350,229	30.00
45.00	04500	NURSING FACILITY	1,218,222	165,716	1,383,938	15,024		1,398,962	45.00
46.00	04600	OTHER LONG TERM CARE	304,407	194,377	498,784	20,642		519,426	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	517,760	537,662	1,055,422	-290,326		765,096	50.00
53.00	05300	ANESTHESIOLOGY	17,748	465,986	483,734	-19,544		464,190	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,797	157,253	518,050	23,248		541,298	54.00
57.00	05700	CT SCAN	0	0	0	0		0	57.00
58.00	05800	MRI	0	175,957	175,957	-13,847		162,110	58.00
60.00	06000	LABORATORY	330,908	538,505	869,413	0		869,413	60.00
65.00	06500	RESPIRATORY THERAPY	335,259	55,833	391,092	-1,082		390,010	65.00
65.01	06501	SLEEP LAB	0	59,700	59,700	0		59,700	65.01
65.02	03160	PULMONARY REHAB	16,913	688	17,601	0		17,601	65.02
66.00	06600	PHYSICAL THERAPY	573,718	53,339	627,057	-2,215		624,842	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	642,422		642,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	154,627	154,627	0		154,627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	343,130	343,130	0		343,130	73.00
76.00	03020	RENEWED HOPE	0	0	0	0		0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	34,584	1,178,540	1,213,124	45,847		1,258,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART							92.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE		412,955	412,955	-412,955		0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,509,250	13,104,510	21,613,760	296,741		21,910,501	118.00
<b>NONREIMBURSABLE COST CENTERS</b>									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,857	29,615	36,472	0		36,472	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	332,878	83,202	416,080	165		416,245	192.00
192.01	19201	SATELLITE OFFICES	341,843	174,128	515,971	0		515,971	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	301,270	1,167,468	1,468,738	0		1,468,738	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	25,159	25,159	0		25,159	194.05
194.06	07955	UNUSED SPACE	0	0	0	0		0	194.06
194.07	07956	WELLNESS CENTER	313,623	129,377	443,000	-11,510		431,490	194.07
194.08	07958	ORTHO	286,748	295,061	581,809	-285,396		296,413	194.08
194.09	07959	MEDICAL MASSAGE	0	0	0	0		0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	10,092,469	15,008,520	25,100,989	0		25,100,989	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A  
Date/Time Prepared:  
10/5/2017 12:04 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	421,431	1.00
1.01	00101	WELLNESS CENTER B&F	-5,938	185,387	1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION	-102,389	618,643	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-85,105	1,270,553	2.00
2.01	00201	WELLNESS CENTER MME	0	51,834	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-156,401	2,220,697	4.00
5.01	00590	PHYSICIAN OFFICE BILLING	0	194,002	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	-3,285	561,454	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-395,182	2,439,817	5.03
6.00	00600	MAINTENANCE & REPAIRS	-2,214	854,556	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	86,046	7.01
7.02	00702	OPERATION OF PLANT ALL	-6,650	355,847	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,846	8.00
9.00	00900	HOUSEKEEPING	0	205,181	9.00
10.00	01000	DIETARY	-1,671	820,716	10.00
11.00	01100	CAFETERIA	-103,502	49,356	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-32	258,708	14.00
15.00	01500	PHARMACY	0	237,524	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-507	454,896	16.00
17.00	01700	SOCIAL SERVICE	0	8,104	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	1,350,229	30.00
45.00	04500	NURSING FACILITY	-6,706	1,392,256	45.00
46.00	04600	OTHER LONG TERM CARE	-45,269	474,157	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	765,096	50.00
53.00	05300	ANESTHESIOLOGY	-274,400	189,790	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,938	533,360	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	162,110	58.00
60.00	06000	LABORATORY	-69	869,344	60.00
65.00	06500	RESPIRATORY THERAPY	-476	389,534	65.00
65.01	06501	SLEEP LAB	0	59,700	65.01
65.02	03160	PULMONARY REHAB	0	17,601	65.02
66.00	06600	PHYSICAL THERAPY	-997	623,845	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	642,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	154,627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	343,130	73.00
76.00	03020	RENEWED HOPE	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	-273,616	985,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,472,347	20,438,154	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,472	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	416,245	192.00
192.01	19201	SATELLITE OFFICES	0	515,971	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	194.01
194.02	07952	RETAIL PHARMACY	0	1,468,738	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	194.03
194.04	07954	TRIPLEXES	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	25,159	194.05
194.06	07955	UNUSED SPACE	0	0	194.06
194.07	07956	WELLNESS CENTER	-568	430,922	194.07
194.08	07958	ORTHO	0	296,413	194.08
194.09	07959	MEDICAL MASSAGE	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-1,472,915	23,628,074	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA	11.00	91,668	61,190	1.00	
	TOTALS		91,668	61,190		
<b>B - INTEREST EXPENSE RECLASS</b>						
1.00	WELLNESS CENTER B&F	1.01	0	18,001	1.00	
2.00	2015 BUILDING RENOVATION & ADDITION	1.02	0	310,402	2.00	
3.00	OPERATION OF PLANT ALL	7.02	0	18,423	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	98	4.00	
5.00	NURSING FACILITY	45.00	0	20,329	5.00	
6.00	OTHER LONG TERM CARE	46.00	0	20,329	6.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	23,766	8.00	
9.00	RESPIRATORY THERAPY	65.00	0	1,442	9.00	
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	165	10.00	
	TOTALS		0	412,955		
<b>C - ER NURSING RECLASS</b>						
1.00	EMERGENCY	91.00	53,449	0	1.00	
	TOTALS		53,449	0		
<b>D - BUILDING DEPRECIATION</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	671,856	1.00	
	TOTALS		0	671,856		
<b>E - WELLNESS CENTER DEP</b>						
1.00	WELLNESS CENTER B&F	1.01	0	100,055	1.00	
2.00	WELLNESS CENTER MME	2.01	0	51,834	2.00	
	TOTALS		0	151,889		
<b>F - WELLNESS CENTER RECLASS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7,081	3,893	1.00	
2.00	OTHER LONG TERM CARE	46.00	231	82	2.00	
3.00	RESPIRATORY THERAPY	65.00	19	7	3.00	
4.00	PHYSICAL THERAPY	66.00	145	52	4.00	
	TOTALS		7,476	4,034		
<b>G - SOCIAL SERVICE RECLASS</b>						
1.00	SOCIAL SERVICE	17.00	8,104	0	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		8,104	0		
<b>H - MEDICAL SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	642,422	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
	TOTALS		0	642,422		
<b>I - BUILDING RENOVATION DEPRE</b>						
1.00	2015 BUILDING RENOVATION & ADDITION	1.02	0	410,630	1.00	
	TOTALS		0	410,630		
500.00	Grand Total: Increases		160,697	2,354,976	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-6

Date/Time Prepared:  
10/5/2017 12:04 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	91,668	61,190	0		1.00
	TOTALS		91,668	61,190			
<b>B - INTEREST EXPENSE RECLASS</b>							
1.00	INTEREST EXPENSE	113.00	0	412,955	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	412,955			
<b>C - ER NURSING RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	53,449	0	0		1.00
	TOTALS		53,449	0			
<b>D - BUILDING DEPRECIATION</b>							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	671,856	9		1.00
	TOTALS		0	671,856			
<b>E - WELLNESS CENTER DEP</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	100,055	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	51,834	9		2.00
	TOTALS		0	151,889			
<b>F - WELLNESS CENTER RECLASS</b>							
1.00	WELLNESS CENTER	194.07	7,476	4,034	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		7,476	4,034			
<b>G - SOCIAL SERVICE RECLASS</b>							
1.00	NURSING FACILITY	45.00	3,770	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	4,334	0	0		2.00
	TOTALS		8,104	0			
<b>H - MEDICAL SUPPLIES</b>							
1.00	PHARMACY	15.00	0	118	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18,574	0		2.00
3.00	NURSING FACILITY	45.00	0	1,535	0		3.00
4.00	OPERATING ROOM	50.00	0	290,326	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	19,544	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	518	0		6.00
7.00	MRI	58.00	0	13,847	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	2,550	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	2,412	0		9.00
10.00	EMERGENCY	91.00	0	7,602	0		10.00
11.00	ORTHO	194.08	0	285,396	0		11.00
	TOTALS		0	642,422			
<b>I - BUILDING RENOVATION DEPRE</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	410,630	9		1.00
	TOTALS		0	410,630			
500.00	Grand Total: Decreases		160,697	2,354,976			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-7  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 pm

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	1,004,596	15,000	0	15,000	0 1.00	
2.00	Land Improvements	1,370,766	343,994	0	343,994	0 2.00	
3.00	Buildings and Fixtures	32,071,960	978,094	0	978,094	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	15,770,661	1,163,639	0	1,163,639	0 6.00	
7.00	HIT designated Assets	0	0	0	0	0 7.00	
8.00	Subtotal (sum of lines 1-7)	50,217,983	2,500,727	0	2,500,727	0 8.00	
9.00	Reconciling Items	-157,225	0	0	0	-9,621 9.00	
10.00	Total (line 8 minus line 9)	50,375,208	2,500,727	0	2,500,727	9,621 10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	1,019,596	0			1.00	
2.00	Land Improvements	1,714,760	0			2.00	
3.00	Buildings and Fixtures	33,050,054	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	16,934,300	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	52,718,710	0			8.00	
9.00	Reconciling Items	-147,604	0			9.00	
10.00	Total (line 8 minus line 9)	52,866,314	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-7  
Part II  
Date/Time Prepared:  
10/5/2017 12:04 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	260,260	0	0	0	0	1.00
1.01	WELLNESS CENTER B&F	73,269	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	2,079,348	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)	2,412,877	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	260,260				1.00
1.01	WELLNESS CENTER B&F	0	73,269				1.01
1.02	2015 BUILDING RENOVATION & ADDITION	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,079,348				2.00
2.01	WELLNESS CENTER MME	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,412,877				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-7  
Part III  
Date/Time Prepared:  
10/5/2017 12:04 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	35,784,410	0	35,784,410	0.678780	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	16,934,300	0	16,934,300	0.321220	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	52,718,710	0	52,718,710	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	421,431	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	173,324	0	1.01
1.02	2015 BUILDING RENOVATION & ADDITION	0	0	0	410,630	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,270,553	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	51,834	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,327,772	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	421,431	1.00
1.01	WELLNESS CENTER B&F	12,063	0	0	0	185,387	1.01
1.02	2015 BUILDING RENOVATION & ADDITION	208,013	0	0	0	618,643	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,270,553	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	51,834	2.01
3.00	Total (sum of lines 1-2)	220,076	0	0	0	2,547,848	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-8

Date/Time Prepared:  
10/5/2017 12:04 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	-261,887			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	-11,729			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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-8

Date/Time Prepared:  
10/5/2017 12:04 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		
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	-84,001		CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00 INVST INCOME-NEW BLDGS AND FIXTURES	B	-102,389		2015 BUILDING RENOVATION & ADDITION	1.02	11	33.00
33.01 INTEREST INCOME OFFSET	B	-5,938		WELLNESS CENTER B&F	1.01	11	33.01
33.02 INTEREST INCOME OFFSET	B	-6,077		OPERATION OF PLANT ALL	7.02	0	33.02
33.03 INTEREST INCOME OFFSET	B	-32		CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04 INTEREST INCOME OFFSET	B	-6,706		NURSING FACILITY	45.00	0	33.04
33.05 INTEREST INCOME OFFSET	B	-6,706		OTHER LONG TERM CARE	46.00	0	33.05
33.06		0			0.00	0	33.06
33.07 INTEREST INCOME OFFSET	B	-7,839		RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08 INTEREST INCOME OFFSET	B	-476		RESPIRATORY THERAPY	65.00	0	33.08
33.09 TRADE, QUANTITY AND TIME DISCOUNTS	B	-6,936		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.09
33.10 CAFETERIA--EMPLOYEES AND GUESTS	B	-103,502		CAFETERIA	11.00	0	33.10
33.11 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-507		MEDICAL RECORDS & LIBRARY	16.00	0	33.11
33.12 EMPLOYEE CHILD CARE REV	B	-155,682		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13 MISC INCOME	B	-24,414		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.14 OTHER INCOME OLTC	B	-24,436		OTHER LONG TERM CARE	46.00	0	33.14
33.15		0			0.00	0	33.15
33.16 PROGRAM INCOME -DIETITIAN	B	-1,671		DIETARY	10.00	0	33.16
33.17		0			0.00	0	33.17
33.18		0			0.00	0	33.18
33.19		0			0.00	0	33.19
33.20 BUYER'S GROUP REBATE	B	-18,682		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.20
33.21		0			0.00	0	33.21
33.22 FLOOD ACTIVITY	B	-45		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.22
33.23 FLOOD ACTIVITY	B	-573		OPERATION OF PLANT ALL	7.02	0	33.23
33.24 FLOOD ACTIVITY	B	-14,127		OTHER LONG TERM CARE	46.00	0	33.24
33.25 FLOOD ACTIVITY	B	-69		LABORATORY	60.00	0	33.25
33.26 FLOOD ACTIVITY	B	-20		PHYSICAL THERAPY	66.00	0	33.26
33.27 FLOOD ACTIVITY	B	-2,214		MAINTENANCE & REPAIRS	6.00	0	33.27
33.28 FLOOD ACTIVITY	B	-568		WELLNESS CENTER	194.07	0	33.28
33.29 TELEPHONE SERVICES	A	-3,285		HOSPITAL ADMIN & GENERAL	5.02	0	33.29
33.30 TELEPHONE EMP BENEFIT EXPENSE	A	-719		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31 TELEPHONE DEPRECIATION	A	-1,104		CAP REL COSTS-MVBLE EQUIP	2.00	9	33.31
33.32 ALCOHOLIC BEVERAGES	A	-673		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.32
33.33 NON-ALLO ADVERTISING SALARIES	A	-661		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.33
33.34 ADVERTISING/MARKETING EXPENSE	A	-54,430		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.34
33.35		0			0.00	0	33.35
33.36 MARKETING PT	A	-977		PHYSICAL THERAPY	66.00	0	33.36
33.37		0			0.00	0	33.37
33.38		0			0.00	0	33.38
33.39		0			0.00	0	33.39
34.00		0			0.00	0	34.00

Provider CCN: 14-1330  
 Period: From 07/01/2016 To 06/30/2017  
 Worksheet A-8  
 Date/Time Prepared: 10/5/2017 12:04 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.	
			1.00	2.00	3.00	4.00
34.01		0		0.00	0	34.01
34.02	MARKETING - RADIOLOGY	-99	RADIOLOGY-DIAGNOSTIC	54.00	0	34.02
34.07	CHARITABLE CONTRIBUTIONS	-15,169	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.07
34.14	ANESTH ON-CALL TIME	-274,400	ANESTHESIOLOGY	53.00	0	34.14
34.15	MEDICAID ASSESSMENT	-261,178	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.15
36.00		0		0.00	0	36.00
36.01	PATIENT TELEVISION EXPENSE	-4,254	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.01
38.02	IHA LOBBYING DUES	-8,740	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	38.02
38.04		0		0.00	0	38.04
41.00		0		0.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	-1,472,915				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: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 10/5/2017 12:04 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	91.00	EMERGENCY	ER PHYSICIAN	139,064	139,064 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MME	17,785	17,785 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMP BENEFITS	61,548	61,548 3.00
4.00	5.01	PHYSICIAN OFFICE BILLING	PHYS BILLING	194,997	194,997 4.00
4.01	5.03	OTHER ADMINISTRATIVE AND GEN	A&G ALL	24,290	24,290 4.01
4.02	6.00	MAINTENANCE & REPAIRS	MAINT AND REPAIRS	4,846	4,846 4.02
4.03	7.02	OPERATION OF PLANT ALL	PLANT OP ALL	20,649	20,649 4.03
4.04	192.00	PHYSICIANS' PRIVATE OFFICES	PHYS OFFICES	405,904	405,904 4.04
4.05	192.01	SATELLITE OFFICES	SATELLITE OFFICES	318,129	318,129 4.05
4.06	91.00	EMERGENCY	RENTAL DUPLEX	6,871	18,600 4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,194,083	1,205,812 5.00

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

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

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

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

6.00	E	0.00	ROSSI PHYSICIANS	0.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:  
10/5/2017 12:04 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	0	0		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	-11,729	0		4.06
5.00	-11,729			5.00

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

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

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

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

6.00	PHYSICIANS		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-8-2

Date/Time Prepared:  
10/5/2017 12:04 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	104,480	6,530	97,950	0	0	1.00
2.00	91.00	EMERGENCY	972,905	255,357	717,548	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			1,077,385	261,887	815,498	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	6,530		1.00
2.00	91.00	EMERGENCY	0	0	0	255,357		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	261,887		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 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		
		0	1.00	1.01	1.02	2.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	421,431	421,431				1.00
1.01	00101	WELLNESS CENTER B&F	185,387	0	185,387			1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION	618,643	0	0	618,643		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,270,553				1,270,553	2.00
2.01	00201	WELLNESS CENTER MME	51,834				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,220,697	7,190	24,568	0	0	4.00
5.01	00590	PHYSICIAN OFFICE BILLING	194,002	2,909	0	0	2,542	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	561,454	9,258	0	71,695	11,750	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	2,439,817	29,907	6,815	0	101,485	5.03
6.00	00600	MAINTENANCE & REPAIRS	854,556	3,989	0	0	19,558	6.00
7.01	00701	WELLNESS CENTER PLANT OP	86,046	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	355,847	2,505	0	0	127,490	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	190,846	7,292	0	0	2,491	8.00
9.00	00900	HOUSEKEEPING	205,181	1,099	0	0	0	9.00
10.00	01000	DIETARY	820,716	8,342	0	0	17,262	10.00
11.00	01100	CAFETERIA	49,356	12,932	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,175	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	258,708	8,228	0	0	14,997	14.00
15.00	01500	PHARMACY	237,524	1,705	0	0	10,839	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	454,896	11,167	788	0	23,794	16.00
17.00	01700	SOCIAL SERVICE	8,104	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,350,229	9,610	0	306,702	264,480	30.00
45.00	04500	NURSING FACILITY	1,392,256	94,006	0	0	4,898	45.00
46.00	04600	OTHER LONG TERM CARE	474,157	173,376	518	0	9,815	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	765,096	17,695	0	43,916	312,978	50.00
53.00	05300	ANESTHESIOLOGY	189,790	475	0	0	182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	533,360	9,923	0	68,935	280,225	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	162,110	0	0	0	0	58.00
60.00	06000	LABORATORY	869,344	5,746	0	0	31,157	60.00
65.00	06500	RESPIRATORY THERAPY	389,534	1,731	9,310	0	12,814	65.00
65.01	06501	SLEEP LAB	59,700	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	17,601	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	623,845	1,171	37,336	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	642,422	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	154,627	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	343,130	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	985,355	0	0	127,395	1,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,438,154	421,431	79,335	618,643	1,250,389	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,472	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	416,245	0	0	0	16,318	192.00
192.01	19201	SATELLITE OFFICES	515,971	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	1,468,738	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	25,159	0	0	0	3,846	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	430,922	0	106,052	0	0	194.07
194.08	07958	ORTHO	296,413	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)	23,628,074	421,431	185,387	618,643	1,270,553	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1330

Period: From 07/01/2016 To 06/30/2017

Worksheet B Part I Date/Time Prepared: 10/5/2017 12:04 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	PHYSICIAN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	
	WELLNESS CENTER MME						
	2.01	4.00					
<b>GENERAL SERVICE COST CENTERS</b>							
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	51,834					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,873	2,259,328				4.00
5.01 00590	PHYSICIAN OFFICE BILLING	0	33,011	232,464	232,464		5.01
5.02 00591	HOSPITAL ADMIN & GENERAL	0	93,539	747,696	0	747,696	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	0	228,346	2,806,370	0	0	5.03
6.00 00600	MAINTENANCE & REPAIRS	0	121,789	999,892	0	0	6.00
7.01 00701	WELLNESS CENTER PLANT OP	0	0	86,046	0	0	7.01
7.02 00702	OPERATION OF PLANT ALL	0	0	485,842	0	0	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	0	39,119	239,748	0	0	8.00
9.00 00900	HOUSEKEEPING	0	35,055	241,335	0	0	9.00
10.00 01000	DIETARY	0	112,349	958,669	0	0	10.00
11.00 01100	CAFETERIA	0	20,883	83,171	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	1,175	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	37,343	319,276	0	0	14.00
15.00 01500	PHARMACY	0	47,959	298,027	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	15,233	505,878	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	1,846	9,950	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	257,256	2,188,277	0	66,210	30.00
45.00 04500	NURSING FACILITY	0	276,657	1,767,817	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	145	69,398	727,409	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	117,949	1,257,634	0	182,084	50.00
53.00 05300	ANESTHESIOLOGY	0	4,043	194,490	0	40,884	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	82,192	974,635	0	119,803	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	162,110	0	21,420	58.00
60.00 06000	LABORATORY	0	75,383	981,630	0	83,777	60.00
65.00 06500	RESPIRATORY THERAPY	10,856	76,378	500,623	0	36,785	65.00
65.01 06501	SLEEP LAB	0	0	59,700	0	5,591	65.01
65.02 03160	PULMONARY REHAB	0	3,853	21,454	0	1,556	65.02
66.00 06600	PHYSICAL THERAPY	4,293	130,729	797,374	0	31,859	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	642,422	0	43,521	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	154,627	0	10,411	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	343,130	0	49,898	73.00
76.00 03020	RENEWED HOPE	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100	EMERGENCY	0	20,054	1,134,436	0	39,522	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,167	1,900,364	19,923,307	0	733,321	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,562	38,034	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	75,832	508,395	107,221	0	192.00
192.01 19201	SATELLITE OFFICES	0	77,874	593,845	125,243	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	68,631	1,537,369	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	29,005	0	0	194.05
194.06 07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07 07956	WELLNESS CENTER	29,667	69,742	636,383	0	0	194.07
194.08 07958	ORTHO	0	65,323	361,736	0	14,375	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			201.00
202.00	TOTAL (sum lines 118-201)	51,834	2,259,328	23,628,074	232,464	747,696	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 10/5/2017 12:04 pm		
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	
<b>GENERAL SERVICE COST CENTERS</b>						
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	2,806,370	2,806,370		5.03
6.00	00600	MAINTENANCE & REPAIRS	999,892	134,766	1,134,658	6.00
7.01	00701	WELLNESS CENTER PLANT OP	86,046	11,597	119,374	7.01
7.02	00702	OPERATION OF PLANT ALL	485,842	65,482	386,084	0
8.00	00800	LAUNDRY & LINEN SERVICE	239,748	32,313	14,864	0
9.00	00900	HOUSEKEEPING	241,335	32,527	0	0
10.00	01000	DIETARY	958,669	129,210	23,410	0
11.00	01100	CAFETERIA	83,171	11,210	4,831	0
13.00	01300	NURSING ADMINISTRATION	1,175	158	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	319,276	43,032	4,924	0
15.00	01500	PHARMACY	298,027	40,168	2,973	0
16.00	01600	MEDICAL RECORDS & LIBRARY	505,878	68,183	7,060	1,110
17.00	01700	SOCIAL SERVICE	9,950	1,341	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	2,254,487	303,867	202,053	0
45.00	04500	NURSING FACILITY	1,767,817	238,268	0	0
46.00	04600	OTHER LONG TERM CARE	727,409	98,041	171,397	730
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	1,439,718	194,047	31,028	0
53.00	05300	ANESTHESIOLOGY	235,374	31,724	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,094,438	147,509	63,171	0
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MRI	183,530	24,736	0	0
60.00	06000	LABORATORY	1,065,407	143,597	7,989	0
65.00	06500	RESPIRATORY THERAPY	537,408	72,432	3,623	13,120
65.01	06501	SLEEP LAB	65,291	8,800	0	0
65.02	03160	PULMONARY REHAB	23,010	3,101	0	0
66.00	06600	PHYSICAL THERAPY	829,233	111,765	6,131	52,613
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	685,943	92,452	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,038	22,244	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	393,028	52,973	0	0
76.00	03020	RENEWED HOPE	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100	EMERGENCY	1,173,958	158,227	3,437	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			59,361
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,676,468	2,273,770	1,052,349	67,573
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,034	5,126	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	615,616	82,973	25,919	0
192.01	19201	SATELLITE OFFICES	719,088	96,919	18,301	0
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	0	25,083	0
194.02	07952	RETAIL PHARMACY	1,537,369	207,208	4,924	0
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0
194.04	07954	TRIPLEXES	0	0	0	0
194.05	07957	WHITE FENCE ESTATES	29,005	3,909	8,082	0
194.06	07955	UNUSED SPACE	0	0	0	0
194.07	07956	WELLNESS CENTER	636,383	85,772	0	149,444
194.08	07958	ORTHO	376,111	50,693	0	0
194.09	07959	MEDICAL MASSAGE	0	0	0	0
200.00		Cross Foot Adjustments	0			
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	23,628,074	2,806,370	1,134,658	217,017

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 10/5/2017 12:04 pm				
Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	337,563				8.00	
9.00	00900	HOUSEKEEPING	0	281,496			9.00	
10.00	01000	DIETARY	485	0	1,169,700		10.00	
11.00	01100	CAFETERIA	0	0	0	189,012	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	9,495	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	67	0	9,008	0	14.00
15.00	01500	PHARMACY	0	0	0	2,558	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	892	0	1,985	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	209	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	43,754	50,115	66,541	28,238	3,737	30.00
45.00	04500	NURSING FACILITY	220,101	83,043	527,806	40,157	5,314	45.00
46.00	04600	OTHER LONG TERM CARE	2,419	79,208	575,353	14,588	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	30,548	0	0	20,807	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	364	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,060	9,385	0	10,199	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	12,506	0	9,130	0	60.00
65.00	06500	RESPIRATORY THERAPY	273	6,599	0	7,531	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0	0	0	342	0	65.02
66.00	06600	PHYSICAL THERAPY	6,081	0	0	10,519	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	9,061	0	0	3,352	444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	318,782	241,815	1,169,700	158,987	9,495	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,017	36,605	0	10,960	0	192.00
192.01	19201	SATELLITE OFFICES	5,775	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	3,076	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	0	0	0	5,745	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	5,989	0	0	12,063	0	194.07
194.08	07958	ORTHO	0	0	0	1,246	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)	337,563	281,496	1,169,700	189,012	9,495	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1330

Period: From 07/01/2016 To 06/30/2017

Worksheet B Part I Date/Time Prepared: 10/5/2017 12:04 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>								
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	433,442					14.00
15.00	01500	PHARMACY	2,594	358,159				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3	0	662,659			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	11,500		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	19,760	0	58,681	3,833	3,244,710	30.00
45.00	04500	NURSING FACILITY	7,114	0	0	7,667	2,897,287	45.00
46.00	04600	OTHER LONG TERM CARE	8,538	0	0	0	1,677,683	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	44,819	0	161,360	0	2,065,667	50.00
53.00	05300	ANESTHESIOLOGY	3,287	0	36,235	0	310,282	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,941	0	106,181	0	1,542,913	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	3,837	0	18,985	0	231,088	58.00
60.00	06000	LABORATORY	83,107	0	74,251	0	1,435,891	60.00
65.00	06500	RESPIRATORY THERAPY	12,144	0	32,602	0	697,753	65.00
65.01	06501	SLEEP LAB	24	0	4,955	0	79,070	65.01
65.02	03160	PULMONARY REHAB	36	0	1,379	0	27,868	65.02
66.00	06600	PHYSICAL THERAPY	1,125	0	28,237	0	1,053,833	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	174,064	0	38,573	0	991,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,851	0	9,228	0	239,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	358,159	44,224	0	848,384	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	4,036	0	35,028	0	1,446,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	412,280	358,159	649,919	11,500	18,789,726	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	43,171	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,980	0	0	0	782,070	192.00
192.01	19201	SATELLITE OFFICES	7,857	0	0	0	847,940	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	28,159	194.01
194.02	07952	RETAIL PHARMACY	3,186	0	0	0	1,758,432	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	40,996	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	5,000	0	0	0	894,651	194.07
194.08	07958	ORTHO	2,139	0	12,740	0	442,929	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)	433,442	358,159	662,659	11,500	23,628,074	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	3,244,710
45.00	04500	NURSING FACILITY	0	2,897,287
46.00	04600	OTHER LONG TERM CARE	0	1,677,683
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	2,065,667
53.00	05300	ANESTHESIOLOGY	0	310,282
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,542,913
57.00	05700	CT SCAN	0	0
58.00	05800	MRI	0	231,088
60.00	06000	LABORATORY	0	1,435,891
65.00	06500	RESPIRATORY THERAPY	0	697,753
65.01	06501	SLEEP LAB	0	79,070
65.02	03160	PULMONARY REHAB	0	27,868
66.00	06600	PHYSICAL THERAPY	0	1,053,833
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	991,032
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	239,361
73.00	07300	DRUGS CHARGED TO PATIENTS	0	848,384
76.00	03020	RENEWED HOPE	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	EMERGENCY	0	1,446,904
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,789,726
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,171
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	782,070
192.01	19201	SATELLITE OFFICES	0	847,940
194.00	07950	ARC (HOPEDALE HALL)	0	0
194.01	07951	OUTSIDE PROPERTY	0	28,159
194.02	07952	RETAIL PHARMACY	0	1,758,432
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0
194.04	07954	TRIPLEXES	0	0
194.05	07957	WHITE FENCE ESTATES	0	40,996
194.06	07955	UNUSED SPACE	0	0
194.07	07956	WELLNESS CENTER	0	894,651
194.08	07958	ORTHO	0	442,929
194.09	07959	MEDICAL MASSAGE	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	23,628,074

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 10/5/2017 12:04 pm
-------------------------------------	--	-----------------------	---	---

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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	7,190	24,568	0	0
5.01	00590	PHYSICIAN OFFICE BILLING	0	2,909	0	0	2,542
5.02	00591	HOSPITAL ADMIN & GENERAL	0	9,258	0	71,695	11,750
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	29,907	6,815	0	101,485
6.00	00600	MAINTENANCE & REPAIRS	0	3,989	0	0	19,558
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0
7.02	00702	OPERATION OF PLANT ALL	0	2,505	0	0	127,490
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,292	0	0	2,491
9.00	00900	HOUSEKEEPING	0	1,099	0	0	0
10.00	01000	DIETARY	0	8,342	0	0	17,262
11.00	01100	CAFETERIA	0	12,932	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	1,175	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,228	0	0	14,997
15.00	01500	PHARMACY	0	1,705	0	0	10,839
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,167	788	0	23,794
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	9,610	0	306,702	264,480
45.00	04500	NURSING FACILITY	0	94,006	0	0	4,898
46.00	04600	OTHER LONG TERM CARE	0	173,376	518	0	9,815
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	17,695	0	43,916	312,978
53.00	05300	ANESTHESIOLOGY	0	475	0	0	182
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,923	0	68,935	280,225
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	0	5,746	0	0	31,157
65.00	06500	RESPIRATORY THERAPY	0	1,731	9,310	0	12,814
65.01	06501	SLEEP LAB	0	0	0	0	0
65.02	03160	PULMONARY REHAB	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	1,171	37,336	0	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	127,395	1,632
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	421,431	79,335	618,643	1,250,389
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	16,318
192.01	19201	SATELLITE OFFICES	0	0	0	0	0
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0
194.02	07952	RETAIL PHARMACY	0	0	0	0	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	0	0	0	0	3,846
194.06	07955	UNUSED SPACE	0	0	0	0	0
194.07	07956	WELLNESS CENTER	0	0	106,052	0	0
194.08	07958	ORTHO	0	0	0	0	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
202.00		TOTAL (sum lines 118-201)	0	421,431	185,387	618,643	1,270,553

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1330

Period: From 07/01/2016 To 06/30/2017

Worksheet B Part II Date/Time Prepared: 10/5/2017 12:04 pm

Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PHYSICIAN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	
	WELLNESS CENTER MME						
	2.01	2A					
<b>GENERAL SERVICE COST CENTERS</b>							
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	6,873	38,631	38,631			4.00
5.01 00590	PHYSICIAN OFFICE BILLING	0	5,451	564	6,015		5.01
5.02 00591	HOSPITAL ADMIN & GENERAL	0	92,703	1,599	0	94,302	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	0	138,207	3,904	0	0	5.03
6.00 00600	MAINTENANCE & REPAIRS	0	23,547	2,082	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	129,995	0	0	0	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,783	669	0	0	8.00
9.00 00900	HOUSEKEEPING	0	1,099	599	0	0	9.00
10.00 01000	DIETARY	0	25,604	1,921	0	0	10.00
11.00 01100	CAFETERIA	0	12,932	357	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,175	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	23,225	638	0	0	14.00
15.00 01500	PHARMACY	0	12,544	820	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	35,749	260	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	32	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	580,792	4,399	0	8,349	30.00
45.00 04500	NURSING FACILITY	0	98,904	4,733	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	145	183,854	1,187	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	374,589	2,017	0	22,975	50.00
53.00 05300	ANESTHESIOLOGY	0	657	69	0	5,156	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	359,083	1,405	0	15,108	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	2,701	58.00
60.00 06000	LABORATORY	0	36,903	1,289	0	10,565	60.00
65.00 06500	RESPIRATORY THERAPY	10,856	34,711	1,306	0	4,639	65.00
65.01 06501	SLEEP LAB	0	0	0	0	705	65.01
65.02 03160	PULMONARY REHAB	0	0	66	0	196	65.02
66.00 06600	PHYSICAL THERAPY	4,293	42,800	2,235	0	4,018	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	5,488	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,313	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,292	73.00
76.00 03020	RENEWED HOPE	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100	EMERGENCY	0	129,027	343	0	4,984	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,167	2,391,965	32,494	0	92,489	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	27	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	16,318	1,297	2,774	0	192.00
192.01 19201	SATELLITE OFFICES	0	0	1,331	3,241	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	1,173	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	3,846	0	0	0	194.05
194.06 07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07 07956	WELLNESS CENTER	29,667	135,719	1,192	0	0	194.07
194.08 07958	ORTHO	0	0	1,117	0	1,813	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				201.00
202.00	TOTAL (sum lines 118-201)	51,834	2,547,848	38,631	6,015	94,302	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 10/5/2017 12:04 pm		
Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	LAUNDRY & LINEN SERVICE
			5.03	6.00	7.01	7.02	8.00
<b>GENERAL SERVICE COST CENTERS</b>							
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	142,111				5.03
6.00	00600	MAINTENANCE & REPAIRS	6,824	32,453			6.00
7.01	00701	WELLNESS CENTER PLANT OP	587	3,414	4,001		7.01
7.02	00702	OPERATION OF PLANT ALL	3,316	11,044	0	144,355	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,636	425	0	7,798	20,311
9.00	00900	HOUSEKEEPING	1,647	0	0	1,176	0
10.00	01000	DIETARY	6,543	670	0	8,920	29
11.00	01100	CAFETERIA	568	138	0	13,829	0
13.00	01300	NURSING ADMINISTRATION	8	0	0	1,257	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,179	141	0	8,798	0
15.00	01500	PHARMACY	2,034	85	0	1,823	0
16.00	01600	MEDICAL RECORDS & LIBRARY	3,453	202	20	11,942	0
17.00	01700	SOCIAL SERVICE	68	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	15,388	5,779	0	32,284	2,633
45.00	04500	NURSING FACILITY	12,065	0	0	0	13,244
46.00	04600	OTHER LONG TERM CARE	4,965	4,902	13	0	146
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	9,826	887	0	22,073	1,838
53.00	05300	ANESTHESIOLOGY	1,606	0	0	508	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,470	1,807	0	15,558	365
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	1,253	0	0	0	0
60.00	06000	LABORATORY	7,271	229	0	6,145	0
65.00	06500	RESPIRATORY THERAPY	3,668	104	242	1,851	16
65.01	06501	SLEEP LAB	446	0	0	0	0
65.02	03160	PULMONARY REHAB	157	0	0	0	0
66.00	06600	PHYSICAL THERAPY	5,660	175	970	1,252	366
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,682	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,126	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,682	0	0	0	0
76.00	03020	RENEWED HOPE	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	8,012	98	0	9,141	545
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	115,140	30,100	1,245	144,355	19,182
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	260	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,202	741	0	0	422
192.01	19201	SATELLITE OFFICES	4,908	523	0	0	347
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	717	0	0	0
194.02	07952	RETAIL PHARMACY	10,493	141	0	0	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	198	231	0	0	0
194.06	07955	UNUSED SPACE	0	0	0	0	0
194.07	07956	WELLNESS CENTER	4,343	0	2,756	0	360
194.08	07958	ORTHO	2,567	0	0	0	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)	142,111	32,453	4,001	144,355	20,311

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 10/5/2017 12:04 pm				
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		9.00	10.00	11.00	13.00	14.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	4,521				9.00	
10.00	01000	DIETARY	0	43,687			10.00	
11.00	01100	CAFETERIA	0	0	27,824		11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,440	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	1,326	0	36,308	14.00
15.00	01500	PHARMACY	0	0	377	0	217	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14	0	292	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	31	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	805	2,485	4,157	960	1,655	30.00
45.00	04500	NURSING FACILITY	1,334	19,713	5,912	1,366	596	45.00
46.00	04600	OTHER LONG TERM CARE	1,272	21,489	2,147	0	715	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	3,063	0	3,754	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151	0	1,501	0	414	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	321	58.00
60.00	06000	LABORATORY	201	0	1,344	0	6,962	60.00
65.00	06500	RESPIRATORY THERAPY	106	0	1,109	0	1,017	65.00
65.01	06501	SLEEP LAB	0	0	0	0	2	65.01
65.02	03160	PULMONARY REHAB	0	0	50	0	3	65.02
66.00	06600	PHYSICAL THERAPY	0	0	1,548	0	94	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	14,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,590	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	493	114	338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,884	43,687	23,404	2,440	34,535	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	588	0	1,613	0	250	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	0	658	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	49	0	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	0	0	846	0	267	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	1,776	0	419	194.07
194.08	07958	ORTHO	0	0	183	0	179	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)	4,521	43,687	27,824	2,440	36,308	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 10/5/2017 12:04 pm
-------------------------------------	--	-----------------------	---	---

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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	17,900				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,932			16.00
17.00	01700	SOCIAL SERVICE	0	0	131		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	4,599	44	664,329	30.00
45.00	04500	NURSING FACILITY	0	0	87	157,954	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	220,690	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	12,645	0	453,667	50.00
53.00	05300	ANESTHESIOLOGY	0	2,840	0	11,165	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,322	0	411,184	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	1,488	0	5,763	58.00
60.00	06000	LABORATORY	0	5,819	0	76,728	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,555	0	51,324	65.00
65.01	06501	SLEEP LAB	0	388	0	1,541	65.01
65.02	03160	PULMONARY REHAB	0	108	0	580	65.02
66.00	06600	PHYSICAL THERAPY	0	2,213	0	61,331	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,023	0	27,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	723	0	6,752	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,900	3,466	0	30,340	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	2,745	0	155,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,900	50,934	131	2,336,963	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	289	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	28,205	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	11,008	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	766	194.01
194.02	07952	RETAIL PHARMACY	0	0	0	12,920	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	4,275	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	0	146,565	194.07
194.08	07958	ORTHO	0	998	0	6,857	194.08
194.09	07959	MEDICAL MASSAGE	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,900	51,932	131	2,547,848	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 10/5/2017 12:04 pm
-------------------------------------	--	-----------------------	---	---

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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		15.00
16.00	01600		16.00
17.00	01700		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	664,329	30.00
45.00	04500	157,954	45.00
46.00	04600	220,690	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	453,667	50.00
53.00	05300	11,165	53.00
54.00	05400	411,184	54.00
57.00	05700	0	57.00
58.00	05800	5,763	58.00
60.00	06000	76,728	60.00
65.00	06500	51,324	65.00
65.01	06501	1,541	65.01
65.02	03160	580	65.02
66.00	06600	61,331	66.00
69.00	06900	0	69.00
71.00	07100	27,775	71.00
72.00	07200	6,752	72.00
73.00	07300	30,340	73.00
76.00	03020	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	155,840	91.00
92.00	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300		113.00
118.00		2,336,963	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	289	190.00
192.00	19200	28,205	192.00
192.01	19201	11,008	192.01
194.00	07950	0	194.00
194.01	07951	766	194.01
194.02	07952	12,920	194.02
194.03	07953	0	194.03
194.04	07954	0	194.04
194.05	07957	4,275	194.05
194.06	07955	0	194.06
194.07	07956	146,565	194.07
194.08	07958	6,857	194.08
194.09	07959	0	194.09
200.00		0	200.00
201.00		0	201.00
202.00		2,547,848	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet B-1 Date/Time Prepared: 10/5/2017 12:04 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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	177,482					1.00
1.01	00101	WELLNESS CENTER B&F	0	35,065				1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION	0	0	17,482			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				1,158,455		2.00
2.01	00201	WELLNESS CENTER MME				0	51,834	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,028	4,647	0	0	6,873	4.00
5.01	00590	PHYSICIAN OFFICE BILLING	1,225	0	0	2,318	0	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	3,899	0	2,026	10,713	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	12,595	1,289	0	92,531	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	1,680	0	0	17,832	0	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	1,055	0	0	116,242	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	3,071	0	0	2,271	0	8.00
9.00	00900	HOUSEKEEPING	463	0	0	0	0	9.00
10.00	01000	DIETARY	3,513	0	0	15,739	0	10.00
11.00	01100	CAFETERIA	5,446	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	495	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,465	0	0	13,674	0	14.00
15.00	01500	PHARMACY	718	0	0	9,883	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,703	149	0	21,695	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	4,047	0	8,667	241,146	0	30.00
45.00	04500	NURSING FACILITY	39,590	0	0	4,466	0	45.00
46.00	04600	OTHER LONG TERM CARE	73,016	98	0	8,949	145	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	7,452	0	1,241	285,365	0	50.00
53.00	05300	ANESTHESIOLOGY	200	0	0	166	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179	0	1,948	255,501	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,420	0	0	28,408	0	60.00
65.00	06500	RESPIRATORY THERAPY	729	1,761	0	11,683	10,856	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	493	7,062	0	0	4,293	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	3,600	1,488	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	177,482	15,006	17,482	1,140,070	22,167	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	14,878	0	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	3,507	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	20,059	0	0	29,667	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		Cost to be allocated (per Wkst. B, Part I)	421,431	185,387	618,643	1,270,553	51,834	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.374500	5.286953	35.387427	1.096765	1.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
10/5/2017 12:04 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	
205.00	Unit cost multiplier (Wkst. B, Part 11)						205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
10/5/2017 12:04 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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	9,917,787				4.00
5.01	00590	PHYSICIAN OFFICE BILLING	144,908	-232,464	1,102,240		5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	410,610	-747,696	0	39,107,254	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	1,002,371	-2,806,370	0	0	-2,806,370
6.00	00600	MAINTENANCE & REPAIRS	534,619	-999,892	0	0	0
7.01	00701	WELLNESS CENTER PLANT OP	0	-86,046	0	0	0
7.02	00702	OPERATION OF PLANT ALL	0	-485,842	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	171,719	-239,748	0	0	0
9.00	00900	HOUSEKEEPING	153,882	-241,335	0	0	0
10.00	01000	DIETARY	493,179	-958,669	0	0	0
11.00	01100	CAFETERIA	91,668	-83,171	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	-1,175	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	163,923	-319,276	0	0	0
15.00	01500	PHARMACY	210,524	-298,027	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	66,870	-505,878	0	0	0
17.00	01700	SOCIAL SERVICE	8,104	-9,950	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,129,276	-2,188,277	0	3,463,054	0
45.00	04500	NURSING FACILITY	1,214,452	-1,767,817	0	0	0
46.00	04600	OTHER LONG TERM CARE	304,638	-727,409	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	517,760	-1,257,634	0	9,523,340	0
53.00	05300	ANESTHESIOLOGY	17,748	-194,490	0	2,138,405	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,797	-974,635	0	6,266,201	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	-162,110	0	1,120,368	0
60.00	06000	LABORATORY	330,908	-981,630	0	4,381,888	0
65.00	06500	RESPIRATORY THERAPY	335,278	-500,623	0	1,924,008	0
65.01	06501	SLEEP LAB	0	-59,700	0	292,422	0
65.02	03160	PULMONARY REHAB	16,913	-21,454	0	81,409	0
66.00	06600	PHYSICAL THERAPY	573,863	-797,374	0	1,666,372	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-642,422	0	2,276,339	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	-154,627	0	544,562	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	-343,130	0	2,609,842	0
76.00	03020	RENEWED HOPE	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	88,033	-1,134,436	0	2,067,171	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,342,043	-19,923,307	0	38,355,381	-2,806,370
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,857	-38,034	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	332,878	0	508,395	0	0
192.01	19201	SATELLITE OFFICES	341,843	0	593,845	0	0
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0
194.02	07952	RETAIL PHARMACY	301,270	-1,537,369	0	0	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	0	-29,005	0	0	0
194.06	07955	UNUSED SPACE	0	0	0	0	0
194.07	07956	WELLNESS CENTER	306,148	-636,383	0	0	0
194.08	07958	ORTHO	286,748	-361,736	0	751,873	0
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0
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)	2,259,328		232,464	747,696	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.227806		0.210901	0.019119	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,631		6,015	94,302	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003895		0.005457	0.002411	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
10/5/2017 12:04 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		
<b>GENERAL SERVICE COST CENTERS</b>								
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	20,821,704				5.03	
6.00	00600	MAINTENANCE & REPAIRS	999,892	12,214			6.00	
7.01	00701	WELLNESS CENTER PLANT OP	86,046	1,285	29,129		7.01	
7.02	00702	OPERATION OF PLANT ALL	485,842	4,156	0	56,850	7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	239,748	160	0	3,071	334,448	8.00
9.00	00900	HOUSEKEEPING	241,335	0	0	463	0	9.00
10.00	01000	DIETARY	958,669	252	0	3,513	481	10.00
11.00	01100	CAFETERIA	83,171	52	0	5,446	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,175	0	0	495	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	319,276	53	0	3,465	0	14.00
15.00	01500	PHARMACY	298,027	32	0	718	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	505,878	76	149	4,703	0	16.00
17.00	01700	SOCIAL SERVICE	9,950	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,254,487	2,175	0	12,714	43,350	30.00
45.00	04500	NURSING FACILITY	1,767,817	0	0	0	218,070	45.00
46.00	04600	OTHER LONG TERM CARE	727,409	1,845	98	0	2,397	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,439,718	334	0	8,693	30,266	50.00
53.00	05300	ANESTHESIOLOGY	235,374	0	0	200	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,094,438	680	0	6,127	6,004	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	183,530	0	0	0	0	58.00
60.00	06000	LABORATORY	1,065,407	86	0	2,420	0	60.00
65.00	06500	RESPIRATORY THERAPY	537,408	39	1,761	729	270	65.00
65.01	06501	SLEEP LAB	65,291	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	23,010	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	829,233	66	7,062	493	6,025	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	685,943	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,038	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393,028	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	1,173,958	37	0	3,600	8,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,870,098	11,328	9,070	56,850	315,840	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,034	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	615,616	279	0	0	6,952	192.00
192.01	19201	SATELLITE OFFICES	719,088	197	0	0	5,722	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	270	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	1,537,369	53	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	29,005	87	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	636,383	0	20,059	0	5,934	194.07
194.08	07958	ORTHO	376,111	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		Cost to be allocated (per Wkst. B, Part I)	2,806,370	1,134,658	217,017	937,408	337,563	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.134781	92.898150	7.450204	16.489147	1.009314	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,111	32,453	4,001	144,355	20,311	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006825	2.657033	0.137355	2.539226	0.060730	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
10/5/2017 12:04 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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	12,627					9.00
10.00	01000	0	119,043				10.00
11.00	01100	0	0	17,142			11.00
13.00	01300	0	0	0	135,345		13.00
14.00	01400	3	0	817	0	1,564,068	14.00
15.00	01500	0	0	232	0	9,362	15.00
16.00	01600	40	0	180	0	11	16.00
17.00	01700	0	0	19	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,248	6,772	2,561	53,266	71,303	30.00
45.00	04500	3,725	53,716	3,642	75,755	25,669	45.00
46.00	04600	3,553	58,555	1,323	0	30,810	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	1,887	0	161,729	50.00
53.00	05300	0	0	33	0	11,861	53.00
54.00	05400	421	0	925	0	17,830	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	13,847	58.00
60.00	06000	561	0	828	0	299,890	60.00
65.00	06500	296	0	683	0	43,823	65.00
65.01	06501	0	0	0	0	86	65.01
65.02	03160	0	0	31	0	130	65.02
66.00	06600	0	0	954	0	4,058	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	628,105	71.00
72.00	07200	0	0	0	0	154,627	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	304	6,324	14,563	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		10,847	119,043	14,419	135,345	1,487,704	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	1	0	0	190.00
192.00	19200	1,642	0	994	0	10,754	192.00
192.01	19201	0	0	0	0	28,351	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	138	0	0	0	0	194.01
194.02	07952	0	0	521	0	11,498	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	1,094	0	18,044	194.07
194.08	07958	0	0	113	0	7,717	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00							201.00
202.00		281,496	1,169,700	189,012	9,495	433,442	202.00
203.00		22.293181	9.825861	11.026251	0.070154	0.277125	203.00
204.00		4,521	43,687	27,824	2,440	36,308	204.00
205.00		0.358042	0.366985	1.623148	0.018028	0.023214	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1  
Date/Time Prepared:  
10/5/2017 12:04 pm

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)	
		15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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	39,107,254		16.00
17.00	01700	0	0	390	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	0	3,463,054	130	30.00
45.00	04500	0	0	260	45.00
46.00	04600	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	0	9,523,340	0	50.00
53.00	05300	0	2,138,405	0	53.00
54.00	05400	0	6,266,201	0	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	1,120,368	0	58.00
60.00	06000	0	4,381,888	0	60.00
65.00	06500	0	1,924,008	0	65.00
65.01	06501	0	292,422	0	65.01
65.02	03160	0	81,409	0	65.02
66.00	06600	0	1,666,372	0	66.00
69.00	06900	0	0	0	69.00
71.00	07100	0	2,276,339	0	71.00
72.00	07200	0	544,562	0	72.00
73.00	07300	100	2,609,842	0	73.00
76.00	03020	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	0	2,067,171	0	91.00
92.00	09200				92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		100	38,355,381	390	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
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	751,873	0	194.08
194.09	07959	0	0	0	194.09
200.00					200.00
201.00					201.00
202.00		358,159	662,659	11,500	202.00
203.00		3,581.590000	0.016945	29.487179	203.00
204.00		17,900	51,932	131	204.00
205.00		179.000000	0.001328	0.335897	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		3,244,710	0	0	30.00
45.00	04500 NURSING FACILITY		2,897,287	0	0	45.00
46.00	04600 OTHER LONG TERM CARE		1,677,683	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		2,065,667	0	0	50.00
53.00	05300 ANESTHESIOLOGY		310,282	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,542,913	0	0	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MRI		231,088	0	0	58.00
60.00	06000 LABORATORY		1,435,891	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	697,753	0	0	65.00
65.01	06501 SLEEP LAB	0	79,070	0	0	65.01
65.02	03160 PULMONARY REHAB	0	27,868	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0	1,053,833	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		991,032	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		239,361	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		848,384	0	0	73.00
76.00	03020 RENEWED HOPE		0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY		1,446,904	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		200,874	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	18,990,600	0	0	200.00
201.00	Less Observation Beds		200,874			201.00
202.00	Total (see instructions)	0	18,789,726	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 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	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,285,542		3,285,542		30.00
45.00	04500	NURSING FACILITY	3,424,722		3,424,722		45.00
46.00	04600	OTHER LONG TERM CARE	1,630,875		1,630,875		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,676,783	5,846,558	9,523,341	0.216906	50.00
53.00	05300	ANESTHESIOLOGY	1,056,092	1,082,313	2,138,405	0.145100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	886,574	5,379,627	6,266,201	0.246228	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	64,086	1,056,282	1,120,368	0.206261	58.00
60.00	06000	LABORATORY	815,114	3,566,774	4,381,888	0.327688	60.00
65.00	06500	RESPIRATORY THERAPY	1,158,939	765,069	1,924,008	0.362656	65.00
65.01	06501	SLEEP LAB	0	292,422	292,422	0.270397	65.01
65.02	03160	PULMONARY REHAB	0	81,409	81,409	0.342321	65.02
66.00	06600	PHYSICAL THERAPY	355,414	1,310,958	1,666,372	0.632412	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,607,098	669,242	2,276,340	0.435362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	257,536	287,026	544,562	0.439548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,706,942	902,900	2,609,842	0.325071	73.00
76.00	03020	RENEWED HOPE	0	0	0	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	50,382	2,016,789	2,067,171	0.699944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,281	164,231	177,512	1.131608	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	19,989,380	23,421,600	43,410,980		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,989,380	23,421,600	43,410,980		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 10/5/2017 12:04 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
45.00	04500	NURSING FACILITY		45.00
46.00	04600	OTHER LONG TERM CARE		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
65.02	03160	PULMONARY REHAB	0.000000	65.02
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 10/5/2017 12:04 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	Total Costs		
			1.00	2.00	3.00		4.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	3,244,710		3,244,710	0	3,244,710	30.00	
45.00 04500 NURSING FACILITY	2,897,287		2,897,287	0	2,897,287	45.00	
46.00 04600 OTHER LONG TERM CARE	1,677,683		1,677,683	0	1,677,683	46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	2,065,667		2,065,667	0	2,065,667	50.00	
53.00 05300 ANESTHESIOLOGY	310,282		310,282	0	310,282	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,542,913		1,542,913	0	1,542,913	54.00	
57.00 05700 CT SCAN	0		0	0	0	57.00	
58.00 05800 MRI	231,088		231,088	0	231,088	58.00	
60.00 06000 LABORATORY	1,435,891		1,435,891	0	1,435,891	60.00	
65.00 06500 RESPIRATORY THERAPY	697,753	0	697,753	0	697,753	65.00	
65.01 06501 SLEEP LAB	79,070	0	79,070	0	79,070	65.01	
65.02 03160 PULMONARY REHAB	27,868	0	27,868	0	27,868	65.02	
66.00 06600 PHYSICAL THERAPY	1,053,833	0	1,053,833	0	1,053,833	66.00	
69.00 06900 ELECTROCARDIOLOGY	0		0	0	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	991,032		991,032	0	991,032	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	239,361		239,361	0	239,361	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	848,384		848,384	0	848,384	73.00	
76.00 03020 RENEWED HOPE	0		0	0	0	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100 EMERGENCY	1,446,904		1,446,904	0	1,446,904	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	200,874		200,874	0	200,874	92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300 INTEREST EXPENSE						113.00	
200.00	Subtotal (see instructions)	18,990,600	0	18,990,600	0	18,990,600	200.00
201.00	Less Observation Beds	200,874		200,874		200,874	201.00
202.00	Total (see instructions)	18,789,726	0	18,789,726	0	18,789,726	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 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	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,285,542		3,285,542		30.00
45.00	04500	NURSING FACILITY	3,424,722		3,424,722		45.00
46.00	04600	OTHER LONG TERM CARE	1,630,875		1,630,875		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,676,783	5,846,558	9,523,341	0.216906	50.00
53.00	05300	ANESTHESIOLOGY	1,056,092	1,082,313	2,138,405	0.145100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	886,574	5,379,627	6,266,201	0.246228	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	64,086	1,056,282	1,120,368	0.206261	58.00
60.00	06000	LABORATORY	815,114	3,566,774	4,381,888	0.327688	60.00
65.00	06500	RESPIRATORY THERAPY	1,158,939	765,069	1,924,008	0.362656	65.00
65.01	06501	SLEEP LAB	0	292,422	292,422	0.270397	65.01
65.02	03160	PULMONARY REHAB	0	81,409	81,409	0.342321	65.02
66.00	06600	PHYSICAL THERAPY	355,414	1,310,958	1,666,372	0.632412	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,607,098	669,242	2,276,340	0.435362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	257,536	287,026	544,562	0.439548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,706,942	902,900	2,609,842	0.325071	73.00
76.00	03020	RENEWED HOPE	0	0	0	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	50,382	2,016,789	2,067,171	0.699944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,281	164,231	177,512	1.131608	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	19,989,380	23,421,600	43,410,980		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,989,380	23,421,600	43,410,980		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 10/5/2017 12:04 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
45.00	04500	NURSING FACILITY		45.00
46.00	04600	OTHER LONG TERM CARE		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
65.02	03160	PULMONARY REHAB	0.000000	65.02
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 10/5/2017 12:04 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)	Hospital 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	453,667	9,523,341	0.047637	1,743,592	83,059	50.00
53.00	05300 ANESTHESIOLOGY	11,165	2,138,405	0.005221	540,715	2,823	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	411,184	6,266,201	0.065619	735,765	48,280	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	5,763	1,120,368	0.005144	37,670	194	58.00
60.00	06000 LABORATORY	76,728	4,381,888	0.017510	406,126	7,111	60.00
65.00	06500 RESPIRATORY THERAPY	51,324	1,924,008	0.026676	513,604	13,701	65.00
65.01	06501 SLEEP LAB	1,541	292,422	0.005270	0	0	65.01
65.02	03160 PULMONARY REHAB	580	81,409	0.007125	0	0	65.02
66.00	06600 PHYSICAL THERAPY	61,331	1,666,372	0.036805	94,253	3,469	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27,775	2,276,340	0.012202	944,480	11,525	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,752	544,562	0.012399	157,112	1,948	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	30,340	2,609,842	0.011625	733,014	8,521	73.00
76.00	03020 RENEWED HOPE	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	155,840	2,067,171	0.075388	8,145	614	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	41,127	177,512	0.231686	0	0	92.00
200.00	Total (lines 50-199)	1,335,117	35,069,841		5,914,476	181,245	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 10/5/2017 12:04 pm
--	-----------------------	---	---

Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 10/5/2017 12:04 pm
--	-----------------------	---------------------------------------	--

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	9,523,341	0.000000	0.000000	1,743,592	50.00
53.00	05300 ANESTHESIOLOGY	0	2,138,405	0.000000	0.000000	540,715	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,266,201	0.000000	0.000000	735,765	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	1,120,368	0.000000	0.000000	37,670	58.00
60.00	06000 LABORATORY	0	4,381,888	0.000000	0.000000	406,126	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,924,008	0.000000	0.000000	513,604	65.00
65.01	06501 SLEEP LAB	0	292,422	0.000000	0.000000	0	65.01
65.02	03160 PULMONARY REHAB	0	81,409	0.000000	0.000000	0	65.02
66.00	06600 PHYSICAL THERAPY	0	1,666,372	0.000000	0.000000	94,253	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,276,340	0.000000	0.000000	944,480	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	544,562	0.000000	0.000000	157,112	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,609,842	0.000000	0.000000	733,014	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	2,067,171	0.000000	0.000000	8,145	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	177,512	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	35,069,841			5,914,476	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 10/5/2017 12:04 pm
--	-----------------------	---	---

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		
Title XVIII						
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
65.02	03160 PULMONARY REHAB	0	0	0		65.02
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: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 10/5/2017 12:04 pm
--	-----------------------	---	--

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.216906	0	2,060,113	0	0
53.00	05300 ANESTHESIOLOGY	0.145100	0	446,372	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246228	0	3,389,538	0	0
57.00	05700 CT SCAN	0.000000	0	0	0	0
58.00	05800 MRI	0.206261	0	444,970	0	0
60.00	06000 LABORATORY	0.327688	0	1,820,619	0	0
65.00	06500 RESPIRATORY THERAPY	0.362656	0	462,017	0	0
65.01	06501 SLEEP LAB	0.270397	0	144,405	0	0
65.02	03160 PULMONARY REHAB	0.342321	0	56,857	0	0
66.00	06600 PHYSICAL THERAPY	0.632412	0	717,462	0	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.435362	0	254,918	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.439548	0	112,510	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.325071	0	424,182	0	0
76.00	03020 RENEWED HOPE	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0.699944	0	910,239	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.131608	0	87,966	0	0
200.00	Subtotal (see instructions)		0	11,332,168	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (line 200 +/- line 201)		0	11,332,168	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 10/5/2017 12:04 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	446,851	0	50.00
53.00	05300	ANESTHESIOLOGY	64,769	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	834,599	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	91,780	0	58.00
60.00	06000	LABORATORY	596,595	0	60.00
65.00	06500	RESPIRATORY THERAPY	167,553	0	65.00
65.01	06501	SLEEP LAB	39,047	0	65.01
65.02	03160	PULMONARY REHAB	19,463	0	65.02
66.00	06600	PHYSICAL THERAPY	453,732	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,982	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,454	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,889	0	73.00
76.00	03020	RENEWED HOPE	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	637,116	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	99,543	0	92.00
200.00		Subtotal (see instructions)	3,749,373	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,749,373	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1330 Component CCN: 14-Z330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 10/5/2017 12:04 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.216906	0	0	0	0 50.00
53.00	05300 ANESTHESIOLOGY	0.145100	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246228	0	0	0	0 54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800 MRI	0.206261	0	0	0	0 58.00
60.00	06000 LABORATORY	0.327688	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.362656	0	0	0	0 65.00
65.01	06501 SLEEP LAB	0.270397	0	0	0	0 65.01
65.02	03160 PULMONARY REHAB	0.342321	0	0	0	0 65.02
66.00	06600 PHYSICAL THERAPY	0.632412	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.435362	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.439548	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.325071	0	0	0	0 73.00
76.00	03020 RENEWED HOPE	0.000000	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0.699944	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.131608	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1330 Component CCN: 14-Z330	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 10/5/2017 12:04 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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
65.02	03160 PULMONARY REHAB	0	0	65.02
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 10/5/2017 12:04 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,454 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,306 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)			1,157 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			548 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)			547 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			27 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)			834 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)			496 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)			495 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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			147.50 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)			3,244,710 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)			3,982 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)			1,484,030 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,760,680 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,760,680 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,348.14 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,124,349 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)			1,124,349 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 10/5/2017 12:04 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)					1,748,774 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,873,123 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)					668,677 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					667,329 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,336,006 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)					149 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,348.15 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					200,874 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1330		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 10/5/2017 12:04 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	664,329	3,244,710	0.204742	200,874	41,127	90.00
91.00	Nursing School cost	0	3,244,710	0.000000	200,874	0	91.00
92.00	Allied health cost	0	3,244,710	0.000000	200,874	0	92.00
93.00	All other Medical Education	0	3,244,710	0.000000	200,874	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 10/5/2017 12:04 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,059,326		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.216906	1,743,592	378,196	50.00
53.00	05300 ANESTHESIOLOGY	0.145100	540,715	78,458	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246228	735,765	181,166	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.206261	37,670	7,770	58.00
60.00	06000 LABORATORY	0.327688	406,126	133,083	60.00
65.00	06500 RESPIRATORY THERAPY	0.362656	513,604	186,262	65.00
65.01	06501 SLEEP LAB	0.270397	0	0	65.01
65.02	03160 PULMONARY REHAB	0.342321	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.632412	94,253	59,607	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.435362	944,480	411,191	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.439548	157,112	69,058	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.325071	733,014	238,282	73.00
76.00	03020 RENEWED HOPE	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.699944	8,145	5,701	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.131608	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,914,476	1,748,774	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)		5,914,476		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1330 Component CCN: 14-Z330	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 10/5/2017 12:04 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.216906	2,512	545	50.00
53.00	05300 ANESTHESIOLOGY	0.145100	3,629	527	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246228	119,766	29,490	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.206261	0	0	58.00
60.00	06000 LABORATORY	0.327688	159,545	52,281	60.00
65.00	06500 RESPIRATORY THERAPY	0.362656	532,881	193,252	65.00
65.01	06501 SLEEP LAB	0.270397	0	0	65.01
65.02	03160 PULMONARY REHAB	0.342321	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.632412	195,946	123,919	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.435362	112,602	49,023	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.439548	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.325071	441,444	143,501	73.00
76.00	03020 RENEWED HOPE	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.699944	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.131608	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,568,325	592,538	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)		1,568,325		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 10/5/2017 12:04 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			3,749,373 1.00
2.00	Medical and other services reimbursed under OPPTS (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)			3,749,373 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,786,867 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			55,745 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,915,359 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)			1,815,763 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)			1,815,763 30.00
31.00	Primary payer payments			407 31.00
32.00	Subtotal (line 30 minus line 31)			1,815,356 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			347,384 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			225,800 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			117,757 36.00
37.00	Subtotal (see instructions)			2,041,156 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)			2,041,156 40.00
40.01	Sequestration adjustment (see instructions)			40,823 40.01
41.00	Interim payments			1,923,327 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			77,006 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
10/5/2017 12:04 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		2,588,988		2,046,097	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	12/13/2016	88,445		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	06/29/2017	124,246	12/13/2016	30,727	3.50	
3.51			0	06/29/2017	92,043	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)		-35,801		-122,770	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)		2,553,187		1,923,327	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		50,457		77,006	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,603,644		2,000,333	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-1330 Component CCN: 14-Z330	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part I Date/Time Prepared: 10/5/2017 12:04 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		1,688,869		0
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
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	12/13/2016	50,778		0
3.02		06/29/2017	76,921		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		127,699		0
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)		1,816,568		0
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
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		56,855		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,873,423		0
				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: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 10/5/2017 12:04 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			336 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			834 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			139 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,157 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			43,410,980 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			556,990 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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
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: 14-1330 Component CCN: 14-Z330	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 10/5/2017 12:04 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,349,366	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		598,463	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		991	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,947,829	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,947,829	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,947,829	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		36,173	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,911,656	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,911,656	0	19.00
19.01	Sequestration adjustment (see instructions)		38,233	0	19.01
20.00	Interim payments		1,816,568	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		56,855	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1330	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 10/5/2017 12:04 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			2,873,123 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)			2,873,123 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,882,604 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			2,882,604 19.00
20.00	Deductibles (exclude professional component)			248,724 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,633,880 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,633,880 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			35,230 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			22,900 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			10,374 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,656,780 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)			2,656,780 30.00
30.01	Sequestration adjustment (see instructions)			53,136 30.01
31.00	Interim payments			2,553,187 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)			50,457 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: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G  
Date/Time Prepared:  
10/5/2017 12:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	5,988,081	0	0	0	1.00
2.00	Temporary investments	3,265,126	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,801,252	0	0	0	4.00
5.00	Other receivable	1,216,427	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	919,468	0	0	0	7.00
8.00	Prepaid expenses	363,626	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,553,980	0	0	0	11.00
<b>FIXED ASSETS</b>						
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	22,663,836	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)	22,663,836	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,780,150	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,780,150	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,997,966	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	387,500	0	0	0	37.00
38.00	Salaries, wages, and fees payable	919,297	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,041,751	0	0	0	40.00
41.00	Deferred income	478,617	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,004,629	0	0	0	43.00
44.00	Other current liabilities	442,426	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,274,220	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,581,458	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	282,600	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,864,058	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,138,278	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	22,859,688	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)	22,859,688	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,997,966	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G-1

Date/Time Prepared:  
10/5/2017 12:04 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		19,818,682			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,219,478				2.00
3.00	Total (sum of line 1 and line 2)		22,038,160			0	3.00
4.00	PRIOR PERIOD ADJUSTMENT	195,505		0			4.00
5.00	TEMPORARILY RESTRICTED NET ASSETS	626,023		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		821,528			0	10.00
11.00	Subtotal (line 3 plus line 10)		22,859,688			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		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)		22,859,688			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	PRIOR PERIOD ADJUSTMENT		0				4.00
5.00	TEMPORARILY RESTRICTED NET ASSETS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
10/5/2017 12:04 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	3,519,143		3,519,143	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	3,424,722		3,424,722	8.00
9.00	OTHER LONG TERM CARE	1,630,875		1,630,875	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,574,740		8,574,740	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)	8,574,740		8,574,740	17.00
18.00	Ancillary services	10,043,879	20,898,217	30,942,096	18.00
19.00	Outpatient services	52,623	2,684,020	2,736,643	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	OTHER NRCC	2,061,479	620,002	2,681,481	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,732,721	24,202,239	44,934,960	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,100,989		29.00
30.00	AUDIT ADJUSTMENT	14,688			30.00
31.00	DISEASE MANAGEMENT - POP HLTH GRNT	3,488			31.00
32.00	UNDERACCRUED ACCOUNTS PAYABLE	35,000			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)		53,176		36.00
37.00	HMC VETERANS MEMORIAL EXPENSE	18,534			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)		18,534		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,135,631		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1330

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G-3

Date/Time Prepared:  
10/5/2017 12:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,934,960	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,131,036	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,803,924	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,135,631	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,331,707	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	RESIDENT SERVICE REVENUE, COMMONS	1,630,875	24.00
24.01	OTHER OPERATING REVENUE	1,182,677	24.01
24.02	NON-OPERATING INCOME	638,599	24.02
24.03	NET ASSEST RELEASED FROM RESTRICTION	99,034	24.03
25.00	Total other income (sum of lines 6-24)	3,551,185	25.00
26.00	Total (line 5 plus line 25)	2,219,478	26.00
27.00		0	27.00
27.01		0	27.01
27.02		0	27.02
27.03		0	27.03
27.04		0	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,219,478	29.00