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 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/8/2018 10:23 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/8/2018 Time: 10:23 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL 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 07/01/2017 and ending 06/30/2018 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.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	27,060	-227,670	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	-102,629	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	-75,569	-227,670	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 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/7/2018 4:40 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) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HOPEDALE MEDICAL COMPLEX	141330	37900	1	10/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HOPEDALE SWING BED	14Z330	37900		10/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/7/2018 4:40 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.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (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)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						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)						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)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/7/2018 4:40 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						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)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						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. Enter in column 4, the 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. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

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

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/7/2018 4:40 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/7/2018 4:40 pm

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a 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. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/7/2018 4:40 pm

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	168,583	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 healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/7/2018 4:40 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/7/2018 4:40 pm

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/7/2018 4:40 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/28/2018	Y	08/28/2018	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 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/7/2018 4:40 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/7/2018 4:40 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/7/2018 4:40 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	25,512.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	25,512.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	25,512.00	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
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/7/2018 4:40 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	732	0	1,106			1.00
2.00	HMO and other (see instructions)	95	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,025	0	1,172			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	97			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,757	0	2,375			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)	1,757	0	2,375	0.00	221.61	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	17,660	0.00	35.52	20.00
21.00	OTHER LONG TERM CARE			22,533	0.00	12.94	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	270.07	27.00
28.00	Observation Bed Days		0	202			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/7/2018 4:40 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	223	1	311	1.00
2.00	HMO and other (see instructions)			24	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	223	1	311	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				67	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/7/2018 4:40 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.416281	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	153,848	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 and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	5,617	5.00
6.00	Medicaid charges	1,104,259	6.00
7.00	Medicaid cost (line 1 times line 6)	459,682	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)	300,217	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
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
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	300,217	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	360,751	297,501	658,252	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	150,174	297,501	447,675	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	150,174	297,501	447,675	23.00

		1.00	
24.00	Does the amount on 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)	391,424	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	131,680	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	202,584	27.01
28.00	Non-Medicare bad debt expense (see instructions)	188,840	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	149,515	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	597,190	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	897,407	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		265,367	265,367	353,905	619,272	1.00
1.01	00101	WELLNESS CENTER B&F		74,065	74,065	117,066	191,131	1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION		0	0	831,776	831,776	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,211,069	2,211,069	-864,700	1,346,369	2.00
2.01	00201	WELLNESS CENTER MME		0	0	54,075	54,075	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	172,821	2,207,667	2,380,488	-28,289	2,352,199	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	137,702	44,260	181,962	0	181,962	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	348,705	171,770	520,475	0	520,475	5.02
5.03	00592	OTHER A AND G	1,034,709	1,938,693	2,973,402	0	2,973,402	5.03
6.00	00600	MAINTENANCE & REPAIRS	496,223	325,652	821,875	0	821,875	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	86,400	86,400	0	86,400	7.01
7.02	00702	OPERATION OF PLANT ALL	0	313,025	313,025	5,366	318,391	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	179,714	22,530	202,244	0	202,244	8.00
9.00	00900	HOUSEKEEPING	165,283	52,013	217,296	0	217,296	9.00
10.00	01000	DIETARY	655,584	410,761	1,066,345	-153,176	913,169	10.00
11.00	01100	CAFETERIA	0	0	0	153,176	153,176	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153,860	140,560	294,420	0	294,420	14.00
15.00	01500	PHARMACY	217,551	23,774	241,325	-119	241,206	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,989	435,114	489,103	0	489,103	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	9,390	9,390	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,189,437	214,885	1,404,322	-91,333	1,312,989	30.00
45.00	04500	NURSING FACILITY	1,261,891	143,113	1,405,004	15,919	1,420,923	45.00
46.00	04600	OTHER LONG TERM CARE	354,231	173,983	528,214	20,375	548,589	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	900,399	1,059,870	1,960,269	-736,452	1,223,817	50.00
53.00	05300	ANESTHESIOLOGY	43,283	450,745	494,028	-20,146	473,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	400,830	198,212	599,042	29,354	628,396	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	202,756	202,756	-23,753	179,003	58.00
60.00	06000	LABORATORY	366,798	553,697	920,495	0	920,495	60.00
65.00	06500	RESPIRATORY THERAPY	362,770	43,738	406,508	-966	405,542	65.00
65.01	06501	SLEEP LAB	0	20,424	20,424	0	20,424	65.01
65.02	03160	PULMONARY REHAB	8,356	27	8,383	0	8,383	65.02
66.00	06600	PHYSICAL THERAPY	562,681	58,627	621,308	-2,322	618,986	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	831,046	831,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	147,767	147,767	0	147,767	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	311,981	311,981	0	311,981	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,408	8	117,416	9,652	127,068	90.00
91.00	09100	EMERGENCY	38,928	1,369,665	1,408,593	69,756	1,478,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		577,610	577,610	-577,610	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,223,153	14,249,828	23,472,981	1,990	23,474,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,552	20,447	26,999	0	26,999	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	384,593	70,330	454,923	79	455,002	192.00
192.01	19201	SATELLITE OFFICES	369,789	113,052	482,841	2,067	484,908	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	312,784	1,201,331	1,514,115	0	1,514,115	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	22,232	22,232	6,802	29,034	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	347,313	112,173	459,486	-10,938	448,548	194.07
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	10,644,184	15,789,393	26,433,577	0	26,433,577	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-10,398	608,874		1.00
1.01	00101	WELLNESS CENTER B&F	-3,027	188,104		1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION	-70,811	760,965		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-86,115	1,260,254		2.00
2.01	00201	WELLNESS CENTER MME	0	54,075		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-224,925	2,127,274		4.00
5.01	00590	PHYSICAIN OFFICE BILLING	0	181,962		5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	-3,722	516,753		5.02
5.03	00592	OTHER A AND G	-569,858	2,403,544		5.03
6.00	00600	MAINTENANCE & REPAIRS	-12,009	809,866		6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	86,400		7.01
7.02	00702	OPERATION OF PLANT ALL	-902	317,489		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	202,244		8.00
9.00	00900	HOUSEKEEPING	0	217,296		9.00
10.00	01000	DIETARY	-2,339	910,830		10.00
11.00	01100	CAFETERIA	-91,430	61,746		11.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	294,420		14.00
15.00	01500	PHARMACY	0	241,206		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-662	488,441		16.00
17.00	01700	SOCIAL SERVICE	0	9,390		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,050	1,310,939		30.00
45.00	04500	NURSING FACILITY	-3,418	1,417,505		45.00
46.00	04600	OTHER LONG TERM CARE	-16,828	531,761		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-351,837	871,980		50.00
53.00	05300	ANESTHESIOLOGY	-285,823	188,059		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,956	623,440		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	179,003		58.00
60.00	06000	LABORATORY	0	920,495		60.00
65.00	06500	RESPIRATORY THERAPY	-175	405,367		65.00
65.01	06501	SLEEP LAB	0	20,424		65.01
65.02	03160	PULMONARY REHAB	0	8,383		65.02
66.00	06600	PHYSICAL THERAPY	-1,282	617,704		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	831,046		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	147,767		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	311,981		73.00
76.00	03950	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-117,408	9,660		90.00
91.00	09100	EMERGENCY	-336,686	1,141,663		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,196,661	21,278,310		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,999		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	455,002		192.00
192.01	19201	SATELLITE OFFICES	0	484,908		192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0		194.00
194.01	07951	OUTSIDE PROPERTY	0	0		194.01
194.02	07952	RETAIL PHAMACY	0	1,514,115		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	29,034		194.05
194.06	07955	UNUSED SPACE	0	0		194.06
194.07	07956	WELLNESS CENTER	0	448,548		194.07
194.09	07959	MEDICAL MASSAGE	0	0		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,196,661	24,236,916		200.00

RECLASSIFICATIONS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/7/2018 4:40 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	94,172	59,004	1.00
	TOTALS		94,172	59,004	
	B - INTEREST EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	61,844	1.00
2.00	WELLNESS CENTER B&F	1.01	0	18,001	2.00
3.00	2015 BUILDING RENOVATION & ADDITION	1.02	0	421,146	3.00
4.00	OPERATION OF PLANT ALL	7.02	0	5,366	4.00
6.00	NURSING FACILITY	45.00	0	20,329	6.00
7.00	OTHER LONG TERM CARE	46.00	0	20,329	7.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,474	9.00
10.00	RESPIRATORY THERAPY	65.00	0	1,042	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	79	11.00
	TOTALS		0	577,610	
	C - ER NURSING RECLASS				
1.00	EMERGENCY	91.00	74,368	0	1.00
	TOTALS		74,368	0	
	D - BUILDING DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	702,691	1.00
	TOTALS		0	702,691	
	E - WELLNESS CENTER DEP				
1.00	WELLNESS CENTER B&F	1.01	0	99,065	1.00
2.00	SATELLITE OFFICES	192.01	0	2,067	2.00
3.00	WHITE FENCE ESTATES	194.05	0	6,802	3.00
4.00	WELLNESS CENTER MME	2.01	0	54,075	4.00
	TOTALS		0	162,009	
	F - WELLNESS CENTER RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7,220	3,067	1.00
2.00	OTHER LONG TERM CARE	46.00	32	14	2.00
3.00	RESPIRATORY THERAPY	65.00	326	138	3.00
4.00	PHYSICAL THERAPY	66.00	99	42	4.00
	TOTALS		7,677	3,261	
	G - SOCIAL SERVICE RECLASS				
1.00	SOCIAL SERVICE	17.00	9,390	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		9,390	0	
	H - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	831,046	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
	TOTALS		0	831,046	
	I - BUILDING RENOVATION DEPRE				
1.00	2015 BUILDING RENOVATION & ADDITION	1.02	0	410,630	1.00
	TOTALS		0	410,630	
	J - ALLOWABLE BENEFIT RECLASS				
1.00	CLINIC	90.00	0	9,652	1.00
2.00	OPERATING ROOM	50.00	0	28,924	2.00
	TOTALS		0	38,576	
500.00	Grand Total: Increases		185,607	2,784,827	500.00

RECLASSIFICATIONS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/7/2018 4:40 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	94,172	59,004	0		1.00
	TOTALS		94,172	59,004			
	B - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	577,610	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	TOTALS		0	577,610			
	C - ER NURSING RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	74,368	0	0		1.00
	TOTALS		74,368	0			
	D - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	702,691	9		1.00
	TOTALS		0	702,691			
	E - WELLNESS CENTER DEP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	162,009	9		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	9		4.00
	TOTALS		0	162,009			
	F - WELLNESS CENTER RECLASS						
1.00	WELLNESS CENTER	194.07	7,677	3,261	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		7,677	3,261			
	G - SOCIAL SERVICE RECLASS						
1.00	NURSING FACILITY	45.00	3,770	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	5,620	0	0		2.00
	TOTALS		9,390	0			
	H - MEDICAL SUPPLIES						
1.00	PHARMACY	15.00	0	119	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	11,345	0		2.00
3.00	NURSING FACILITY	45.00	0	640	0		3.00
4.00	OPERATING ROOM	50.00	0	765,376	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	20,146	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	120	0		6.00
7.00	MRI	58.00	0	23,753	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	2,472	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	2,463	0		9.00
10.00	EMERGENCY	91.00	0	4,612	0		10.00
	TOTALS		0	831,046			
	I - BUILDING RENOVATION DEPRE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	410,630	9		1.00
	TOTALS		0	410,630			
	J - ALLOWABLE BENEFIT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38,576	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	38,576			
500.00	Grand Total: Decreases		185,607	2,784,827			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/7/2018 4:40 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,019,596	354,572	0	354,572	0	1.00
2.00	Land Improvements	1,714,760	317,580	0	317,580	0	2.00
3.00	Buildings and Fixtures	33,050,054	713,410	0	713,410	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	16,934,300	0	0	0	1,944,033	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,718,710	1,385,562	0	1,385,562	1,944,033	8.00
9.00	Reconciling Items	-147,604	-4,393,156	0	-4,393,156	0	9.00
10.00	Total (line 8 minus line 9)	52,866,314	5,778,718	0	5,778,718	1,944,033	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,374,168	0	1.00
2.00	Land Improvements	2,032,340	0	2.00
3.00	Buildings and Fixtures	33,763,464	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	14,990,267	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,160,239	0	8.00
9.00	Reconciling Items	-4,540,760	0	9.00
10.00	Total (line 8 minus line 9)	56,700,999	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/7/2018 4:40 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	265,367	0	0	0	0	1.00
1.01	WELLNESS CENTER B&F	74,065	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	2,211,069	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)	2,550,501	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	265,367		1.00
1.01	WELLNESS CENTER B&F	0	74,065		1.01
1.02	2015 BUILDING RENOVATION & ADDITION	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,211,069		2.00
2.01	WELLNESS CENTER MME	0	0		2.01
3.00	Total (sum of lines 1-2)	0	2,550,501		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/7/2018 4:40 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	37,169,972	0	37,169,972	0.712611	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	14,990,267	0	14,990,267	0.287389	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	52,160,239	0	52,160,239	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	557,428	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	173,130	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	1,260,254	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	54,075	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,455,517	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	51,446	0	0	0	608,874	1.00
1.01	WELLNESS CENTER B&F	14,974	0	0	0	188,104	1.01
1.02	2015 BUILDING RENOVATION & ADDITION	350,335	0	0	0	760,965	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,260,254	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	54,075	2.01
3.00	Total (sum of lines 1-2)	416,755	0	0	0	2,872,272	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/7/2018 4:40 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	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-10,398	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - WELLNESS CENTER B&F (chapter 2)		0	WELLNESS CENTER B&F	1.01	0	1.01
1.02	Investment income - 2015 BUILDING RENOVATION & ADDITION (chapter 2)		0	2015 BUILDING RENOVATION & ADDITION	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - WELLNESS CENTER MME (chapter 2)		0	WELLNESS CENTER MME	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-797,444			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	-8,487			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - WELLNESS CENTER B&F		0	WELLNESS CENTER B&F	1.01	0	26.01
26.02	Depreciation - 2015 BUILDING RENOVATION & ADDITION		0	2015 BUILDING RENOVATION & ADDITION	1.02	0	26.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/7/2018 4:40 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	5.00	
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	-84,960	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	B	-70,811	2015 BUILDING RENOVATION & ADDITION	1.02	11	33.00
33.01	INTEREST INCOME OFFSET	B	-3,027	WELLNESS CENTER B&F	1.01	11	33.01
33.02	INTEREST INCOME OFFSET	B	-902	OPERATION OF PLANT ALL	7.02	0	33.02
33.03	INTEREST INCOME OFFSET	B	0	CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04	INTEREST INCOME OFFSET	B	-3,418	NURSING FACILITY	45.00	0	33.04
33.05	INTEREST INCOME OFFSET	B	-3,418	OTHER LONG TERM CARE	46.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	INTEREST INCOME OFFSET	B	-4,956	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	INTEREST INCOME OFFSET	B	-175	RESPIRATORY THERAPY	65.00	0	33.08
33.09	TRADE, QUANTITY AND TIME DISCOUNTS	B	-6,042	OTHER A AND G	5.03	0	33.09
33.10	CAFETERIA--EMPLOYEES AND GUESTS	B	-91,430	CAFETERIA	11.00	0	33.10
33.11	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-662	MEDICAL RECORDS & LIBRARY	16.00	0	33.11
33.12	EMPLOYEE CHILD CARE REV	B	-154,690	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	MISC INCOME	B	-78,681	OTHER A AND G	5.03	0	33.13
33.14	OTHER INCOME OLTC	B	-12,650	OTHER LONG TERM CARE	46.00	0	33.14
33.15	INSURANCE PROCEEDS - A&G	B	-8,762	OTHER A AND G	5.03	0	33.15
33.16	PROGRAM INCOME -DIETITIAN	B	-2,339	DIETARY	10.00	0	33.16
33.17	CRNA SALARY COST	A	-22,423	ANESTHESIOLOGY	53.00	0	33.17
33.18	CRNA BENEFIT COST	A	-3,171	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	BUYER'S GROUP REBATE	B	-43,313	OTHER A AND G	5.03	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	INSURANCE PROCEEDS - A&P	B	-2,050	ADULTS & PEDIATRICS	30.00	0	33.26
33.27	INSURANCE PROCEEDS - MAINT	B	-12,009	MAINTENANCE & REPAIRS	6.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29	TELEPHONE SERVICES	A	-3,335	HOSPITAL ADMIN & GENERAL	5.02	0	33.29
33.30	TELEPHONE EMP BENEFIT EXPENSE	A	-697	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31	TELEPHONE DEPRECIATION	A	-1,155	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.31
33.32	ALCOHOLIC BEVERAGES	A	-380	OTHER A AND G	5.03	0	33.32
33.33	NON-ALLO ADVERTISING SALARIES	A	-13,815	OTHER A AND G	5.03	0	33.33
33.34	ADVERTISING/MARKETING EXPENSE	A	-128,134	OTHER A AND G	5.03	0	33.34
33.35	MARKETING OLTC	A	-760	OTHER LONG TERM CARE	46.00	0	33.35
33.36	MARKETING PT	A	-1,282	PHYSICAL THERAPY	66.00	0	33.36
33.37	MARKETING A&G	A	-387	HOSPITAL ADMIN & GENERAL	5.02	0	33.37
33.38	CLINIC DR BENEFITS	A	-16,605	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.38

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/7/2018 4:40 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	5.00	
33.39	ORTHO PHYSICIAN BENEFITS	A	-49,762	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
34.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.01
34.02	MARKETING - RADIOLOGY	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	34.02
34.07	CHARITABLE CONTRIBUTIONS	A	-24,466	OTHER A AND G	5.03	0	34.07
34.14	ANESTH ON-CALL TIME	A	-263,400	ANESTHESIOLOGY	53.00	0	34.14
34.15	MEDICAID ASSESSMENT	A	-252,768	OTHER A AND G	5.03	0	34.15
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
36.01	PATIENT TELEVISION EXPENSE	A	-4,568	OTHER A AND G	5.03	0	36.01
38.02	IHA LOBBYING DUES	A	-8,929	OTHER A AND G	5.03	0	38.02
38.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.04
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,196,661				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 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/7/2018 4:40 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	91.00	EMERGENCY	ER PHYSICIAN	8,707	8,707	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MME	20,922	20,922	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMP BENEFITS	65,259	65,259	3.00
4.00	5.01	PHYSICAIN OFFICE BILLING	PHYS BILLING	181,962	181,962	4.00
4.01	5.03	OTHER A AND G	A&G ALL	26,438	26,438	4.01
4.02	6.00	MAINTENANCE & REPAIRS	MAINT AND REPAIRS	5,609	5,609	4.02
4.03	0.00			0	0	4.03
4.04	192.00	PHYSICIANS' PRIVATE OFFICES	PHYS OFFICES	454,923	454,923	4.04
4.05	192.01	SATELLITE OFFICES	SATELLITE OFFICES	319,315	319,315	4.05
4.06	91.00	EMERGENCY	RENTAL DUPLEX	10,113	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.			1,093,248	1,101,735	5.00

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

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

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

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

6.00	E		0.00	ROSSI PHYSICIANS	100.00	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 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/7/2018 4:40 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	-8,487	0		4.06
5.00	-8,487			5.00

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

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

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

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

6.00	PHYSCIANS		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/7/2018 4:40 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	8,707	544	8,163	0	0	1.00
2.00	91.00	EMERGENCY	1,233,891	327,655	906,236	0	0	2.00
3.00	90.00	CLINIC	117,408	117,408	0	0	0	3.00
4.00	50.00	OPERATING ROOM	351,837	351,837	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			1,711,843	797,444	914,399		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	90.00	CLINIC	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	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	544		1.00
2.00	91.00	EMERGENCY	0	0	0	327,655		2.00
3.00	90.00	CLINIC	0	0	0	117,408		3.00
4.00	50.00	OPERATING ROOM	0	0	0	351,837		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	797,444		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/7/2018 4:40 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	608,874	608,874				1.00
1.01	00101	WELLNESS CENTER B&F	188,104	0	188,104			1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION	760,965	0	0	760,965		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,260,254				1,260,254	2.00
2.01	00201	WELLNESS CENTER MME	54,075				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,127,274	10,388	32,145	0	0	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	181,962	4,203	0	0	4,019	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	516,753	13,376	0	88,189	10,836	5.02
5.03	00592	OTHER A AND G	2,403,544	43,209	6,915	0	92,603	5.03
6.00	00600	MAINTENANCE & REPAIRS	809,866	5,763	0	0	18,037	6.00
7.01	00701	WELLNESS CENTER PLANT OP	86,400	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	317,489	3,619	0	0	115,289	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	202,244	10,535	0	0	2,297	8.00
9.00	00900	HOUSEKEEPING	217,296	1,588	0	0	104	9.00
10.00	01000	DIETARY	910,830	12,052	0	0	20,446	10.00
11.00	01100	CAFETERIA	61,746	18,683	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,698	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	294,420	11,887	0	0	0	14.00
15.00	01500	PHARMACY	241,206	2,463	0	0	10,514	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	488,441	16,134	799	0	12,429	16.00
17.00	01700	SOCIAL SERVICE	9,390	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,310,939	13,884	0	377,261	241,582	30.00
45.00	04500	NURSING FACILITY	1,417,505	135,818	0	0	4,561	45.00
46.00	04600	OTHER LONG TERM CARE	531,761	250,492	145	0	4,514	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	871,980	25,565	0	54,019	327,635	50.00
53.00	05300	ANESTHESIOLOGY	188,059	686	0	0	1,007	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,440	14,337	0	84,793	332,184	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	179,003	0	0	0	0	58.00
60.00	06000	LABORATORY	920,495	8,302	0	0	15,101	60.00
65.00	06500	RESPIRATORY THERAPY	405,367	2,501	10,853	0	11,818	65.00
65.01	06501	SLEEP LAB	20,424	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	8,383	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	617,704	1,691	37,992	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	831,046	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147,767	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	311,981	0	0	0	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,660	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,141,663	0	0	156,703	8,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,278,310	608,874	88,849	760,965	1,233,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,999	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	455,002	0	0	0	13,185	192.00
192.01	19201	SATELLITE OFFICES	484,908	0	0	0	10,213	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	1,514,115	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	29,034	0	0	0	3,547	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	448,548	0	99,255	0	0	194.07
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	201.00
202.00		TOTAL (sum lines 118 through 201)	24,236,916	608,874	188,104	760,965	1,260,254	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	CAPITAL RELATED COSTS WELLNESS CENTER MME	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	PHYSICAIN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME	54,075					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,881	2,179,688				4.00
5.01	00590	PHYSICAIN OFFICE BILLING	0	30,149	220,333	220,333		5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	0	75,618	704,772	0	704,772	5.02
5.03	00592	OTHER A AND G	0	223,522	2,769,793	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	108,647	942,313	0	0	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	86,400	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	0	0	436,397	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	39,348	254,424	0	0	8.00
9.00	00900	HOUSEKEEPING	0	36,188	255,176	0	0	9.00
10.00	01000	DIETARY	0	122,919	1,066,247	0	0	10.00
11.00	01100	CAFETERIA	0	20,619	101,048	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,698	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,687	339,994	0	0	14.00
15.00	01500	PHARMACY	0	47,632	301,815	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,821	529,624	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,056	11,446	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	242,911	2,186,577	0	62,545	30.00
45.00	04500	NURSING FACILITY	0	275,460	1,833,344	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	44	77,565	864,521	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	120,106	1,399,305	0	184,081	50.00
53.00	05300	ANESTHESIOLOGY	0	4,567	194,319	0	44,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	87,761	1,142,515	0	110,149	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	179,003	0	22,295	58.00
60.00	06000	LABORATORY	0	80,309	1,024,207	0	81,700	60.00
65.00	06500	RESPIRATORY THERAPY	11,290	79,499	521,328	0	34,597	65.00
65.01	06501	SLEEP LAB	0	0	20,424	0	1,842	65.01
65.02	03160	PULMONARY REHAB	0	1,830	10,213	0	696	65.02
66.00	06600	PHYSICAL THERAPY	2,347	123,219	782,953	0	28,946	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	831,046	0	42,338	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	147,767	0	8,131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	311,981	0	45,763	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	9,660	1,870	354	90.00
91.00	09100	EMERGENCY	0	24,806	1,331,505	0	37,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,562	1,870,239	20,812,148	1,870	704,772	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,435	28,434	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	84,205	552,392	106,938	0	192.00
192.01	19201	SATELLITE OFFICES	0	80,964	576,085	111,525	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	68,483	1,582,598	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	32,581	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	30,513	74,362	652,678	0	0	194.07
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	54,075	2,179,688	24,236,916	220,333	704,772	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	Subtotal	OTHER A AND G	MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	
			5A.02	5.03	6.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G	2,769,793	2,769,793				5.03
6.00	00600	MAINTENANCE & REPAIRS	942,313	121,582	1,063,895			6.00
7.01	00701	WELLNESS CENTER PLANT OP	86,400	11,148	94,546	192,094		7.01
7.02	00702	OPERATION OF PLANT ALL	436,397	56,306	346,241	0	838,944	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	254,424	32,827	21,234	0	45,319	8.00
9.00	00900	HOUSEKEEPING	255,176	32,924	0	0	6,833	9.00
10.00	01000	DIETARY	1,066,247	137,573	31,668	0	51,842	10.00
11.00	01100	CAFETERIA	101,048	13,038	16,749	0	80,367	11.00
13.00	01300	NURSING ADMINISTRATION	1,698	219	0	0	7,305	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	339,994	43,868	12,173	0	51,134	14.00
15.00	01500	PHARMACY	301,815	38,942	3,295	0	10,596	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	529,624	68,335	9,519	1,030	69,403	16.00
17.00	01700	SOCIAL SERVICE	11,446	1,477	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,249,122	290,189	160,536	0	187,622	30.00
45.00	04500	NURSING FACILITY	1,833,344	236,547	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	864,521	111,545	233,116	187	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,583,386	204,296	35,512	0	128,284	50.00
53.00	05300	ANESTHESIOLOGY	238,413	30,761	0	0	2,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,252,664	161,625	14,003	0	90,417	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	201,298	25,972	0	0	0	58.00
60.00	06000	LABORATORY	1,105,907	142,690	5,858	0	35,712	60.00
65.00	06500	RESPIRATORY THERAPY	555,925	71,728	3,753	13,987	10,758	65.00
65.01	06501	SLEEP LAB	22,266	2,873	0	0	0	65.01
65.02	03160	PULMONARY REHAB	10,909	1,408	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	811,899	104,755	4,210	48,966	7,275	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	873,384	112,688	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,898	20,115	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	357,744	46,158	0	0	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,884	1,533	0	0	0	90.00
91.00	09100	EMERGENCY	1,368,746	176,602	4,119	0	53,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,593,685	2,299,724	996,532	64,170	838,944	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,434	3,669	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	659,330	85,070	23,522	0	0	192.00
192.01	19201	SATELLITE OFFICES	687,610	88,719	9,519	0	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	14,736	0	0	194.01
194.02	07952	RETAIL PHAMACY	1,582,598	204,195	2,837	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	32,581	4,204	16,749	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	652,678	84,212	0	127,924	0	194.07
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,236,916	2,769,793	1,063,895	192,094	838,944	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G						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	353,804					8.00
9.00	00900	HOUSEKEEPING	0	294,933				9.00
10.00	01000	DIETARY	538	0	1,287,868			10.00
11.00	01100	CAFETERIA	0	0	0	211,202		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	9,222	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22	0	9,744	0	14.00
15.00	01500	PHARMACY	0	0	0	2,797	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,305	0	1,919	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	238	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,248	43,600	72,263	30,550	3,553	30.00
45.00	04500	NURSING FACILITY	233,755	91,601	540,399	44,545	5,178	45.00
46.00	04600	OTHER LONG TERM CARE	2,185	91,756	675,206	16,228	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,927	0	0	24,768	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	451	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,853	10,751	0	11,462	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	12,343	0	10,886	0	60.00
65.00	06500	RESPIRATORY THERAPY	199	3,893	0	8,277	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0	0	0	201	0	65.02
66.00	06600	PHYSICAL THERAPY	6,112	0	0	11,049	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	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,840	0	0	4,226	491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	336,657	255,271	1,287,868	177,341	9,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	163	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,818	35,835	0	13,845	0	192.00
192.01	19201	SATELLITE OFFICES	5,893	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	3,827	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	0	6,296	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	5,436	0	0	13,557	0	194.07
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 through 201)	353,804	294,933	1,287,868	211,202	9,222	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G						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	456,935					14.00
15.00	01500	PHARMACY	1,502	358,947				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35	0	681,170			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	13,161		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,720	0	60,451	4,387	3,174,241	30.00
45.00	04500	NURSING FACILITY	8,101	0	0	8,774	3,002,244	45.00
46.00	04600	OTHER LONG TERM CARE	7,233	0	0	0	2,001,977	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,427	0	177,911	0	2,231,511	50.00
53.00	05300	ANESTHESIOLOGY	4,415	0	42,618	0	319,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,906	0	106,461	0	1,659,142	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	57	0	21,548	0	248,875	58.00
60.00	06000	LABORATORY	78,074	0	78,965	0	1,470,435	60.00
65.00	06500	RESPIRATORY THERAPY	8,047	0	33,439	0	710,006	65.00
65.01	06501	SLEEP LAB	0	0	1,780	0	26,919	65.01
65.02	03160	PULMONARY REHAB	0	0	673	0	13,191	65.02
66.00	06600	PHYSICAL THERAPY	1,065	0	27,977	0	1,023,308	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	216,825	0	40,921	0	1,243,818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,553	0	7,859	0	222,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	358,947	44,231	0	807,080	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	342	0	13,759	90.00
91.00	09100	EMERGENCY	3,499	0	35,994	0	1,655,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	443,459	358,947	681,170	13,161	19,824,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	32,266	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,081	0	0	0	826,501	192.00
192.01	19201	SATELLITE OFFICES	3,446	0	0	0	795,187	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	18,563	194.01
194.02	07952	RETAIL PHAMACY	3,306	0	0	0	1,799,232	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	37	0	0	0	53,571	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	3,606	0	0	0	887,413	194.07
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	456,935	358,947	681,170	13,161	24,236,916	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLNESS CENTER B&F				1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	WELLNESS CENTER MME				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	PHYSICAIN OFFICE BILLING				5.01
5.02	00591	HOSPITAL ADMIN & GENERAL				5.02
5.03	00592	OTHER A AND G				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.01	00701	WELLNESS CENTER PLANT OP				7.01
7.02	00702	OPERATION OF PLANT ALL				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,174,241		30.00
45.00	04500	NURSING FACILITY	0	3,002,244		45.00
46.00	04600	OTHER LONG TERM CARE	0	2,001,977		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,231,511		50.00
53.00	05300	ANESTHESIOLOGY	0	319,609		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,659,142		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	248,875		58.00
60.00	06000	LABORATORY	0	1,470,435		60.00
65.00	06500	RESPIRATORY THERAPY	0	710,006		65.00
65.01	06501	SLEEP LAB	0	26,919		65.01
65.02	03160	PULMONARY REHAB	0	13,191		65.02
66.00	06600	PHYSICAL THERAPY	0	1,023,308		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,243,818		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	222,425		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	807,080		73.00
76.00	03950	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	13,759		90.00
91.00	09100	EMERGENCY	0	1,655,643		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,824,183		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,266		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	826,501		192.00
192.01	19201	SATELLITE OFFICES	0	795,187		192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0		194.00
194.01	07951	OUTSIDE PROPERTY	0	18,563		194.01
194.02	07952	RETAIL PHAMACY	0	1,799,232		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	53,571		194.05
194.06	07955	UNUSED SPACE	0	0		194.06
194.07	07956	WELLNESS CENTER	0	887,413		194.07
194.09	07959	MEDICAL MASSAGE	0	0		194.09
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	24,236,916		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/7/2018 4:40 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	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,388	32,145	0	0	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	0	4,203	0	0	4,019	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	0	13,376	0	88,189	10,836	5.02
5.03	00592	OTHER A AND G	0	43,209	6,915	0	92,603	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	5,763	0	0	18,037	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	0	3,619	0	0	115,289	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,535	0	0	2,297	8.00
9.00	00900	HOUSEKEEPING	0	1,588	0	0	104	9.00
10.00	01000	DIETARY	0	12,052	0	0	20,446	10.00
11.00	01100	CAFETERIA	0	18,683	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,698	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,887	0	0	0	14.00
15.00	01500	PHARMACY	0	2,463	0	0	10,514	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,134	799	0	12,429	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	13,884	0	377,261	241,582	30.00
45.00	04500	NURSING FACILITY	0	135,818	0	0	4,561	45.00
46.00	04600	OTHER LONG TERM CARE	0	250,492	145	0	4,514	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	25,565	0	54,019	327,635	50.00
53.00	05300	ANESTHESIOLOGY	0	686	0	0	1,007	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,337	0	84,793	332,184	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	8,302	0	0	15,101	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,501	10,853	0	11,818	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	1,691	37,992	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	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	156,703	8,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	608,874	88,849	760,965	1,233,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	13,185	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	0	10,213	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	0	0	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	TRIPLEXES	0	0	0	0	0	194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0	0	3,547	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	99,255	0	0	194.07
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	201.00
202.00		TOTAL (sum lines 118 through 201)	0	608,874	188,104	760,965	1,260,254	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	CAPITAL RELATED COSTS WELLNESS CENTER MME	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PHYSICAIN OFFICE BILLING	HOSPITAL ADMIN & GENERAL	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,881	52,414	52,414			4.00
5.01	00590	PHYSICAIN OFFICE BILLING	0	8,222	725	8,947		5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	0	112,401	1,818	0	114,219	5.02
5.03	00592	OTHER A AND G	0	142,727	5,375	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	23,800	2,613	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	118,908	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,832	946	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,692	870	0	0	9.00
10.00	01000	DIETARY	0	32,498	2,956	0	0	10.00
11.00	01100	CAFETERIA	0	18,683	496	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,698	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,887	810	0	0	14.00
15.00	01500	PHARMACY	0	12,977	1,145	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,362	284	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	49	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	632,727	5,841	0	10,136	30.00
45.00	04500	NURSING FACILITY	0	140,379	6,625	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	44	255,195	1,865	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	407,219	2,888	0	29,833	50.00
53.00	05300	ANESTHESIOLOGY	0	1,693	110	0	7,146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	431,314	2,110	0	17,851	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	3,613	58.00
60.00	06000	LABORATORY	0	23,403	1,931	0	13,241	60.00
65.00	06500	RESPIRATORY THERAPY	11,290	36,462	1,912	0	5,607	65.00
65.01	06501	SLEEP LAB	0	0	0	0	299	65.01
65.02	03160	PULMONARY REHAB	0	0	44	0	113	65.02
66.00	06600	PHYSICAL THERAPY	2,347	42,030	2,963	0	4,691	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	6,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,417	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	76	57	90.00
91.00	09100	EMERGENCY	0	165,036	597	0	6,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,562	2,715,559	44,973	76	114,219	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	34	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,185	2,025	4,342	0	192.00
192.01	19201	SATELLITE OFFICES	0	10,213	1,947	4,529	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	1,647	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	3,547	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	30,513	129,768	1,788	0	0	194.07
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	54,075	2,872,272	52,414	8,947	114,219	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	OTHER A AND G	MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	LAUNDRY & LINEN SERVICE	
			5.03	6.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G	148,102					5.03
6.00	00600	MAINTENANCE & REPAIRS	6,501	32,914				6.00
7.01	00701	WELLNESS CENTER PLANT OP	596	2,925	3,521			7.01
7.02	00702	OPERATION OF PLANT ALL	3,011	10,712	0	132,631		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,755	657	0	7,165	23,355	8.00
9.00	00900	HOUSEKEEPING	1,760	0	0	1,080	0	9.00
10.00	01000	DIETARY	7,356	980	0	8,196	35	10.00
11.00	01100	CAFETERIA	697	518	0	12,706	0	11.00
13.00	01300	NURSING ADMINISTRATION	12	0	0	1,155	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,346	377	0	8,084	0	14.00
15.00	01500	PHARMACY	2,082	102	0	1,675	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,654	294	19	10,972	0	16.00
17.00	01700	SOCIAL SERVICE	79	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,517	4,967	0	29,660	2,987	30.00
45.00	04500	NURSING FACILITY	12,648	0	0	0	15,431	45.00
46.00	04600	OTHER LONG TERM CARE	5,964	7,212	3	0	144	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,924	1,099	0	20,281	2,174	50.00
53.00	05300	ANESTHESIOLOGY	1,645	0	0	467	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,642	433	0	14,294	452	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	1,389	0	0	0	0	58.00
60.00	06000	LABORATORY	7,630	181	0	5,646	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,835	116	256	1,701	13	65.00
65.01	06501	SLEEP LAB	154	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	75	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	5,601	130	898	1,150	403	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,025	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,076	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,468	0	0	0	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	82	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,443	127	0	8,399	584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,967	30,830	1,176	132,631	22,223	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	196	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,549	728	0	0	384	192.00
192.01	19201	SATELLITE OFFICES	4,744	294	0	0	389	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	456	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	10,918	88	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	225	518	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	4,503	0	2,345	0	359	194.07
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 through 201)	148,102	32,914	3,521	132,631	23,355	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G						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	5,402					9.00
10.00	01000	DIETARY	0	52,021				10.00
11.00	01100	CAFETERIA	0	0	33,100			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,865		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,527	0	25,031	14.00
15.00	01500	PHARMACY	0	0	438	0	82	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24	0	301	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	37	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	799	2,919	4,788	1,104	1,464	30.00
45.00	04500	NURSING FACILITY	1,678	21,828	6,981	1,608	444	45.00
46.00	04600	OTHER LONG TERM CARE	1,681	27,274	2,543	0	396	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,882	0	2,434	50.00
53.00	05300	ANESTHESIOLOGY	0	0	71	0	242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197	0	1,796	0	269	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	3	58.00
60.00	06000	LABORATORY	226	0	1,706	0	4,277	60.00
65.00	06500	RESPIRATORY THERAPY	71	0	1,297	0	441	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0	0	31	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	1,732	0	58	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	11,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	662	153	192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,676	52,021	27,792	2,865	24,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	26	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	656	0	2,170	0	169	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	0	189	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	70	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	987	0	181	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	2	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	2,125	0	198	194.07
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 through 201)	5,402	52,021	33,100	2,865	25,031	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/7/2018 4:40 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G						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	18,501					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,912				16.00
17.00	01700	SOCIAL SERVICE	0	0	165			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,986	55	716,950	0	30.00
45.00	04500	NURSING FACILITY	0	0	110	207,732	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	302,277	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,731	0	492,465	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,810	0	14,184	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,019	0	484,377	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	1,421	0	6,426	0	58.00
60.00	06000	LABORATORY	0	5,206	0	63,447	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,205	0	53,916	0	65.00
65.01	06501	SLEEP LAB	0	117	0	570	0	65.01
65.02	03160	PULMONARY REHAB	0	44	0	307	0	65.02
66.00	06600	PHYSICAL THERAPY	0	1,845	0	61,501	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,698	0	27,461	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	518	0	5,024	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,501	2,916	0	31,302	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	23	0	238	0	90.00
91.00	09100	EMERGENCY	0	2,373	0	193,601	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,501	44,912	165	2,661,778	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	256	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	28,208	0	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	22,305	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	526	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	0	13,821	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	4,292	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	0	141,086	0	194.07
194.09	07959	MEDICAL MASSAGE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,501	44,912	165	2,872,272	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	WELLNESS CENTER B&F			1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	WELLNESS CENTER MME			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	PHYSICAIN OFFICE BILLING			5.01
5.02	00591	HOSPITAL ADMIN & GENERAL			5.02
5.03	00592	OTHER A AND G			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.01	00701	WELLNESS CENTER PLANT OP			7.01
7.02	00702	OPERATION OF PLANT ALL			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	716,950		30.00
45.00	04500	NURSING FACILITY	207,732		45.00
46.00	04600	OTHER LONG TERM CARE	302,277		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	492,465		50.00
53.00	05300	ANESTHESIOLOGY	14,184		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	484,377		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	6,426		58.00
60.00	06000	LABORATORY	63,447		60.00
65.00	06500	RESPIRATORY THERAPY	53,916		65.00
65.01	06501	SLEEP LAB	570		65.01
65.02	03160	PULMONARY REHAB	307		65.02
66.00	06600	PHYSICAL THERAPY	61,501		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,461		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,024		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,302		73.00
76.00	03950	RENEWED HOPE	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	238		90.00
91.00	09100	EMERGENCY	193,601		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,661,778		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,208		192.00
192.01	19201	SATELLITE OFFICES	22,305		192.01
194.00	07950	ARC (HOPEDALE HALL)	0		194.00
194.01	07951	OUTSIDE PROPERTY	526		194.01
194.02	07952	RETAIL PHAMACY	13,821		194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0		194.03
194.04	07954	TRIPLEXES	0		194.04
194.05	07957	WHITE FENCE ESTATES	4,292		194.05
194.06	07955	UNUSED SPACE	0		194.06
194.07	07956	WELLNESS CENTER	141,086		194.07
194.09	07959	MEDICAL MASSAGE	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 through 201)	2,872,272		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	WELLNESS CENTER B&F (SQUARE FEET)	2015 BUILDING RENOVATION & ADDITION (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	WELLNESS CENTER MME (DOLLAR VALUE)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	177,482					1.00
1.01	00101	WELLNESS CENTER B&F	0	35,064				1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION	0	0	17,482			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				1,245,901		2.00
2.01	00201	WELLNESS CENTER MME				0	54,075	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,028	5,992	0	0	9,881	4.00
5.01	00590	PHYSICAIN OFFICE BILLING	1,225	0	0	3,973	0	5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	3,899	0	2,026	10,713	0	5.02
5.03	00592	OTHER A AND G	12,595	1,289	0	91,548	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	113,976	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	103	0	9.00
10.00	01000	DIETARY	3,513	0	0	20,213	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	0	0	14.00
15.00	01500	PHARMACY	718	0	0	10,394	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,703	149	0	12,287	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,047	0	8,667	238,831	0	30.00
45.00	04500	NURSING FACILITY	39,590	0	0	4,509	0	45.00
46.00	04600	OTHER LONG TERM CARE	73,016	27	0	4,463	44	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,452	0	1,241	323,904	0	50.00
53.00	05300	ANESTHESIOLOGY	200	0	0	996	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179	0	1,948	328,399	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	14,929	0	60.00
65.00	06500	RESPIRATORY THERAPY	729	2,023	0	11,683	11,290	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	7,082	0	0	2,347	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	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	3,600	8,238	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	177,482	16,562	17,482	1,219,262	23,562	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	13,035	0	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	10,097	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	0	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	18,502	0	0	30,513	194.07
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)	608,874	188,104	760,965	1,260,254	54,075	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.430624	5.364590	43.528486	1.011520	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 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 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 II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	PHYSICAIN OFFICE BILLING (ACCUM. COST)	HOSPITAL ADMIN & GENERAL (GROSS REV)	Reconciliation	
			4.00	5A.01	5.01	5.02	5A.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	9,955,325					4.00
5.01	00590	PHYSICAIN OFFICE BILLING	137,702	-220,333	1,138,137			5.01
5.02	00591	HOSPITAL ADMIN & GENERAL	345,370	-704,772	0	42,208,393		5.02
5.03	00592	OTHER A AND G	1,020,894	-2,769,793	0	0	-2,769,793	5.03
6.00	00600	MAINTENANCE & REPAIRS	496,223	-942,313	0	0	0	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	-86,400	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	0	-436,397	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	179,714	-254,424	0	0	0	8.00
9.00	00900	HOUSEKEEPING	165,283	-255,176	0	0	0	9.00
10.00	01000	DIETARY	561,412	-1,066,247	0	0	0	10.00
11.00	01100	CAFETERIA	94,172	-101,048	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	-1,698	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153,860	-339,994	0	0	0	14.00
15.00	01500	PHARMACY	217,551	-301,815	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,989	-529,624	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	9,390	-11,446	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,109,449	-2,186,577	0	3,745,900	0	30.00
45.00	04500	NURSING FACILITY	1,258,121	-1,833,344	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	354,263	-864,521	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	548,562	-1,399,305	0	11,023,651	0	50.00
53.00	05300	ANESTHESIOLOGY	20,860	-194,319	0	2,640,834	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	400,830	-1,142,515	0	6,596,923	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	-179,003	0	1,335,248	0	58.00
60.00	06000	LABORATORY	366,798	-1,024,207	0	4,893,111	0	60.00
65.00	06500	RESPIRATORY THERAPY	363,096	-521,328	0	2,072,060	0	65.00
65.01	06501	SLEEP LAB	0	-20,424	0	110,324	0	65.01
65.02	03160	PULMONARY REHAB	8,356	-10,213	0	41,677	0	65.02
66.00	06600	PHYSICAL THERAPY	562,780	-782,953	0	1,733,621	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-831,046	0	2,535,675	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	-147,767	0	486,998	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	-311,981	0	2,740,770	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	9,660	21,200	0	90.00
91.00	09100	EMERGENCY	113,296	-1,331,505	0	2,230,401	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,541,971	-20,802,488	9,660	42,208,393	-2,769,793	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,552	-28,434	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	384,593	0	552,392	0	0	192.00
192.01	19201	SATELLITE OFFICES	369,789	0	576,085	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 PHAMACY	312,784	-1,582,598	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	-32,581	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	339,636	-652,678	0	0	0	194.07
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)	2,179,688		220,333	704,772		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.218947		0.193591	0.016697		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,414		8,947	114,219		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005265		0.007861	0.002706		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	PHYSICAIN OFFICE BILLING (ACCUM. COST)	HOSPITAL ADMIN & GENERAL (GROSS REV)	Reconciliation	
			4.00	5A.01	5.01	5.02	5A.03	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	OTHER A AND G (ACCUM. COST)	MAINTENANCE & REPAIRS (MAINT TIME)	WELLNESS CENTER PLANT OP (SQUARE FEET)	OPERATION OF PLANT ALL (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	6.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
1.02	00102	2015 BUILDING RENOVATION & ADDITION						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G	21,467,123					5.03
6.00	00600	MAINTENANCE & REPAIRS	942,313	11,624				6.00
7.01	00701	WELLNESS CENTER PLANT OP	86,400	1,033	27,783			7.01
7.02	00702	OPERATION OF PLANT ALL	436,397	3,783	0	56,850		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	254,424	232	0	3,071	365,323	8.00
9.00	00900	HOUSEKEEPING	255,176	0	0	463	0	9.00
10.00	01000	DIETARY	1,066,247	346	0	3,513	555	10.00
11.00	01100	CAFETERIA	101,048	183	0	5,446	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,698	0	0	495	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	339,994	133	0	3,465	0	14.00
15.00	01500	PHARMACY	301,815	36	0	718	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	529,624	104	149	4,703	0	16.00
17.00	01700	SOCIAL SERVICE	11,446	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,249,122	1,754	0	12,714	46,721	30.00
45.00	04500	NURSING FACILITY	1,833,344	0	0	0	241,367	45.00
46.00	04600	OTHER LONG TERM CARE	864,521	2,547	27	0	2,256	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,583,386	388	0	8,693	33,999	50.00
53.00	05300	ANESTHESIOLOGY	238,413	0	0	200	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,252,664	153	0	6,127	7,076	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	201,298	0	0	0	0	58.00
60.00	06000	LABORATORY	1,105,907	64	0	2,420	0	60.00
65.00	06500	RESPIRATORY THERAPY	555,925	41	2,023	729	205	65.00
65.01	06501	SLEEP LAB	22,266	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	10,909	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	811,899	46	7,082	493	6,311	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	873,384	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,898	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	357,744	0	0	0	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,884	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,368,746	45	0	3,600	9,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,823,892	10,888	9,281	56,850	347,618	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,434	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	659,330	257	0	0	6,007	192.00
192.01	19201	SATELLITE OFFICES	687,610	104	0	0	6,085	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	161	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	1,582,598	31	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	32,581	183	0	0	0	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	652,678	0	18,502	0	5,613	194.07
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)	2,769,793	1,063,895	192,094	838,944	353,804	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.129025	91.525723	6.914084	14.757150	0.968469	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	148,102	32,914	3,521	132,631	23,355	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006899	2.831555	0.126732	2.332999	0.063930	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	OTHER A AND G (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	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS G HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	PHYSICAIN OFFICE BILLING						5.01
5.02	00591	HOSPITAL ADMIN & GENERAL						5.02
5.03	00592	OTHER A AND G						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	13,333					9.00
10.00	01000	DIETARY	0	126,821				10.00
11.00	01100	CAFETERIA	0	0	16,841			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	131,585		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	777	0	1,751,343	14.00
15.00	01500	PHARMACY	0	0	223	0	5,758	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59	0	153	0	134	16.00
17.00	01700	SOCIAL SERVICE	0	0	19	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,971	7,116	2,436	50,697	102,413	30.00
45.00	04500	NURSING FACILITY	4,141	53,215	3,552	73,882	31,049	45.00
46.00	04600	OTHER LONG TERM CARE	4,148	66,490	1,294	0	27,722	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,975	0	170,281	50.00
53.00	05300	ANESTHESIOLOGY	0	0	36	0	16,923	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486	0	914	0	18,802	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	218	58.00
60.00	06000	LABORATORY	558	0	868	0	299,244	60.00
65.00	06500	RESPIRATORY THERAPY	176	0	660	0	30,841	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0	0	16	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	881	0	4,083	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	831,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	147,767	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	337	7,006	13,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,540	126,821	14,141	131,585	1,699,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	13	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,620	0	1,104	0	11,808	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	0	13,207	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	173	0	0	0	0	194.01
194.02	07952	RETAIL PHAMACY	0	0	502	0	12,670	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	143	194.05
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	0	1,081	0	13,823	194.07
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)	294,933	1,287,868	211,202	9,222	456,935	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.120528	10.155006	12.540942	0.070084	0.260905	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,402	52,021	33,100	2,865	25,031	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.405160	0.410192	1.965441	0.021773	0.014292	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 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	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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	PHYSICAIN OFFICE BILLING					5.01
5.02	00591	HOSPITAL ADMIN & GENERAL					5.02
5.03	00592	OTHER A AND G					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	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,208,393			16.00
17.00	01700	SOCIAL SERVICE	0	0	390		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,745,900	130		30.00
45.00	04500	NURSING FACILITY	0	0	260		45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,023,651	0		50.00
53.00	05300	ANESTHESIOLOGY	0	2,640,834	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,596,923	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	1,335,248	0		58.00
60.00	06000	LABORATORY	0	4,893,111	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,072,060	0		65.00
65.01	06501	SLEEP LAB	0	110,324	0		65.01
65.02	03160	PULMONARY REHAB	0	41,677	0		65.02
66.00	06600	PHYSICAL THERAPY	0	1,733,621	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,535,675	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	486,998	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	2,740,770	0		73.00
76.00	03950	RENEWED HOPE	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	21,200	0		90.00
91.00	09100	EMERGENCY	0	2,230,401	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	42,208,393	390		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	SATELLITE OFFICES	0	0	0		192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0		194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0		194.01
194.02	07952	RETAIL PHAMACY	0	0	0		194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0		194.03
194.04	07954	TRIPLEXES	0	0	0		194.04
194.05	07957	WHITE FENCE ESTATES	0	0	0		194.05
194.06	07955	UNUSED SPACE	0	0	0		194.06
194.07	07956	WELLNESS CENTER	0	0	0		194.07
194.09	07959	MEDICAL MASSAGE	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)	358,947	681,170	13,161		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,589.470000	0.016138	33.746154		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,501	44,912	165		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	185.010000	0.001064	0.423077		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/7/2018 4:40 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)		
			15.00	16.00	17.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/7/2018 4:40 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	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,174,241		3,174,241	0	0	30.00
45.00	04500	NURSING FACILITY	3,002,244		3,002,244	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	2,001,977		2,001,977	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,231,511		2,231,511	0	0	50.00
53.00	05300	ANESTHESIOLOGY	319,609		319,609	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,659,142		1,659,142	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	248,875		248,875	0	0	58.00
60.00	06000	LABORATORY	1,470,435		1,470,435	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	710,006	0	710,006	0	0	65.00
65.01	06501	SLEEP LAB	26,919	0	26,919	0	0	65.01
65.02	03160	PULMONARY REHAB	13,191	0	13,191	0	0	65.02
66.00	06600	PHYSICAL THERAPY	1,023,308	0	1,023,308	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,243,818		1,243,818	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	222,425		222,425	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	807,080		807,080	0	0	73.00
76.00	03950	RENEWED HOPE	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,759		13,759	0	0	90.00
91.00	09100	EMERGENCY	1,655,643		1,655,643	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	257,318		257,318		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,081,501	0	20,081,501	0	0	200.00
201.00		Less Observation Beds	257,318		257,318		0	201.00
202.00		Total (see instructions)	19,824,183	0	19,824,183	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,515,096		3,515,096			30.00
45.00	04500	NURSING FACILITY	3,463,285		3,463,285			45.00
46.00	04600	OTHER LONG TERM CARE	1,950,415		1,950,415			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,937,210	7,086,441	11,023,651	0.202429	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,178,021	1,462,813	2,640,834	0.121026	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	919,939	5,676,984	6,596,923	0.251502	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	46,820	1,288,428	1,335,248	0.186389	0.000000	58.00
60.00	06000	LABORATORY	780,562	4,112,549	4,893,111	0.300511	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,301,466	770,594	2,072,060	0.342657	0.000000	65.00
65.01	06501	SLEEP LAB	0	110,324	110,324	0.243999	0.000000	65.01
65.02	03160	PULMONARY REHAB	0	41,677	41,677	0.316506	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	394,336	1,339,285	1,733,621	0.590272	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,457,462	1,078,213	2,535,675	0.490527	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	194,654	292,344	486,998	0.456727	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,664,868	1,075,902	2,740,770	0.294472	0.000000	73.00
76.00	03950	RENEWED HOPE	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,200	21,200	0.649009	0.000000	90.00
91.00	09100	EMERGENCY	56,658	2,173,743	2,230,401	0.742307	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,488	222,316	230,804	1.114877	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,869,280	26,752,813	47,622,093			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,869,280	26,752,813	47,622,093			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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	03950	RENEWED HOPE	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/7/2018 4:40 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	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,174,241		3,174,241	0	3,174,241	30.00
45.00	04500	NURSING FACILITY	3,002,244		3,002,244	0	3,002,244	45.00
46.00	04600	OTHER LONG TERM CARE	2,001,977		2,001,977	0	2,001,977	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,231,511		2,231,511	0	2,231,511	50.00
53.00	05300	ANESTHESIOLOGY	319,609		319,609	0	319,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,659,142		1,659,142	0	1,659,142	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	248,875		248,875	0	248,875	58.00
60.00	06000	LABORATORY	1,470,435		1,470,435	0	1,470,435	60.00
65.00	06500	RESPIRATORY THERAPY	710,006	0	710,006	0	710,006	65.00
65.01	06501	SLEEP LAB	26,919	0	26,919	0	26,919	65.01
65.02	03160	PULMONARY REHAB	13,191	0	13,191	0	13,191	65.02
66.00	06600	PHYSICAL THERAPY	1,023,308	0	1,023,308	0	1,023,308	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,243,818		1,243,818	0	1,243,818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	222,425		222,425	0	222,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	807,080		807,080	0	807,080	73.00
76.00	03950	RENEWED HOPE	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,759		13,759	0	13,759	90.00
91.00	09100	EMERGENCY	1,655,643		1,655,643	0	1,655,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	257,318		257,318		257,318	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,081,501	0	20,081,501	0	20,081,501	200.00
201.00		Less Observation Beds	257,318		257,318		257,318	201.00
202.00		Total (see instructions)	19,824,183	0	19,824,183	0	19,824,183	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/7/2018 4:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,515,096		3,515,096			30.00
45.00	04500	NURSING FACILITY	3,463,285		3,463,285			45.00
46.00	04600	OTHER LONG TERM CARE	1,950,415		1,950,415			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,937,210	7,086,441	11,023,651	0.202429	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,178,021	1,462,813	2,640,834	0.121026	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	919,939	5,676,984	6,596,923	0.251502	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	46,820	1,288,428	1,335,248	0.186389	0.000000	58.00
60.00	06000	LABORATORY	780,562	4,112,549	4,893,111	0.300511	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,301,466	770,594	2,072,060	0.342657	0.000000	65.00
65.01	06501	SLEEP LAB	0	110,324	110,324	0.243999	0.000000	65.01
65.02	03160	PULMONARY REHAB	0	41,677	41,677	0.316506	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	394,336	1,339,285	1,733,621	0.590272	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,457,462	1,078,213	2,535,675	0.490527	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	194,654	292,344	486,998	0.456727	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,664,868	1,075,902	2,740,770	0.294472	0.000000	73.00
76.00	03950	RENEWED HOPE	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,200	21,200	0.649009	0.000000	90.00
91.00	09100	EMERGENCY	56,658	2,173,743	2,230,401	0.742307	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,488	222,316	230,804	1.114877	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,869,280	26,752,813	47,622,093			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,869,280	26,752,813	47,622,093			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/7/2018 4:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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	03950	RENEWED HOPE	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	492,465	11,023,651	0.044673	2,010,099	89,797	50.00
53.00	05300	ANESTHESIOLOGY	14,184	2,640,834	0.005371	645,840	3,469	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	484,377	6,596,923	0.073425	556,768	40,881	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	6,426	1,335,248	0.004813	33,817	163	58.00
60.00	06000	LABORATORY	63,447	4,893,111	0.012967	401,452	5,206	60.00
65.00	06500	RESPIRATORY THERAPY	53,916	2,072,060	0.026020	502,325	13,070	65.00
65.01	06501	SLEEP LAB	570	110,324	0.005167	0	0	65.01
65.02	03160	PULMONARY REHAB	307	41,677	0.007366	0	0	65.02
66.00	06600	PHYSICAL THERAPY	61,501	1,733,621	0.035475	87,773	3,114	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,461	2,535,675	0.010830	783,019	8,480	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,024	486,998	0.010316	102,321	1,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,302	2,740,770	0.011421	685,697	7,831	73.00
76.00	03950	RENEWED HOPE	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	238	21,200	0.011226	0	0	90.00
91.00	09100	EMERGENCY	193,601	2,230,401	0.086801	7,618	661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	58,119	230,804	0.251811	0	0	92.00
200.00		Total (lines 50 through 199)	1,492,938	38,693,297		5,816,729	173,728	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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	03950	RENEWED HOPE	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	11,023,651	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,640,834	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,596,923	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	1,335,248	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	4,893,111	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,072,060	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	110,324	0.000000	65.01
65.02	03160	PULMONARY REHAB	0	0	0	41,677	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	1,733,621	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,535,675	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	486,998	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,740,770	0.000000	73.00
76.00	03950	RENEWED HOPE	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	21,200	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,230,401	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	230,804	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	38,693,297		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,010,099	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	645,840	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	556,768	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	33,817	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	401,452	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	502,325	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0.000000	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.000000	87,773	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	0.000000	783,019	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	102,321	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	685,697	0	0	0	73.00
76.00	03950	RENEWED HOPE	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	7,618	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,816,729	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202429	0	2,757,924	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.121026	0	644,887	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.251502	0	3,678,150	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.186389	0	551,928	0	0	58.00
60.00	06000	LABORATORY	0.300511	0	2,085,138	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.342657	0	425,189	0	0	65.00
65.01	06501	SLEEP LAB	0.243999	0	53,303	0	0	65.01
65.02	03160	PULMONARY REHAB	0.316506	0	37,626	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.590272	0	598,694	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.490527	0	345,094	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.456727	0	208,865	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294472	0	425,235	0	0	73.00
76.00	03950	RENEWED HOPE	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.649009	0	59	0	0	90.00
91.00	09100	EMERGENCY	0.742307	0	1,091,770	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.114877	0	121,116	0	0	92.00
200.00		Subtotal (see instructions)		0	13,024,978	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	13,024,978	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	558,284	0		50.00
53.00	05300	ANESTHESIOLOGY	78,048	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	925,062	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	102,873	0		58.00
60.00	06000	LABORATORY	626,607	0		60.00
65.00	06500	RESPIRATORY THERAPY	145,694	0		65.00
65.01	06501	SLEEP LAB	13,006	0		65.01
65.02	03160	PULMONARY REHAB	11,909	0		65.02
66.00	06600	PHYSICAL THERAPY	353,392	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	169,278	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,394	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,220	0		73.00
76.00	03950	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	38	0		90.00
91.00	09100	EMERGENCY	810,429	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	135,029	0		92.00
200.00		Subtotal (see instructions)	4,150,263	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,150,263	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1330 | Component CCN: 14-Z330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202429	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.121026	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.251502	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.186389	0	0	0	0	58.00
60.00	06000	LABORATORY	0.300511	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.342657	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.243999	0	0	0	0	65.01
65.02	03160	PULMONARY REHAB	0.316506	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.590272	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	0.490527	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.456727	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294472	0	0	0	0	73.00
76.00	03950	RENEWED HOPE	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.649009	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.742307	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.114877	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1330 | Component CCN: 14-Z330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
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	03950	RENEWED HOPE	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			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 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,577	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,308	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)	1,106	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	586	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)	586	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	49	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)	48	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	732	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)	513	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)	512	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,174,241	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)	7,615	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)	7,460	25.00
26.00	Total swing-bed cost (see instructions)	1,508,039	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,666,202	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,666,202	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,273.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	932,466	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)	932,466	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/7/2018 4:40 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)	1,614,371	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,546,837	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)	653,490	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	652,216	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,305,706	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)	202	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,273.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	257,318	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

	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	716,950	3,174,241	0.225865	257,318	58,119	90.00
91.00	Nursing School cost	0	3,174,241	0.000000	257,318	0	91.00
92.00	Allied health cost	0	3,174,241	0.000000	257,318	0	92.00
93.00	All other Medical Education	0	3,174,241	0.000000	257,318	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		933,720		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202429	2,010,099	406,902	50.00
53.00	05300	ANESTHESIOLOGY	0.121026	645,840	78,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.251502	556,768	140,028	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.186389	33,817	6,303	58.00
60.00	06000	LABORATORY	0.300511	401,452	120,641	60.00
65.00	06500	RESPIRATORY THERAPY	0.342657	502,325	172,125	65.00
65.01	06501	SLEEP LAB	0.243999	0	0	65.01
65.02	03160	PULMONARY REHAB	0.316506	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.590272	87,773	51,810	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.490527	783,019	384,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.456727	102,321	46,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294472	685,697	201,919	73.00
76.00	03950	RENEWED HOPE	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.649009	0	0	90.00
91.00	09100	EMERGENCY	0.742307	7,618	5,655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.114877	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,816,729	1,614,371	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,816,729		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3

Component CCN: 14-Z330 | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202429	5,023	1,017	50.00
53.00	05300	ANESTHESIOLOGY	0.121026	2,387	289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.251502	101,147	25,439	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.186389	0	0	58.00
60.00	06000	LABORATORY	0.300511	180,095	54,121	60.00
65.00	06500	RESPIRATORY THERAPY	0.342657	573,629	196,558	65.00
65.01	06501	SLEEP LAB	0.243999	0	0	65.01
65.02	03160	PULMONARY REHAB	0.316506	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.590272	201,034	118,665	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.490527	80,779	39,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.456727	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294472	472,866	139,246	73.00
76.00	03950	RENEWED HOPE	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.649009	0	0	90.00
91.00	09100	EMERGENCY	0.742307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.114877	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,616,960	574,959	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,616,960		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/7/2018 4:40 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,150,263	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
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 lines 3, 4, and 4.01, 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)	4,150,263	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,191,766	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, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	47,876	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,216,299	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)	1,927,591	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)	1,927,591	30.00
31.00	Primary payer payments	47	31.00
32.00	Subtotal (line 30 minus line 31)	1,927,544	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	174,158	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	113,203	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	54,712	36.00
37.00	Subtotal (see instructions)	2,040,747	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
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)	2,040,747	40.00
40.01	Sequestration adjustment (see instructions)	40,815	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,227,602	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-227,670	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/7/2018 4:40 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		2,235,242		2,209,054	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/07/2017	17,305	12/07/2017	18,548	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		17,305		18,548	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)		2,252,547		2,227,602	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		27,060		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		227,670	6.02
7.00	Total Medicare program liability (see instructions)		2,279,607		1,999,932	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 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/7/2018 4:40 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		1,917,170		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/07/2017	12,828		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		12,828		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,929,998		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		102,629		0	6.02
7.00	Total Medicare program liability (see instructions)		1,827,369		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/7/2018 4:40 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1330 | Component CCN: 14-Z330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 11/7/2018 4:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,318,763	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)	580,709	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,025	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)	1,899,472	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,899,472	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)	1,899,472	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	34,810	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)	1,864,662	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
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)	1,864,662	0	19.00
19.01	Sequestration adjustment (see instructions)	37,293	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,929,998	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)	-102,629	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1330	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/7/2018 4:40 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,546,837	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)	2,546,837	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,546,837	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,546,837	19.00
20.00	Deductibles (exclude professional component)	239,184	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,307,653	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,307,653	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,426	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,477	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,972	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,326,130	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	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,326,130	30.00
30.01	Sequestration adjustment (see instructions)	46,523	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,252,547	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, 30.02, 31, and 32)	27,060	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 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/7/2018 4:40 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,189,746	0	0	0	1.00
2.00	Temporary investments	4,111,057	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,956,905	0	0	0	4.00
5.00	Other receivable	249,428	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	970,637	0	0	0	7.00
8.00	Prepaid expenses	326,087	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,175,959	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,979,819	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	27,335,218	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)	27,335,218	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,681,350	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,681,350	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,996,387	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	951,797	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,031,487	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,329,204	0	0	0	40.00
41.00	Deferred income	450,637	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,475,084	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,238,209	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,852,462	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	105,820	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,958,282	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,196,491	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,799,896				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	25,799,896	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,996,387	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/7/2018 4:40 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		22,859,688		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,922,949				2.00
3.00	Total (sum of line 1 and line 2)		25,782,637		0		3.00
4.00	PRIOR PERIOD ADJUSTMENT	17,259		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		17,259		0		10.00
11.00	Subtotal (line 3 plus line 10)		25,799,896		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,799,896		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			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 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/7/2018 4:40 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,806,973		3,806,973	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	3,463,285		3,463,285	8.00
9.00	OTHER LONG TERM CARE	1,950,415		1,950,415	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,220,673		9,220,673	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)	9,220,673		9,220,673	17.00
18.00	Ancillary services	12,301,887	24,584,772	36,886,659	18.00
19.00	Outpatient services	59,808	3,046,863	3,106,671	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	0	14,689	14,689	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,582,368	27,646,324	49,228,692	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,433,577		29.00
30.00	AUDITOR ADJUSTMENT TO FINANCIAL STAT	13,964			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		13,964		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	INVESTMENT EXPENSES	21,039			38.00
39.00	GAIN/LOSS ON ASSETS -NON OP RV	41,747			39.00
40.00	DISEASE MGMT-POP HLTH GRNT	8,370			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		71,156		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,376,385		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1330 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/7/2018 4:40 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,228,692	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,080,611	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,148,081	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,376,385	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-228,304	5.00
	OTHER INCOME		
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	OTHER (SPECIFY)	0	24.00
24.01	OTHER OPERATING REVENUE	2,914,409	24.01
24.02	NON-OPERATING INCOME	212,716	24.02
24.03	NET ASSEST RELEASED FROM RESTRICTION	24,128	24.03
25.00	Total other income (sum of lines 6-24)	3,151,253	25.00
26.00	Total (line 5 plus line 25)	2,922,949	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
27.03	OTHER EXPENSES (SPECIFY)	0	27.03
27.04	OTHER EXPENSES (SPECIFY)	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)	2,922,949	29.00