

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 12/7/2011 11:14 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input type="checkbox"/> Electronically filed cost report Date: 12/7/2011 Time: 11:14 am 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	96,704	96,550	0	0
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	147,621	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 Skilled Nursing Facility	0	0	0	0	0
8.00 Nursing Facility	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	244,325	96,550	0	0

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.

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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 12/7/2011 Time: 11:14 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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Encryption Information
 ECR: Date: 12/7/2011 Time: 11:14 am
 ce5sASYI FoAEF36WoXnETa7NGJX8j 0
 Q8P7y09zhocFzQ: GBDSCATxdScQXGK
 Win: 0e1WcTOAeCN7
 PI: Date: 12/7/2011 Time: 11:14 am
 NH1nFPBDNeOPW.pGJcOXZe33WO8XMO
 J3paf00vechBKRJb9x5yC2VvKT6t6v
 stDaAzQJju0pVBxg

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	96,704	96,550	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	147,621	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 Skilled Nursing Facility	0	0	0		0	7.00
8.00 Nursing Facility	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	244,325	96,550	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 141330		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 12/6/2011 6:27 pm					
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: SECOND STREET			PO Box:							1.00		
2.00	City: HOPEDALE			State: IL		Zip Code: 61747-		County: TAZEWELL			2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
								V	XVIII	XIX			
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		HOPEDALE MEDICAL COMPLEX	141330	37900	1	10/01/2003	N	0	0	3.00		
4.00	Subprovider - IPF										4.00		
5.00	Subprovider - IRF										5.00		
6.00	Subprovider - (Other)										6.00		
7.00	Swing Beds - SNF		HOPEDALE SWING BED	14Z330	37900		10/01/2003	N	0	N	7.00		
8.00	Swing Beds - NF							N		N	8.00		
9.00	Hospital-Based SNF										9.00		
10.00	Hospital-Based NF							N		N	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) 1										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)						07/01/2010	06/30/2011		20.00			
21.00	Type of Control (see instructions)						2		21.00				
Inpatient PPS Information													
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N	N		22.00			
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 days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	25.00
							1.00						
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								1	26.00			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								1	27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0	35.00			
							Beginning:	Ending:					
							1.00	2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.								0	37.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.									38.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/6/2011 6:27 pm		
		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 the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
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 Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1 the program name. 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
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (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 or "N" for no.			N	80.00	
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.			N	86.00	
				V	XIX	
				1.00	2.00	
Title V or XIX Inpatient 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	N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00

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			V	XIX	
			1.00	2.00	
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
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 yes, enter the method used (A, B, or E only) in column 2.		N		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
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		1,000,000	3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? 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? 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 implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:	Zip Code:		143.00
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330			Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 12/6/2011 6:27 pm		
		1.00		2.00					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00			
149.00	Was the change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00			
		Part A		Part B					
		1.00		2.00					
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		155.00			
156.00	Subprovider - IPF	N		N		156.00			
157.00	Subprovider - IRF	N		N		157.00			
158.00	Subprovider - Other	N		N		158.00			
159.00	SNF	N		N		159.00			
160.00	HHA	N		N		160.00			
161.00	CMHC			N		161.00			
				1.00					
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00			
		Name		County		State		Zip Code	
		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							0.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			N				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/6/2011 6:27 pm
			Y/N	Date
			1.00	2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
			Y/N	Date
			1.00	2.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
			Y/N	Type
			1.00	2.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N	Legal Oper.
			1.00	2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			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.			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N	10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			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		
		Description	Y/N	Date
		0	1.00	2.00
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		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		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		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		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/6/2011 6:27 pm
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		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		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.		Y		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.				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?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-2
Part II
Date/Time Prepared:
12/6/2011 6:27 pm

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
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		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		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	33,696.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					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)		25	9,125	33,696.00	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	33,696.00	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	45.00	74	27,010		20.00
21.00 OTHER LONG TERM CARE	46.00	86	31,390		21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		185			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
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
12/6/2011 6:27 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	920	42	1,422		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	1,213	0	1,395		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	24		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,133	42	2,841		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	2,133	42	2,841		14.00
15.00 CAH visits	0	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		0	17,478		20.00
21.00 OTHER LONG TERM CARE				19,612		21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	394		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		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
12/6/2011 6:27 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	279	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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	192.93	0.00	0	279	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	32.87	0.00			20.00
21.00 OTHER LONG TERM CARE	0.00	15.32	0.00			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	241.12	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
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
12/6/2011 6:27 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	12	558		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				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)	12	558		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				20.00
21.00 OTHER LONG TERM CARE		42		21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				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
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 12/6/2011 6:27 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.418127	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		468,021	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		1,745,933	6.00	
7.00	Medicaid cost (line 1 times line 6)		730,022	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)		262,001	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		262,001	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	747,627	1	747,628	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	312,603	0	312,603	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	312,603	0	312,603	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,253,682	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		52,676	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,201,006	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		502,173	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		814,776	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,076,777	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 12/6/2011 6:27 pm
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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 NEW CAP REL COSTS-BLDG & FIXT		327,469	327,469	280,014	607,483	1.00
1.01 WELLNESS CENTER B&F		58,150	58,150	109,422	167,572	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP		972,279	972,279	-396,332	575,947	2.00
2.01 WELLNESS CENTER MME		0	0	23,087	23,087	2.01
4.00 EMPLOYEE BENEFITS	166,570	1,802,515	1,969,085	22,266	1,991,351	4.00
5.01 PHYSICIAN BILLING OFFICE	106,237	30,220	136,457	0	136,457	5.01
5.02 HOSPITAL BUSINESS OFFICE	152,731	731,270	884,001	0	884,001	5.02
5.03 ADMIN & GENERAL ALL	576,470	1,559,528	2,135,998	22,955	2,158,953	5.03
6.00 MAINTENANCE & REPAIRS	326,632	274,324	600,956	0	600,956	6.00
7.01 WELLNESS CENTER PLANT OP	0	76,250	76,250	0	76,250	7.01
7.02 OPERATION OF PLANT ALL	0	430,566	430,566	0	430,566	7.02
8.00 LAUNDRY & LINEN SERVICE	116,601	19,213	135,814	0	135,814	8.00
9.00 HOUSEKEEPING	117,864	45,423	163,287	0	163,287	9.00
10.00 DIETARY	471,799	436,949	908,748	-142,949	765,799	10.00
11.00 CAFETERIA	0	0	0	142,599	142,599	11.00
13.00 NURSING ADMINISTRATION	0	0	0	96,112	96,112	13.00
14.00 CENTRAL SERVICES & SUPPLY	173,587	165,978	339,565	0	339,565	14.00
15.00 PHARMACY	200,717	27,897	228,614	-5,329	223,285	15.00
16.00 MEDICAL RECORDS & LIBRARY	78,968	298,104	377,072	0	377,072	16.00
17.00 SOCIAL SERVICE	0	0	0	442	442	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,254,983	268,749	1,523,732	-168,669	1,355,063	30.00
45.00 NURSING FACILITY	1,030,887	233,340	1,264,227	7,215	1,271,442	45.00
46.00 OTHER LONG TERM CARE	361,596	194,704	556,300	7,342	563,642	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	386,696	489,784	876,480	-77,869	798,611	50.00
53.00 ANESTHESIOLOGY	14,426	145,646	160,072	-1,808	158,264	53.00
54.00 RADIOLOGY-DIAGNOSTIC	379,293	624,924	1,004,217	18,913	1,023,130	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	97,755	97,755	0	97,755	58.00
60.00 LABORATORY	271,985	582,069	854,054	0	854,054	60.00
65.00 RESPIRATORY THERAPY	282,701	53,224	335,925	4,763	340,688	65.00
66.00 PHYSICAL THERAPY	502,287	69,690	571,977	-5,559	566,418	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	115,959	115,959	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	254,158	254,158	0	254,158	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	267,237	267,237	0	267,237	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	98,736	1,115,819	1,214,555	58,876	1,273,431	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		86,879	86,879	-86,879	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,071,766	11,740,113	18,811,879	24,571	18,836,450	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	306,015	86,895	392,910	0	392,910	192.00
192.01 SATELLITE OFFICES	195,389	38,771	234,160	0	234,160	192.01
194.00 ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01 OUTSIDE PROPERTY	0	3,733	3,733	0	3,733	194.01
194.02 RETAIL PHARMACY	266,995	1,569,813	1,836,808	0	1,836,808	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04 TRIPLEXES	0	0	0	0	0	194.04
194.06 UNUSED SPACE	0	0	0	0	0	194.06
194.07 WELLNESS CENTER	318,314	104,520	422,834	-24,571	398,263	194.07
200.00 TOTAL (SUM OF LINES 118-199)	8,158,479	13,543,845	21,702,324	0	21,702,324	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
	6.00	7.00	
GENERAL SERVICE COST CENTERS			
1.00 NEW CAP REL COSTS-BLDG & FIXT	-4,307	603,176	1.00
1.01 WELLNESS CENTER B&F	-5,425	162,147	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	-148,096	427,851	2.00
2.01 WELLNESS CENTER MME	0	23,087	2.01
4.00 EMPLOYEE BENEFITS	-183,212	1,808,139	4.00
5.01 PHYSICIAN BILLING OFFICE	0	136,457	5.01
5.02 HOSPITAL BUSINESS OFFICE	-48,053	835,948	5.02
5.03 ADMIN & GENERAL ALL	-383,833	1,775,120	5.03
6.00 MAINTENANCE & REPAIRS	0	600,956	6.00
7.01 WELLNESS CENTER PLANT OP	0	76,250	7.01
7.02 OPERATION OF PLANT ALL	0	430,566	7.02
8.00 LAUNDRY & LINEN SERVICE	0	135,814	8.00
9.00 HOUSEKEEPING	0	163,287	9.00
10.00 DIETARY	-432	765,367	10.00
11.00 CAFETERIA	-83,453	59,146	11.00
13.00 NURSING ADMINISTRATION	0	96,112	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	339,565	14.00
15.00 PHARMACY	0	223,285	15.00
16.00 MEDICAL RECORDS & LIBRARY	-4,666	372,406	16.00
17.00 SOCIAL SERVICE	0	442	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	-666	1,354,397	30.00
45.00 NURSING FACILITY	-7,204	1,264,238	45.00
46.00 OTHER LONG TERM CARE	-14,368	549,274	46.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	-7,490	791,121	50.00
53.00 ANESTHESIOLOGY	-125,988	32,276	53.00
54.00 RADIOLOGY-DIAGNOSTIC	-109,730	913,400	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	97,755	58.00
60.00 LABORATORY	0	854,054	60.00
65.00 RESPIRATORY THERAPY	-3,033	337,655	65.00
66.00 PHYSICAL THERAPY	-6,868	559,550	66.00
69.00 ELECTROCARDIOLOGY	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115,959	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	254,158	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	267,237	73.00
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	-349,096	924,335	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-1,485,920	17,350,530	118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	392,910	192.00
192.01 SATELLITE OFFICES	0	234,160	192.01
194.00 ARC (HOPEDALE HALL)	0	0	194.00
194.01 OUTSIDE PROPERTY	0	3,733	194.01
194.02 RETAIL PHARMACY	0	1,836,808	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	194.03
194.04 TRIPLEXES	0	0	194.04
194.06 UNUSED SPACE	0	0	194.06
194.07 WELLNESS CENTER	0	398,263	194.07
200.00 TOTAL (SUM OF LINES 118-199)	-1,485,920	20,216,404	200.00

RECLASSIFICATIONS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-6
Date/Time Prepared:
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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	71,894	70,705	1.00	
	TOTALS		71,894	70,705		
B - INTEREST RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,043	1.00	
2.00	WELLNESS CENTER B&F	1.01	0	6,352	2.00	
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,796	3.00	
4.00	ADMIN & GENERAL ALL	5.03	0	22,955	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	780	5.00	
6.00	NURSING FACILITY	45.00	0	7,088	6.00	
7.00	OTHER LONG TERM CARE	46.00	0	6,527	7.00	
8.00	OPERATING ROOM	50.00	0	8,770	8.00	
9.00	ANESTHESIOLOGY	53.00	0	1,961	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,056	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	3,551	11.00	
	TOTALS		0	86,879		
C - ER NURSING RECLASS						
1.00	EMERGENCY	91.00	61,614	0	1.00	
	TOTALS		61,614	0		
D - BUILDING DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	378,041	1.00	
	TOTALS		0	378,041		
E - DEFAULT						
1.00	WELLNESS CENTER B&F	1.01	0	103,070	1.00	
2.00	WELLNESS CENTER MME	2.01	0	23,087	2.00	
	TOTALS		0	126,157		
F - NURSING ADMIN RECLASS						
1.00	NURSING ADMINISTRATION	13.00	96,112	0	1.00	
	TOTALS		96,112	0		
G - WELLNESS CENTER RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	16,762	5,504	1.00	
2.00	NURSING FACILITY	45.00	110	36	2.00	
3.00	OTHER LONG TERM CARE	46.00	614	201	3.00	
4.00	RESPIRATORY THERAPY	65.00	994	327	4.00	
5.00	PHYSICAL THERAPY	66.00	17	6	5.00	
	TOTALS		18,497	6,074		
H - SOCIAL SERVICE RECLASS						
1.00	SOCIAL SERVICE	17.00	0	442	1.00	
	TOTALS		0	442		
I - MEDICAL SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	115,959	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	115,959		
500.00	Grand Total: Increases		248,117	784,257	500.00	

RECLASSIFICATIONS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-6

Date/Time Prepared:
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		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	71,894	70,705	0		1.00
	TOTALS		71,894	70,705			
B - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	86,879	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	TOTALS		0	86,879			
C - ER NURSING RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	61,614	0	0		1.00
	TOTALS		61,614	0			
D - BUILDING DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	378,041	9		1.00
	TOTALS		0	378,041			
E - DEFAULT							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	103,070	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	23,087	9		2.00
	TOTALS		0	126,157			
F - NURSING ADMIN RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	96,112	0	0		1.00
	TOTALS		96,112	0			
G - WELLNESS CENTER RECLASS							
1.00	WELLNESS CENTER	194.07	18,497	6,074	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		18,497	6,074			
H - SOCIAL SERVICE RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	442	0		1.00
	TOTALS		0	442			
I - MEDICAL SUPPLY RECLASS							
1.00	DIETARY	10.00	0	350	0		1.00
2.00	PHARMACY	15.00	0	5,329	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	11,281	0		3.00
4.00	NURSING FACILITY	45.00	0	19	0		4.00
5.00	OPERATING ROOM	50.00	0	86,639	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	3,769	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	143	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	109	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	5,582	0		9.00
10.00	EMERGENCY	91.00	0	2,738	0		10.00
	TOTALS		0	115,959			
500.00	Grand Total: Decreases		248,117	784,257			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	663,463	88,804	0	88,804	0	1.00
2.00	Land Improvements	407,284	10,400	0	10,400	0	2.00
3.00	Buildings and Fixtures	17,657,403	856,122	0	856,122	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	12,561,026	0	0	0	786,690	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,289,176	955,326	0	955,326	786,690	8.00
9.00	Reconciling Items	-1,692,633	-133,957	0	-133,957	0	9.00
10.00	Total (line 8 minus line 9)	32,981,809	1,089,283	0	1,089,283	786,690	10.00
SUMMARY OF CAPITAL							
Cost Center Description		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	NEW CAP REL COSTS-BLDG & FIXT	327,469	0	0	0	0	1.00
1.01	WELLNESS CENTER B&F	58,150	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	972,279	0	0	0	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,357,898	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	19,683,476	0	19,683,476	0.625710	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11,774,336	0	11,774,336	0.374290	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	31,457,812	0	31,457,812	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	752,267	0			1.00	
2.00	Land Improvements	417,684	0			2.00	
3.00	Buildings and Fixtures	18,513,525	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	11,774,336	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	31,457,812	0			8.00	
9.00	Reconciling Items	-1,826,590	0			9.00	
10.00	Total (line 8 minus line 9)	33,284,402	0			10.00	
SUMMARY OF CAPITAL							
Cost Center Description		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	NEW CAP REL COSTS-BLDG & FIXT	0	327,469			1.00	
1.01	WELLNESS CENTER B&F	0	58,150			1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	972,279			2.00	
2.01	WELLNESS CENTER MME	0	0			2.01	
3.00	Total (sum of lines 1-2)	0	1,357,898			3.00	
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	602,440	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	161,220	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	571,151	-144,000	2.00
2.01	WELLNESS CENTER MME	0	0	0	23,087	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,357,898	-144,000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	736	0	0	0	603,176	1.00
1.01	WELLNESS CENTER B&F	927	0	0	0	162,147	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	700	0	0	0	427,851	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	23,087	2.01
3.00	Total (sum of lines 1-2)	2,363	0	0	0	1,216,261	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8

Date/Time Prepared:
12/6/2011 6:27 pm

	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #		
			1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)	B	-4,307	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)	B	-4,096	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-19,604	ADMIN & GENERAL ALL	5.03	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-727	ADMIN & GENERAL ALL	5.03	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,701	HOSPITAL BUSINESS OFFICE	5.02	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-257,873			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-83,453	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-4,666	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	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 - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	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
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		0		0.00	32.00
33.00	INTEREST INCOME OFFSET	B	-5,425	WELLNESS CENTER B&F	1.01	33.00
33.01	INTEREST INCOME OFFSET	B	-666	ADULTS & PEDIATRICS	30.00	33.01
33.02	INTEREST INCOME OFFSET	B	-6,053	NURSING FACILITY	45.00	33.02
33.03	INTEREST INCOME OFFSET	B	-5,575	OTHER LONG TERM CARE	46.00	33.03
33.04	INTEREST INCOME OFFSET	B	-7,490	OPERATING ROOM	50.00	33.04
33.05	INTEREST INCOME OFFSET	B	-1,675	ANESTHESIOLOGY	53.00	33.05
33.06	INTEREST INCOME OFFSET	B	-16,274	RADIOLOGY-DIAGNOSTIC	54.00	33.06
33.07	INTEREST INCOME OFFSET	B	-3,033	RESPIRATORY THERAPY	65.00	33.07
33.08	EMPLOYEE CHILD CARE REV	B	-180,957	EMPLOYEE BENEFITS	4.00	33.08
34.00	MISC INCOME	B	-260	ADMIN & GENERAL ALL	5.03	34.00
34.01	DIETITIAN	B	-320	DIETARY	10.00	34.01
34.02	OTHER INCOME OLTC	B	-1,031	OTHER LONG TERM CARE	46.00	34.02
34.03	PHYSICAL THERAPY MISC REV	B	-755	PHYSICAL THERAPY	66.00	34.03
34.04	ALCOHOLIC BEVERAGES	A	-644	ADMIN & GENERAL ALL	5.03	34.04
34.05	ANESTH ON-CALL TIME	A	-120,725	ANESTHESIOLOGY	53.00	34.05
34.06	NON-ALLO ADVERTISING SALARIES	A	-29,329	ADMIN & GENERAL ALL	5.03	34.06
34.07	ADVERTISING/MARKETING EXPENSE	A	-126,479	ADMIN & GENERAL ALL	5.03	34.07
34.08	MARKETING DIET	A	-112	DIETARY	10.00	34.08
34.09	MARKETING NURSING HOME	A	-582	NURSING FACILITY	45.00	34.09
34.10	MARKETING OLTC	A	-7,140	OTHER LONG TERM CARE	46.00	34.10

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8

Date/Time Prepared:
12/6/2011 6:27 pm

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
34.11	MARKETING RAD	A	-100	RADIOLOGY-DIAGNOSTIC	54.00 34.11
34.12	MARKETING - MRI MOBI	A	-336	RADIOLOGY-DIAGNOSTIC	54.00 34.12
34.13	MARKETING PT	A	-6,113	PHYSICAL THERAPY	66.00 34.13
34.14			0		0.00 34.14
34.15			0		0.00 34.15
35.00			0		0.00 35.00
36.00			0		0.00 36.00
37.00	CHARITABLE CONTRIBUTIONS	A	-11,408	ADMIN & GENERAL ALL	5.03 37.00
38.00	TELEPHONE EMP BENEFIT EXPENSE	A	-1,469	EMPLOYEE BENEFITS	4.00 38.00
38.01	PATIENT TELEVISION EXPENSE	A	-446	ADMIN & GENERAL ALL	5.03 38.01
38.02	PATIENT TELEVISION	A	-837	HOSPITAL BUSINESS OFFICE	5.02 38.02
38.03	PATIENT TELEVISION	A	-569	NURSING FACILITY	45.00 38.03
38.04	PATIENT TELEVISION	A	-622	OTHER LONG TERM CARE	46.00 38.04
39.00	CAPITAL CAMPAIGN EXPENSE	A	-4,961	ADMIN & GENERAL ALL	5.03 39.00
39.02	MEDI CAID ASSESSMENT	A	-40,515	HOSPITAL BUSINESS OFFICE	5.02 39.02
40.00	MEDI CAID ASSESSMENT	A	-182,348	ADMIN & GENERAL ALL	5.03 40.00
41.00	CRNA NURSING SALARY OFFSET	A	-3,588	ANESTHESIOLOGY	53.00 41.00
42.00	CRNA NURSING EMP BENEFITS OFFSET	A	-786	EMPLOYEE BENEFITS	4.00 42.00
43.00			0		0.00 43.00
44.00	ER PHYSICIAN ASSISTANT - SALARIES	A	-74,824	EMERGENCY	91.00 44.00
45.01	ER PHYSICIAN ASSISTANT - BENEFITS	A	-16,399	EMERGENCY	91.00 45.01
45.02	IHA LOBBYING DUES	A	-7,627	ADMIN & GENERAL ALL	5.03 45.02
45.03	LEASE ADJUSTMENTS - CSK-2	A	-93,020	RADIOLOGY-DIAGNOSTIC	54.00 45.03
45.05	LEASE ADJUSTMENTS - CSK-3	A	-144,000	NEW CAP REL COSTS-MVBLE EQUIP	2.00 45.05
45.06			0		0.00 45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,485,920		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8
Date/Time Prepared:
12/6/2011 6:27 pm

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	11	1.00
2.00	Investment income - movable equipment (chapter 2)	11	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	INTEREST INCOME OFFSET	11	33.00
33.01	INTEREST INCOME OFFSET	0	33.01
33.02	INTEREST INCOME OFFSET	0	33.02
33.03	INTEREST INCOME OFFSET	0	33.03
33.04	INTEREST INCOME OFFSET	0	33.04
33.05	INTEREST INCOME OFFSET	0	33.05
33.06	INTEREST INCOME OFFSET	0	33.06
33.07	INTEREST INCOME OFFSET	0	33.07
33.08	EMPLOYEE CHILD CARE REV	0	33.08
34.00	MISC INCOME	0	34.00
34.01	DIETITIAN	0	34.01
34.02	OTHER INCOME OLTC	0	34.02
34.03	PHYSICAL THERAPY MISC REV	0	34.03
34.04	ALCOHOLIC BEVERAGES	0	34.04
34.05	ANESTH ON-CALL TIME	0	34.05
34.06	NON-ALLO ADVERTISING SALARIES	0	34.06
34.07	ADVERTISING/MARKETING EXPENSE	0	34.07
34.08	MARKETING DIET	0	34.08
34.09	MARKETING NURSING HOME	0	34.09
34.10	MARKETING OLTC	0	34.10
34.11	MARKETING RAD	0	34.11
34.12	MARKETING - MRI MOBI	0	34.12
34.13	MARKETING PT	0	34.13
34.14		0	34.14
34.15		0	34.15
35.00		0	35.00
36.00		0	36.00
37.00	CHARITABLE CONTRIBUTIONS	0	37.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8

Date/Time Prepared:
12/6/2011 6:27 pm

		Wkst. A-7 Ref.	
		5.00	
38.00	TELEPHONE EMP BENEFIT EXPENSE	0	38.00
38.01	PATIENT TELEVISION EXPENSE	0	38.01
38.02	PATIENT TELEVISION	0	38.02
38.03	PATIENT TELEVISION	0	38.03
38.04	PATIENT TELEVISION	0	38.04
39.00	CAPITAL CAMPAIGN EXPENSE	0	39.00
39.02	MEDI CAID ASSESSMENT	0	39.02
40.00	MEDI CAID ASSESSMENT	0	40.00
41.00	CRNA NURSING SALARY OFFSET	0	41.00
42.00	CRNA NURSING EMP BENEFITS OFFSET	0	42.00
43.00		0	43.00
44.00	ER PHYSICIAN ASSISTANT - SALARIES	0	44.00
45.01	ER PHYSICIAN ASSISTANT - BENEFITS	0	45.01
45.02	IHA LOBBYING DUES	0	45.02
45.03	LEASE ADJUSTMENTS - CSK-2	0	45.03
45.05	LEASE ADJUSTMENTS - CSK-3	10	45.05
45.06		0	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-1

Date/Time Prepared:
12/6/2011 6:27 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
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	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	MME	2.00
3.00	4.00	EMPLOYEE BENEFITS	EMP BENEFITS	3.00
4.00	5.01	PHYSICIAN BILLING OFFICE	PHYS BILLING	4.00
4.01	5.03	ADMIN & GENERAL ALL	A&G ALL	4.01
4.02	6.00	MAINTENANCE & REPAIRS	MAINT AND REPAIRS	4.02
4.03	7.02	OPERATION OF PLANT ALL	PLANT OP ALL	4.03
4.04	192.00	PHYSICIANS' PRIVATE OFFICES	PHYS OFFICES	4.04
4.06	192.01	SATELLITE OFFICES	SATELLITE OFFICES	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	G	HOPEDALE MEDICA	0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00
		FAMILY RELATION		

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 141330
 Period: From 07/01/2010 To 06/30/2011
 Worksheet A-8-1
 Date/Time Prepared: 12/6/2011 6:27 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	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	203,224	203,224	0	0	1.00
2.00	4,837	4,837	0	9	2.00
3.00	51,199	51,199	0	0	3.00
4.00	136,456	136,456	0	0	4.00
4.01	14,870	14,870	0	0	4.01
4.02	7,013	7,013	0	0	4.02
4.03	23,754	23,754	0	0	4.03
4.04	392,909	392,909	0	0	4.04
4.06	234,158	234,158	0	0	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,068,420	1,068,420	0	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		
	Name	Percentage of Ownership	Type of Business
	4.00	5.00	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	ROSSI PHYSICIAN	0.00	PHYSICIANS	6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
12/6/2011 6:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	LOCUM TENENS ROSSI ER PHYS	227,136	14,196	1.00
2.00	50.00	PROF. SERVICES-SURGERY	0	0	2.00
3.00	60.00	PROFESSIONAL SERVICES-LAB	0	0	3.00
4.00	91.00	EMERGENCY	874,214	243,677	4.00
5.00	66.00	PHYSICAL THERAPY DIRECTOR	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
200.00		TOTAL (lines 1.00 through 199.00)	1,101,350	257,873	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
12/6/2011 6:27 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	212,940	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	630,538	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	843,478		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
12/6/2011 6:27 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2
Date/Time Prepared:
12/6/2011 6:27 pm

	RCE	Adjustment	
	Disallowance	18.00	
	17.00		
1.00	0	14,196	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	243,677	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	257,873	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
12/6/2011 6:27 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	WELLNESS CENTER B&F	NEW MVBLE EQUIP	WELLNESS CENTER MME	
		0	1.00	1.01	2.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	603,176	603,176				1.00
1.01 WELLNESS CENTER B&F	162,147	0	162,147			1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	427,851			427,851		2.00
2.01 WELLNESS CENTER MME	23,087			0	23,087	2.01
4.00 EMPLOYEE BENEFITS	1,808,139	37,125	31,417	1,352	5,466	4.00
5.01 PHYSICIAN BILLING OFFICE	136,457	3,913	0	0	0	5.01
5.02 HOSPITAL BUSINESS OFFICE	835,948	12,455	0	7,554	0	5.02
5.03 ADMIN & GENERAL ALL	1,775,120	45,741	5,961	64,995	0	5.03
6.00 MAINTENANCE & REPAIRS	600,956	5,367	0	1,801	0	6.00
7.01 WELLNESS CENTER PLANT OP	76,250	0	0	0	0	7.01
7.02 OPERATION OF PLANT ALL	430,566	3,370	0	37,351	0	7.02
8.00 LAUNDRY & LINEN SERVICE	135,814	10,474	0	2,321	0	8.00
9.00 HOUSEKEEPING	163,287	2,345	0	0	0	9.00
10.00 DIETARY	765,367	12,548	0	3,249	0	10.00
11.00 CAFETERIA	59,146	17,397	0	0	0	11.00
13.00 NURSING ADMINISTRATION	96,112	2,242	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	339,565	12,062	0	0	0	14.00
15.00 PHARMACY	223,285	2,294	0	3,409	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	372,406	15,023	689	0	0	16.00
17.00 SOCIAL SERVICE	442	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,354,397	34,730	0	55,405	0	30.00
45.00 NURSING FACILITY	1,264,238	99,208	208	4,091	36	45.00
46.00 OTHER LONG TERM CARE	549,274	203,473	1,151	5,595	200	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	791,121	23,805	0	41,886	0	50.00
53.00 ANESTHESIOLOGY	32,276	639	0	23,032	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	913,400	20,994	0	133,220	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	97,755	0	0	0	0	58.00
60.00 LABORATORY	854,054	7,730	0	10,741	0	60.00
65.00 RESPIRATORY THERAPY	337,655	2,993	9,970	14,296	325	65.00
66.00 PHYSICAL THERAPY	559,550	1,575	32,402	9,678	3,075	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	115,959	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	254,158	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	267,237	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	924,335	5,970	0	1,848	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	17,350,530	583,473	81,798	421,824	9,102	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	392,910	0	0	1,683	0	192.00
192.01 SATELLITE OFFICES	234,160	0	0	2,245	0	192.01
194.00 ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01 OUTSIDE PROPERTY	3,733	0	0	0	0	194.01
194.02 RETAIL PHARMACY	1,836,808	0	0	247	0	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04 TRIPLEXES	0	0	0	0	0	194.04
194.06 UNUSED SPACE	0	19,703	0	0	0	194.06
194.07 WELLNESS CENTER	398,263	0	80,349	1,852	13,985	194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	20,216,404	603,176	162,147	427,851	23,087	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part I Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description		EMPLOYEE BENEFITS	Subtotal	PHYSICIAN BILLING OFFICE	HOSPITAL BUSINESS OFFICE	Subtotal	
		4.00	4A	5.01	5.02	5A.02	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	WELLNESS CENTER B&F						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	WELLNESS CENTER MME						2.01
4.00	EMPLOYEE BENEFITS	1,883,499					4.00
5.01	PHYSICIAN BILLING OFFICE	25,533	165,903	165,903			5.01
5.02	HOSPITAL BUSINESS OFFICE	35,097	891,054	0	891,054		5.02
5.03	ADMIN & GENERAL ALL	131,500	2,023,317	0	0	2,023,317	5.03
6.00	MAINTENANCE & REPAIRS	78,503	686,627	0	0	686,627	6.00
7.01	WELLNESS CENTER PLANT OP	0	76,250	0	0	76,250	7.01
7.02	OPERATION OF PLANT ALL	0	471,287	0	0	471,287	7.02
8.00	LAUNDRY & LINEN SERVICE	28,024	176,633	0	0	176,633	8.00
9.00	HOUSEKEEPING	28,328	193,960	0	0	193,960	9.00
10.00	DIETARY	96,114	877,278	0	0	877,278	10.00
11.00	CAFETERIA	17,279	93,822	0	0	93,822	11.00
13.00	NURSING ADMINISTRATION	23,100	121,454	0	0	121,454	13.00
14.00	CENTRAL SERVICES & SUPPLY	41,720	393,347	0	0	393,347	14.00
15.00	PHARMACY	48,241	277,229	0	0	277,229	15.00
16.00	MEDICAL RECORDS & LIBRARY	18,979	407,097	0	0	407,097	16.00
17.00	SOCIAL SERVICE	0	442	0	0	442	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	263,711	1,708,243	0	121,325	1,829,568	30.00
45.00	NURSING FACILITY	247,791	1,615,572	0	0	1,615,572	45.00
46.00	OTHER LONG TERM CARE	87,054	846,747	0	0	846,747	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	92,939	949,751	0	214,364	1,164,115	50.00
53.00	ANESTHESIOLOGY	2,605	58,552	0	47,983	106,535	53.00
54.00	RADIOLOGY-DIAGNOSTIC	91,160	1,158,774	0	191,040	1,349,814	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	97,755	0	17,611	115,366	58.00
60.00	LABORATORY	65,369	937,894	0	107,116	1,045,010	60.00
65.00	RESPIRATORY THERAPY	68,184	433,423	0	33,028	466,451	65.00
66.00	PHYSICAL THERAPY	120,724	727,004	0	42,028	769,032	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115,959	0	17,977	133,936	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	254,158	0	12,616	266,774	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	267,237	0	51,209	318,446	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	14,808	946,961	0	34,757	981,718	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,626,763	16,973,730	0	891,054	16,807,827	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	73,548	468,141	23,951	0	492,092	192.00
192.01	SATELLITE OFFICES	46,960	283,365	14,498	0	297,863	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	0	3,733	191	0	3,924	194.01
194.02	RETAIL PHARMACY	64,170	1,901,225	97,271	0	1,998,496	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	0	0	0	194.04
194.06	UNUSED SPACE	0	19,703	1,008	0	20,711	194.06
194.07	WELLNESS CENTER	72,058	566,507	28,984	0	595,491	194.07
200.00	Cross Foot Adjustments		0			0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,883,499	20,216,404	165,903	891,054	20,216,404	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMIN & GENERAL ALL	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	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	WELLNESS CENTER B&F						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	WELLNESS CENTER MME						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.01	PHYSICIAN BILLING OFFICE						5.01
5.02	HOSPITAL BUSINESS OFFICE						5.02
5.03	ADMIN & GENERAL ALL	2,023,317					5.03
6.00	MAINTENANCE & REPAIRS	76,363	762,990				6.00
7.01	WELLNESS CENTER PLANT OP	8,480	92,234	176,964			7.01
7.02	OPERATION OF PLANT ALL	52,414	319,930	0	843,631		7.02
8.00	LAUNDRY & LINEN SERVICE	19,644	6,792	0	38,393	241,462	8.00
9.00	HOUSEKEEPING	21,571	0	0	8,594	13,824	9.00
10.00	DIETARY	97,566	23,661	0	45,992	223	10.00
11.00	CAFETERIA	10,434	3,067	0	63,766	0	11.00
13.00	NURSING ADMINISTRATION	13,507	0	0	8,220	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	43,746	2,702	0	44,212	0	14.00
15.00	PHARMACY	30,832	2,629	0	8,407	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	45,275	9,128	977	55,067	0	16.00
17.00	SOCIAL SERVICE	49	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	203,474	134,882	0	127,299	40,704	30.00
45.00	NURSING FACILITY	179,674	0	295	0	134,402	45.00
46.00	OTHER LONG TERM CARE	94,170	55,428	1,633	0	1,844	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	129,466	25,414	0	87,254	20,476	50.00
53.00	ANESTHESIOLOGY	11,848	0	0	2,342	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	150,118	11,684	0	76,950	4,741	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	12,830	0	0	0	0	58.00
60.00	LABORATORY	116,220	7,084	0	28,335	0	60.00
65.00	RESPIRATORY THERAPY	51,876	4,455	14,140	10,971	655	65.00
66.00	PHYSICAL THERAPY	85,527	6,719	45,956	5,772	6,205	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,896	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	29,669	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	35,416	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	109,181	2,848	0	21,884	7,229	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,644,246	708,657	63,001	633,458	230,303	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	54,728	18,038	0	0	4,105	192.00
192.01	SATELLITE OFFICES	33,127	13,291	0	126,233	2,218	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	436	20,156	0	0	0	194.01
194.02	RETAIL PHARMACY	222,250	2,848	0	7,716	0	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	0	76,224	0	194.04
194.06	UNUSED SPACE	2,303	0	0	0	0	194.06
194.07	WELLNESS CENTER	66,227	0	113,963	0	4,836	194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,023,317	762,990	176,964	843,631	241,462	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 WELLNESS CENTER B&F						1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 WELLNESS CENTER MME						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 PHYSICIAN BILLING OFFICE						5.01
5.02 HOSPITAL BUSINESS OFFICE						5.02
5.03 ADMIN & GENERAL ALL						5.03
6.00 MAINTENANCE & REPAIRS						6.00
7.01 WELLNESS CENTER PLANT OP						7.01
7.02 OPERATION OF PLANT ALL						7.02
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING	237,949					9.00
10.00 DIETARY	0	1,044,720				10.00
11.00 CAFETERIA	0	0	171,089			11.00
13.00 NURSING ADMINISTRATION	0	0	1,270	144,451		13.00
14.00 CENTRAL SERVICES & SUPPLY	137	0	6,149	0	490,293	14.00
15.00 PHARMACY	0	0	2,942	0	3,203	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,099	0	3,218	0	43	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	46,765	77,116	28,428	128,439	47,441	30.00
45.00 NURSING FACILITY	78,530	478,937	34,790	0	15,289	45.00
46.00 OTHER LONG TERM CARE	67,881	488,667	16,215	0	4,150	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	9,272	0	140,717	50.00
53.00 ANESTHESIOLOGY	0	0	222	0	5,643	53.00
54.00 RADIOLOGY-DIAGNOSTIC	7,924	0	10,679	0	17,279	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	6,642	0	8,816	0	154,008	60.00
65.00 RESPIRATORY THERAPY	0	0	6,731	0	14,920	65.00
66.00 PHYSICAL THERAPY	0	0	10,182	0	2,154	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	52,266	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	0	3,546	16,012	6,744	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	208,978	1,044,720	142,460	144,451	463,857	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	23,635	0	11,833	0	5,442	192.00
192.01 SATELLITE OFFICES	0	0	0	0	7,012	192.01
194.00 ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01 OUTSIDE PROPERTY	5,290	0	0	0	1,574	194.01
194.02 RETAIL PHARMACY	0	0	5,461	0	6,413	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04 TRIPLEXES	0	0	0	0	0	194.04
194.06 UNUSED SPACE	0	0	0	0	0	194.06
194.07 WELLNESS CENTER	46	0	11,335	0	5,995	194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	237,949	1,044,720	171,089	144,451	490,293	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 WELLNESS CENTER B&F						1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 WELLNESS CENTER MME						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 PHYSICIAN BILLING OFFICE						5.01
5.02 HOSPITAL BUSINESS OFFICE						5.02
5.03 ADMIN & GENERAL ALL						5.03
6.00 MAINTENANCE & REPAIRS						6.00
7.01 WELLNESS CENTER PLANT OP						7.01
7.02 OPERATION OF PLANT ALL						7.02
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	325,242					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	521,904				16.00
17.00 SOCIAL SERVICE	0	0	491			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	71,065	491	2,735,672	0	30.00
45.00 NURSING FACILITY	0	0	0	2,537,489	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	1,576,735	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	125,539	0	1,702,253	0	50.00
53.00 ANESTHESIOLOGY	0	28,106	0	154,696	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	111,900	0	1,741,089	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	10,315	0	138,511	0	58.00
60.00 LABORATORY	0	62,742	0	1,428,857	0	60.00
65.00 RESPIRATORY THERAPY	0	19,346	0	589,545	0	65.00
66.00 PHYSICAL THERAPY	0	24,617	0	956,164	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,530	0	211,628	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	7,390	0	303,833	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	325,242	29,995	0	709,099	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	20,359	0	1,169,521	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	325,242	521,904	491	15,955,092	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	609,873	0	192.00
192.01 SATELLITE OFFICES	0	0	0	479,744	0	192.01
194.00 ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01 OUTSIDE PROPERTY	0	0	0	31,380	0	194.01
194.02 RETAIL PHARMACY	0	0	0	2,243,184	0	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04 TRIPLEXES	0	0	0	76,224	0	194.04
194.06 UNUSED SPACE	0	0	0	23,014	0	194.06
194.07 WELLNESS CENTER	0	0	0	797,893	0	194.07
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	325,242	521,904	491	20,216,404	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	WELLNESS CENTER B&F		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	WELLNESS CENTER MME		2.01
4.00	EMPLOYEE BENEFITS		4.00
5.01	PHYSICIAN BILLING OFFICE		5.01
5.02	HOSPITAL BUSINESS OFFICE		5.02
5.03	ADMIN & GENERAL ALL		5.03
6.00	MAINTENANCE & REPAIRS		6.00
7.01	WELLNESS CENTER PLANT OP		7.01
7.02	OPERATION OF PLANT ALL		7.02
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
15.00	PHARMACY		15.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
17.00	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,735,672	30.00
45.00	NURSING FACILITY	2,537,489	45.00
46.00	OTHER LONG TERM CARE	1,576,735	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	1,702,253	50.00
53.00	ANESTHESIOLOGY	154,696	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,741,089	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	138,511	58.00
60.00	LABORATORY	1,428,857	60.00
65.00	RESPIRATORY THERAPY	589,545	65.00
66.00	PHYSICAL THERAPY	956,164	66.00
69.00	ELECTROCARDIOLOGY	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	211,628	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	303,833	72.00
73.00	DRUGS CHARGED TO PATIENTS	709,099	73.00
OUTPATIENT SERVICE COST CENTERS			
91.00	EMERGENCY	1,169,521	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	15,955,092	118.00
NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	609,873	192.00
192.01	SATELLITE OFFICES	479,744	192.01
194.00	ARC (HOPEDALE HALL)	0	194.00
194.01	OUTSIDE PROPERTY	31,380	194.01
194.02	RETAIL PHARMACY	2,243,184	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	194.03
194.04	TRIPLEXES	76,224	194.04
194.06	UNUSED SPACE	23,014	194.06
194.07	WELLNESS CENTER	797,893	194.07
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	20,216,404	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
12/6/2011 6:27 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	WELLNESS CENTER B&F	NEW MVBLE EQUIP	WELLNESS CENTER MME	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	WELLNESS CENTER B&F					1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	WELLNESS CENTER MME					2.01
4.00	EMPLOYEE BENEFITS	0	37,125	31,417	1,352	5,466
5.01	PHYSICIAN BILLING OFFICE	0	3,913	0	0	0
5.02	HOSPITAL BUSINESS OFFICE	0	12,455	0	7,554	0
5.03	ADMIN & GENERAL ALL	0	45,741	5,961	64,995	0
6.00	MAINTENANCE & REPAIRS	0	5,367	0	1,801	0
7.01	WELLNESS CENTER PLANT OP	0	0	0	0	0
7.02	OPERATION OF PLANT ALL	0	3,370	0	37,351	0
8.00	LAUNDRY & LINEN SERVICE	0	10,474	0	2,321	0
9.00	HOUSEKEEPING	0	2,345	0	0	0
10.00	DIETARY	0	12,548	0	3,249	0
11.00	CAFETERIA	0	17,397	0	0	0
13.00	NURSING ADMINISTRATION	0	2,242	0	0	0
14.00	CENTRAL SERVICES & SUPPLY	0	12,062	0	0	0
15.00	PHARMACY	0	2,294	0	3,409	0
16.00	MEDICAL RECORDS & LIBRARY	0	15,023	689	0	0
17.00	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	34,730	0	55,405	0
45.00	NURSING FACILITY	0	99,208	208	4,091	36
46.00	OTHER LONG TERM CARE	0	203,473	1,151	5,595	200
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	23,805	0	41,886	0
53.00	ANESTHESIOLOGY	0	639	0	23,032	0
54.00	RADIOLOGY-DIAGNOSTIC	0	20,994	0	133,220	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	LABORATORY	0	7,730	0	10,741	0
65.00	RESPIRATORY THERAPY	0	2,993	9,970	14,296	325
66.00	PHYSICAL THERAPY	0	1,575	32,402	9,678	3,075
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	5,970	0	1,848	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	583,473	81,798	421,824	9,102
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,683	0
192.01	SATELLITE OFFICES	0	0	0	2,245	0
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	OUTSIDE PROPERTY	0	0	0	0	0
194.02	RETAIL PHARMACY	0	0	0	247	0
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
194.04	TRIPLEXES	0	0	0	0	0
194.06	UNUSED SPACE	0	19,703	0	0	0
194.07	WELLNESS CENTER	0	0	80,349	1,852	13,985
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	603,176	162,147	427,851	23,087

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 141330		Period: From 07/01/2010 To 06/30/2011		Worksheet B Part II Date/Time Prepared: 12/6/2011 6:27 pm	
Cost Center Description		Subtotal	EMPLOYEE BENEFITS	PHYSICIAN BILLING OFFICE	HOSPITAL BUSINESS OFFICE	ADMIN & GENERAL ALL	
		2A	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	WELLNESS CENTER B&F						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	WELLNESS CENTER MME						2.01
4.00	EMPLOYEE BENEFITS	75,360	75,360				4.00
5.01	PHYSICIAN BILLING OFFICE	3,913	1,022	4,935			5.01
5.02	HOSPITAL BUSINESS OFFICE	20,009	1,404	0	21,413		5.02
5.03	ADMIN & GENERAL ALL	116,697	5,261	0	0	121,958	5.03
6.00	MAINTENANCE & REPAIRS	7,168	3,141	0	0	4,603	6.00
7.01	WELLNESS CENTER PLANT OP	0	0	0	0	511	7.01
7.02	OPERATION OF PLANT ALL	40,721	0	0	0	3,160	7.02
8.00	LAUNDRY & LINEN SERVICE	12,795	1,121	0	0	1,184	8.00
9.00	HOUSEKEEPING	2,345	1,133	0	0	1,300	9.00
10.00	DIETARY	15,797	3,845	0	0	5,881	10.00
11.00	CAFETERIA	17,397	691	0	0	629	11.00
13.00	NURSING ADMINISTRATION	2,242	924	0	0	814	13.00
14.00	CENTRAL SERVICES & SUPPLY	12,062	1,669	0	0	2,637	14.00
15.00	PHARMACY	5,703	1,930	0	0	1,859	15.00
16.00	MEDICAL RECORDS & LIBRARY	15,712	759	0	0	2,729	16.00
17.00	SOCIAL SERVICE	0	0	0	0	3	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	90,135	10,557	0	2,913	12,265	30.00
45.00	NURSING FACILITY	103,543	9,914	0	0	10,831	45.00
46.00	OTHER LONG TERM CARE	210,419	3,483	0	0	5,677	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	65,691	3,718	0	5,163	7,804	50.00
53.00	ANESTHESIOLOGY	23,671	104	0	1,152	714	53.00
54.00	RADIOLOGY-DIAGNOSTIC	154,214	3,647	0	4,588	9,049	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	423	773	58.00
60.00	LABORATORY	18,471	2,615	0	2,572	7,006	60.00
65.00	RESPIRATORY THERAPY	27,584	2,728	0	793	3,127	65.00
66.00	PHYSICAL THERAPY	46,730	4,830	0	1,009	5,156	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	432	898	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	303	1,788	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	1,230	2,135	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	7,818	592	0	835	6,581	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,096,197	65,088	0	21,413	99,114	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,683	2,943	713	0	3,299	192.00
192.01	SATELLITE OFFICES	2,245	1,879	431	0	1,997	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	0	0	6	0	26	194.01
194.02	RETAIL PHARMACY	247	2,567	2,893	0	13,391	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	0	0	0	194.04
194.06	UNUSED SPACE	19,703	0	30	0	139	194.06
194.07	WELLNESS CENTER	96,186	2,883	862	0	3,992	194.07
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,216,261	75,360	4,935	21,413	121,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

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Cost Center Description		MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		6.00	7.01	7.02	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	WELLNESS CENTER B&F						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	WELLNESS CENTER MME						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.01	PHYSICIAN BILLING OFFICE						5.01
5.02	HOSPITAL BUSINESS OFFICE						5.02
5.03	ADMIN & GENERAL ALL						5.03
6.00	MAINTENANCE & REPAIRS	14,912					6.00
7.01	WELLNESS CENTER PLANT OP	1,803	2,314				7.01
7.02	OPERATION OF PLANT ALL	6,253	0	50,134			7.02
8.00	LAUNDRY & LINEN SERVICE	133	0	2,282	17,515		8.00
9.00	HOUSEKEEPING	0	0	511	1,003	6,292	9.00
10.00	DIETARY	462	0	2,733	16	0	10.00
11.00	CAFETERIA	60	0	3,789	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	488	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	53	0	2,627	0	4	14.00
15.00	PHARMACY	51	0	500	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	178	13	3,272	0	29	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,636	0	7,565	2,953	1,237	30.00
45.00	NURSING FACILITY	0	4	0	9,748	2,075	45.00
46.00	OTHER LONG TERM CARE	1,083	21	0	134	1,795	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	497	0	5,185	1,485	0	50.00
53.00	ANESTHESIOLOGY	0	0	139	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	228	0	4,573	344	210	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	138	0	1,684	0	176	60.00
65.00	RESPIRATORY THERAPY	87	185	652	48	0	65.00
66.00	PHYSICAL THERAPY	131	601	343	450	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	56	0	1,300	524	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,849	824	37,643	16,705	5,526	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	353	0	0	298	625	192.00
192.01	SATELLITE OFFICES	260	0	7,502	161	0	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	394	0	0	0	140	194.01
194.02	RETAIL PHARMACY	56	0	459	0	0	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	4,530	0	0	194.04
194.06	UNUSED SPACE	0	0	0	0	0	194.06
194.07	WELLNESS CENTER	0	1,490	0	351	1	194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,912	2,314	50,134	17,515	6,292	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 WELLNESS CENTER B&F						1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 WELLNESS CENTER MME						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 PHYSICIAN BILLING OFFICE						5.01
5.02 HOSPITAL BUSINESS OFFICE						5.02
5.03 ADMIN & GENERAL ALL						5.03
6.00 MAINTENANCE & REPAIRS						6.00
7.01 WELLNESS CENTER PLANT OP						7.01
7.02 OPERATION OF PLANT ALL						7.02
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	28,734					10.00
11.00 CAFETERIA	0	22,566				11.00
13.00 NURSING ADMINISTRATION	0	168	4,636			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	811	0	19,863		14.00
15.00 PHARMACY	0	388	0	130	10,561	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	424	0	2	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,121	3,750	4,122	1,922	0	30.00
45.00 NURSING FACILITY	13,173	4,587	0	619	0	45.00
46.00 OTHER LONG TERM CARE	13,440	2,139	0	168	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	1,223	0	5,701	0	50.00
53.00 ANESTHESIOLOGY	0	29	0	229	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,409	0	700	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	1,163	0	6,240	0	60.00
65.00 RESPIRATORY THERAPY	0	888	0	604	0	65.00
66.00 PHYSICAL THERAPY	0	1,343	0	87	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,117	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	10,561	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	468	514	273	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	28,734	18,790	4,636	18,792	10,561	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	1,561	0	220	0	192.00
192.01 SATELLITE OFFICES	0	0	0	284	0	192.01
194.00 ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01 OUTSIDE PROPERTY	0	0	0	64	0	194.01
194.02 RETAIL PHARMACY	0	720	0	260	0	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04 TRIPLEXES	0	0	0	0	0	194.04
194.06 UNUSED SPACE	0	0	0	0	0	194.06
194.07 WELLNESS CENTER	0	1,495	0	243	0	194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	28,734	22,566	4,636	19,863	10,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 12/6/2011 6:27 pm	
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	WELLNESS CENTER B&F					1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	WELLNESS CENTER MME					2.01
4.00	EMPLOYEE BENEFITS					4.00
5.01	PHYSICIAN BILLING OFFICE					5.01
5.02	HOSPITAL BUSINESS OFFICE					5.02
5.03	ADMIN & GENERAL ALL					5.03
6.00	MAINTENANCE & REPAIRS					6.00
7.01	WELLNESS CENTER PLANT OP					7.01
7.02	OPERATION OF PLANT ALL					7.02
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY	23,118				16.00
17.00	SOCIAL SERVICE	0	3			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,150	3	145,329	0	30.00
45.00	NURSING FACILITY	0	0	154,494	0	45.00
46.00	OTHER LONG TERM CARE	0	0	238,359	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,551	0	102,018	0	50.00
53.00	ANESTHESIOLOGY	1,246	0	27,284	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,959	0	183,921	0	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	457	0	1,653	0	58.00
60.00	LABORATORY	2,781	0	42,846	0	60.00
65.00	RESPIRATORY THERAPY	857	0	37,553	0	65.00
66.00	PHYSICAL THERAPY	1,091	0	61,771	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	467	0	3,914	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	328	0	2,419	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,329	0	15,255	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	902	0	19,863	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,118	3	1,036,679	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	11,695	0	192.00
192.01	SATELLITE OFFICES	0	0	14,759	0	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	0	0	630	0	194.01
194.02	RETAIL PHARMACY	0	0	20,593	0	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	4,530	0	194.04
194.06	UNUSED SPACE	0	0	19,872	0	194.06
194.07	WELLNESS CENTER	0	0	107,503	0	194.07
200.00	Cross Foot Adjustments			0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	23,118	3	1,216,261	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

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Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS					EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	WELLNESS CENTER B&F (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	WELLNESS CENTER MME (DOLLAR VALUE)			
	1.00	1.01	2.00	2.01	4.00		
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	188,823					1.00
1.01	WELLNESS CENTER B&F	0	35,065				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP			427,150			2.00
2.01	WELLNESS CENTER MME			0	23,260		2.01
4.00	EMPLOYEE BENEFITS	11,622	6,794	1,350	5,507	7,836,792	4.00
5.01	PHYSICIAN BILLING OFFICE	1,225	0	0	0	106,237	5.01
5.02	HOSPITAL BUSINESS OFFICE	3,899	0	7,542	0	146,030	5.02
5.03	ADMIN & GENERAL ALL	14,319	1,289	64,889	0	547,141	5.03
6.00	MAINTENANCE & REPAIRS	1,680	0	1,798	0	326,632	6.00
7.01	WELLNESS CENTER PLANT OP	0	0	0	0	0	7.01
7.02	OPERATION OF PLANT ALL	1,055	0	37,290	0	0	7.02
8.00	LAUNDRY & LINEN SERVICE	3,279	0	2,317	0	116,601	8.00
9.00	HOUSEKEEPING	734	0	0	0	117,864	9.00
10.00	DIETARY	3,928	0	3,244	0	399,905	10.00
11.00	CAFETERIA	5,446	0	0	0	71,894	11.00
13.00	NURSING ADMINISTRATION	702	0	0	0	96,112	13.00
14.00	CENTRAL SERVICES & SUPPLY	3,776	0	0	0	173,587	14.00
15.00	PHARMACY	718	0	3,403	0	200,717	15.00
16.00	MEDICAL RECORDS & LIBRARY	4,703	149	0	0	78,968	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,872	0	55,314	0	1,097,257	30.00
45.00	NURSING FACILITY	31,057	45	4,084	36	1,030,997	45.00
46.00	OTHER LONG TERM CARE	63,697	249	5,586	202	362,210	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,452	0	41,817	0	386,696	50.00
53.00	ANESTHESIOLOGY	200	0	22,994	0	10,838	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,572	0	133,002	0	379,293	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	2,420	0	10,723	0	271,985	60.00
65.00	RESPIRATORY THERAPY	937	2,156	14,273	327	283,695	65.00
66.00	PHYSICAL THERAPY	493	7,007	9,662	3,098	502,304	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	1,869	0	1,845	0	61,614	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	182,655	17,689	421,133	9,170	6,768,577	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	1,680	0	306,015	192.00
192.01	SATELLITE OFFICES	0	0	2,241	0	195,389	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	RETAIL PHARMACY	0	0	247	0	266,995	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	0	0	0	194.04
194.06	UNUSED SPACE	6,168	0	0	0	0	194.06
194.07	WELLNESS CENTER	0	17,376	1,849	14,090	299,816	194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	603,176	162,147	427,851	23,087	1,883,499	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.194399	4.624184	1.001641	0.992562	0.240341	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)					75,360	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)					0.009616	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	Reconciliation	PHYSICIAN BILLING OFFICE	HOSPITAL BUSINESS OFFICE (GROSS REV)	Reconciliation	ADMIN & GENERAL ALL (ACCUM. COST)	
		(ACCUM. COST)				
	5A.01	5.01	5.02	5A.03	5.03	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 WELLNESS CENTER B&F						1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 WELLNESS CENTER MME						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 PHYSICIAN BILLING OFFICE	-165,903	3,242,674				5.01
5.02 HOSPITAL BUSINESS OFFICE	-891,054	0	34,679,015			5.02
5.03 ADMIN & GENERAL ALL	-2,023,317	0	0	-2,023,317	18,193,087	5.03
6.00 MAINTENANCE & REPAIRS	-686,627	0	0	0	686,627	6.00
7.01 WELLNESS CENTER PLANT OP	-76,250	0	0	0	76,250	7.01
7.02 OPERATION OF PLANT ALL	-471,287	0	0	0	471,287	7.02
8.00 LAUNDRY & LINEN SERVICE	-176,633	0	0	0	176,633	8.00
9.00 HOUSEKEEPING	-193,960	0	0	0	193,960	9.00
10.00 DIETARY	-877,278	0	0	0	877,278	10.00
11.00 CAFETERIA	-93,822	0	0	0	93,822	11.00
13.00 NURSING ADMINISTRATION	-121,454	0	0	0	121,454	13.00
14.00 CENTRAL SERVICES & SUPPLY	-393,347	0	0	0	393,347	14.00
15.00 PHARMACY	-277,229	0	0	0	277,229	15.00
16.00 MEDICAL RECORDS & LIBRARY	-407,097	0	0	0	407,097	16.00
17.00 SOCIAL SERVICE	-442	0	0	0	442	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	-1,708,243	0	4,721,930	0	1,829,568	30.00
45.00 NURSING FACILITY	-1,615,572	0	0	0	1,615,572	45.00
46.00 OTHER LONG TERM CARE	-846,747	0	0	0	846,747	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	-949,751	0	8,342,534	0	1,164,115	50.00
53.00 ANESTHESIOLOGY	-58,552	0	1,867,480	0	106,535	53.00
54.00 RADIOLOGY-DIAGNOSTIC	-1,158,774	0	7,435,184	0	1,349,814	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	-97,755	0	685,408	0	115,366	58.00
60.00 LABORATORY	-937,894	0	4,168,925	0	1,045,010	60.00
65.00 RESPIRATORY THERAPY	-433,423	0	1,285,421	0	466,451	65.00
66.00 PHYSICAL THERAPY	-727,004	0	1,635,699	0	769,032	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	-115,959	0	699,654	0	133,936	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	-254,158	0	491,024	0	266,774	72.00
73.00 DRUGS CHARGED TO PATIENTS	-267,237	0	1,993,018	0	318,446	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	-946,961	0	1,352,738	0	981,718	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-16,973,730	0	34,679,015	-2,023,317	14,784,510	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	468,141	0	0	492,092	192.00
192.01 SATELLITE OFFICES	0	283,365	0	0	297,863	192.01
194.00 ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01 OUTSIDE PROPERTY	0	3,733	0	0	3,924	194.01
194.02 RETAIL PHARMACY	0	1,901,225	0	0	1,998,496	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04 TRIPLEXES	0	0	0	0	0	194.04
194.06 UNUSED SPACE	0	19,703	0	0	20,711	194.06
194.07 WELLNESS CENTER	0	566,507	0	0	595,491	194.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)		165,903	891,054		2,023,317	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)		0.051162	0.025694		0.111214	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		4,935	21,413		121,958	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.001522	0.000617		0.006704	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (MAINT TIME)	WELLNESS CENTER PLANT OP (SQUARE FEET)	OPERATION OF PLANT ALL (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.00	7.01	7.02	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	WELLNESS CENTER B&F						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	WELLNESS CENTER MME						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.01	PHYSICIAN BILLING OFFICE						5.01
5.02	HOSPITAL BUSINESS OFFICE						5.02
5.03	ADMIN & GENERAL ALL						5.03
6.00	MAINTENANCE & REPAIRS	10,448					6.00
7.01	WELLNESS CENTER PLANT OP	1,263	26,982				7.01
7.02	OPERATION OF PLANT ALL	4,381	0	72,051			7.02
8.00	LAUNDRY & LINEN SERVICE	93	0	3,279	173,624		8.00
9.00	HOUSEKEEPING	0	0	734	9,940	10,390	9.00
10.00	DIETARY	324	0	3,928	160	0	10.00
11.00	CAFETERIA	42	0	5,446	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	702	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	37	0	3,776	0	6	14.00
15.00	PHARMACY	36	0	718	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	125	149	4,703	0	48	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,847	0	10,872	29,268	2,042	30.00
45.00	NURSING FACILITY	0	45	0	96,643	3,429	45.00
46.00	OTHER LONG TERM CARE	759	249	0	1,326	2,964	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	348	0	7,452	14,723	0	50.00
53.00	ANESTHESIOLOGY	0	0	200	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	160	0	6,572	3,409	346	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	97	0	2,420	0	290	60.00
65.00	RESPIRATORY THERAPY	61	2,156	937	471	0	65.00
66.00	PHYSICAL THERAPY	92	7,007	493	4,462	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	39	0	1,869	5,198	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,704	9,606	54,101	165,600	9,125	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	247	0	0	2,952	1,032	192.00
192.01	SATELLITE OFFICES	182	0	10,781	1,595	0	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	276	0	0	0	231	194.01
194.02	RETAIL PHARMACY	39	0	659	0	0	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	6,510	0	0	194.04
194.06	UNUSED SPACE	0	0	0	0	0	194.06
194.07	WELLNESS CENTER	0	17,376	0	3,477	2	194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	762,990	176,964	843,631	241,462	237,949	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	73.027374	6.558595	11.708803	1.390718	22.901732	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	14,912	2,314	50,134	17,515	6,292	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.427259	0.085761	0.695813	0.100879	0.605582	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	WELLNESS CENTER B&F						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	WELLNESS CENTER MME						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.01	PHYSICIAN BILLING OFFICE						5.01
5.02	HOSPITAL BUSINESS OFFICE						5.02
5.03	ADMIN & GENERAL ALL						5.03
6.00	MAINTENANCE & REPAIRS						6.00
7.01	WELLNESS CENTER PLANT OP						7.01
7.02	OPERATION OF PLANT ALL						7.02
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	114,679					10.00
11.00	CAFETERIA	0	16,165				11.00
13.00	NURSING ADMINISTRATION	0	120	62,835			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	581	0	1,087,789		14.00
15.00	PHARMACY	0	278	0	7,107	100	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	304	0	96	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	8,465	2,686	55,870	105,254	0	30.00
45.00	NURSING FACILITY	52,573	3,287	0	33,922	0	45.00
46.00	OTHER LONG TERM CARE	53,641	1,532	0	9,207	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	876	0	312,202	0	50.00
53.00	ANESTHESIOLOGY	0	21	0	12,520	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,009	0	38,335	0	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	833	0	341,689	0	60.00
65.00	RESPIRATORY THERAPY	0	636	0	33,102	0	65.00
66.00	PHYSICAL THERAPY	0	962	0	4,780	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	115,959	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	335	6,965	14,963	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	114,679	13,460	62,835	1,029,136	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,118	0	12,074	0	192.00
192.01	SATELLITE OFFICES	0	0	0	15,557	0	192.01
194.00	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	OUTSIDE PROPERTY	0	0	0	3,493	0	194.01
194.02	RETAIL PHARMACY	0	516	0	14,229	0	194.02
194.03	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	TRIPLEXES	0	0	0	0	0	194.04
194.06	UNUSED SPACE	0	0	0	0	0	194.06
194.07	WELLNESS CENTER	0	1,071	0	13,300	0	194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,044,720	171,089	144,451	490,293	325,242	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.109950	10.583916	2.298894	0.450724	3,252.420000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	28,734	22,566	4,636	19,863	10,561	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.250560	1.395979	0.073781	0.018260	105.610000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1
Date/Time Prepared:
12/6/2011 6:27 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)	
	16.00	17.00	
GENERAL SERVICE COST CENTERS			
1.00 NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01 WELLNESS CENTER B&F			1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01 WELLNESS CENTER MME			2.01
4.00 EMPLOYEE BENEFITS			4.00
5.01 PHYSICIAN BILLING OFFICE			5.01
5.02 HOSPITAL BUSINESS OFFICE			5.02
5.03 ADMIN & GENERAL ALL			5.03
6.00 MAINTENANCE & REPAIRS			6.00
7.01 WELLNESS CENTER PLANT OP			7.01
7.02 OPERATION OF PLANT ALL			7.02
8.00 LAUNDRY & LINEN SERVICE			8.00
9.00 HOUSEKEEPING			9.00
10.00 DIETARY			10.00
11.00 CAFETERIA			11.00
13.00 NURSING ADMINISTRATION			13.00
14.00 CENTRAL SERVICES & SUPPLY			14.00
15.00 PHARMACY			15.00
16.00 MEDICAL RECORDS & LIBRARY	34,679,015		16.00
17.00 SOCIAL SERVICE	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	4,721,930	100	30.00
45.00 NURSING FACILITY	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	8,342,534	0	50.00
53.00 ANESTHESIOLOGY	1,867,480	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	7,435,184	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	685,408	0	58.00
60.00 LABORATORY	4,168,925	0	60.00
65.00 RESPIRATORY THERAPY	1,285,421	0	65.00
66.00 PHYSICAL THERAPY	1,635,699	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	699,654	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	491,024	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,993,018	0	73.00
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	1,352,738	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	34,679,015	100	118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01 SATELLITE OFFICES	0	0	192.01
194.00 ARC (HOPEDALE HALL)	0	0	194.00
194.01 OUTSIDE PROPERTY	0	0	194.01
194.02 RETAIL PHARMACY	0	0	194.02
194.03 DURABLE MEDICAL EQUIPMENT	0	0	194.03
194.04 TRIPLEXES	0	0	194.04
194.06 UNUSED SPACE	0	0	194.06
194.07 WELLNESS CENTER	0	0	194.07
200.00 Cross Foot Adjustments			200.00
201.00 Negative Cost Centers			201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	521,904	491	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.015050	4.910000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	23,118	3	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000667	0.030000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/6/2011 6:27 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	ADULTS & PEDIATRICS		2,735,672	0	0	30.00
45.00	NURSING FACILITY		2,537,489	0	0	45.00
46.00	OTHER LONG TERM CARE		1,576,735	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		1,702,253	0	0	50.00
53.00	ANESTHESIOLOGY		154,696	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		1,741,089	0	0	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		138,511	0	0	58.00
60.00	LABORATORY		1,428,857	0	0	60.00
65.00	RESPIRATORY THERAPY	0	589,545	0	0	65.00
66.00	PHYSICAL THERAPY	0	956,164	0	0	66.00
69.00	ELECTROCARDIOLOGY		0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		211,628	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		303,833	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		709,099	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY		1,169,521	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		335,333	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		16,290,425	0	0	200.00
201.00	Less Observation Beds		335,333			201.00
202.00	Total (see instructions)		15,955,092	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4,304,729		4,304,729			30.00
45.00 NURSING FACILITY	2,673,379		2,673,379			45.00
46.00 OTHER LONG TERM CARE	1,608,042		1,608,042			46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	3,216,939	5,125,595	8,342,534	0.204045	0.000000	50.00
53.00 ANESTHESIOLOGY	991,090	876,390	1,867,480	0.082837	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	944,789	6,490,395	7,435,184	0.234169	0.000000	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	13,238	672,170	685,408	0.202085	0.000000	58.00
60.00 LABORATORY	712,535	3,456,390	4,168,925	0.342740	0.000000	60.00
65.00 RESPIRATORY THERAPY	609,193	676,228	1,285,421	0.458640	0.000000	65.00
66.00 PHYSICAL THERAPY	260,726	1,374,973	1,635,699	0.584560	0.000000	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	463,526	236,128	699,654	0.302475	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	412,497	78,527	491,024	0.618774	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,343,610	649,408	1,993,018	0.355792	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	44,171	1,308,567	1,352,738	0.864558	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	9,824	407,377	417,201	0.803768	0.000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	17,608,288	21,352,148	38,960,436			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	17,608,288	21,352,148	38,960,436			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/6/2011 6:27 pm
		Title XVIII	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
45.00 NURSING FACILITY			45.00
46.00 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
53.00 ANESTHESIOLOGY	0.000000		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00 LABORATORY	0.000000		60.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
69.00 ELECTROCARDIOLOGY	0.000000		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE			113.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 12/6/2011 6:27 pm	
Cost Center Description			Title XVIII	Hospital	Cost	
	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	OPERATING ROOM	102,018	8,342,534	0.012229	1,643,913	20,103 50.00
53.00	ANESTHESIOLOGY	27,284	1,867,480	0.014610	548,713	8,017 53.00
54.00	RADIOLOGY-DIAGNOSTIC	183,921	7,435,184	0.024737	531,503	13,148 54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	1,653	685,408	0.002412	10,078	24 58.00
60.00	LABORATORY	42,846	4,168,925	0.010277	309,948	3,185 60.00
65.00	RESPIRATORY THERAPY	37,553	1,285,421	0.029215	223,231	6,522 65.00
66.00	PHYSICAL THERAPY	61,771	1,635,699	0.037764	51,847	1,958 66.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,914	699,654	0.005594	281,505	1,575 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,419	491,024	0.004926	264,708	1,304 72.00
73.00	DRUGS CHARGED TO PATIENTS	15,255	1,993,018	0.007654	551,260	4,219 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	19,863	1,352,738	0.014684	621	9 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	417,201	0.000000	4,430	0 92.00
200.00	Total (lines 50-199)	498,497	30,374,286		4,421,757	60,064 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description	Title XVIII				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description	Title XVIII					
	Hospital					Cost
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	8,342,534	0.000000	0.000000	1,643,913	50.00
53.00 ANESTHESIOLOGY	0	1,867,480	0.000000	0.000000	548,713	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	7,435,184	0.000000	0.000000	531,503	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	685,408	0.000000	0.000000	10,078	58.00
60.00 LABORATORY	0	4,168,925	0.000000	0.000000	309,948	60.00
65.00 RESPIRATORY THERAPY	0	1,285,421	0.000000	0.000000	223,231	65.00
66.00 PHYSICAL THERAPY	0	1,635,699	0.000000	0.000000	51,847	66.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	699,654	0.000000	0.000000	281,505	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	491,024	0.000000	0.000000	264,708	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,993,018	0.000000	0.000000	551,260	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	1,352,738	0.000000	0.000000	621	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	417,201	0.000000	0.000000	4,430	92.00
200.00 Total (lines 50-199)	0	30,374,286			4,421,757	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description	Title XVIII			Hospital		Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/6/2011 6:27 pm
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		Cost
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/6/2011 6:27 pm		
		Title XVIII	Hospital	Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.204045	0	2,361,068	0	50.00
53.00	ANESTHESIOLOGY	0.082837	0	404,658	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.234169	0	3,417,692	0	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.202085	0	268,469	0	58.00
60.00	LABORATORY	0.342740	0	1,889,133	0	60.00
65.00	RESPIRATORY THERAPY	0.458640	0	388,476	0	65.00
66.00	PHYSICAL THERAPY	0.584560	0	648,775	0	66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.302475	0	107,588	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.618774	0	43,620	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.355792	0	355,992	176	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0.864558	0	586,545	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.803768	0	284,769	0	92.00
200.00	Subtotal (see instructions)		0	10,756,785	176	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	10,756,785	176	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/6/2011 6:27 pm
Title XVIII		Hospital	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	481,764	0		50.00
53.00 ANESTHESIOLOGY	0	33,521	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	800,318	0		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	54,254	0		58.00
60.00 LABORATORY	0	647,481	0		60.00
65.00 RESPIRATORY THERAPY	0	178,171	0		65.00
66.00 PHYSICAL THERAPY	0	379,248	0		66.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,543	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	26,991	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	126,659	63		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	507,102	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	228,888	0		92.00
200.00 Subtotal (see instructions)	0	3,496,940	63		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,496,940	63		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330 Component CCN: 14Z330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/6/2011 6:27 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.204045	0	0	0	50.00
53.00 ANESTHESIOLOGY	0.082837	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.234169	0	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.202085	0	0	0	58.00
60.00 LABORATORY	0.342740	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0.458640	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.584560	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.302475	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.618774	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.355792	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0.864558	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.803768	0	0	0	92.00
200.00 Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330 Component CCN: 14Z330	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/6/2011 6:27 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00 LABORATORY	0	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	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	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/6/2011 6:27 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,235 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,816 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,816 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			698 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)			697 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			12 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)			12 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			920 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)			607 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)			606 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			116.26 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			116.26 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,735,672 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)			1,395 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)			1,395 25.00
26.00	Total swing-bed cost (see instructions)			1,190,074 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,545,598 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			4,748,024 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			4,748,024 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.325524 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)			2,614.55 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)			1,545,598 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)			851.10 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			783,012 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)			783,012 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/6/2011 6:27 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)					1,195,482 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,978,494 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)					516,618 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					515,767 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,032,385 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					394 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					851.10 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					335,333 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141330		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 12/6/2011 6:27 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 12/6/2011 6:27 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,302,715		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.204045	1,643,913	335,432	50.00
53.00	ANESTHESIOLOGY	0.082837	548,713	45,454	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.234169	531,503	124,462	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.202085	10,078	2,037	58.00
60.00	LABORATORY	0.342740	309,948	106,232	60.00
65.00	RESPIRATORY THERAPY	0.458640	223,231	102,383	65.00
66.00	PHYSICAL THERAPY	0.584560	51,847	30,308	66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.302475	281,505	85,148	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.618774	264,708	163,794	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.355792	551,260	196,134	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.864558	621	537	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.803768	4,430	3,561	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,421,757	1,195,482	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,421,757		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Component CCN: 14Z330		Date/Time Prepared: 12/6/2011 6:27 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	ADULTS & PEDIATRICS		1,409,495		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.204045	57,915	11,817	50.00
53.00	ANESTHESIOLOGY	0.082837	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.234169	61,030	14,291	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.202085	3,160	639	58.00
60.00	LABORATORY	0.342740	162,489	55,691	60.00
65.00	RESPIRATORY THERAPY	0.458640	181,907	83,430	65.00
66.00	PHYSICAL THERAPY	0.584560	159,670	93,337	66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.302475	4,614	1,396	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.618774	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.355792	328,995	117,054	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.864558	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.803768	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		959,780	377,655	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		959,780		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/6/2011 6:27 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,497,003 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,497,003 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 Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,531,973 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			51,817 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,773,246 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,706,910 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,706,910 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			1,706,910 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			52,676 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			52,676 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			52,676 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,759,586 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,759,586 40.00
41.00	Interim payments			1,663,036 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			96,550 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			45,380 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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/6/2011 6:27 pm
	Title XVIII	Hospital	Cost
			Overrides
WORKSHEET OVERRIDE VALUES			1.00
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 141330		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 12/6/2011 6:27 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		1,269,759		1,668,436	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	04/01/2011	24,757	04/01/2011	51,039	3.01	
3.02		06/10/2011	405,423	06/10/2011	53,951	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	01/21/2011	38,332	01/21/2011	110,390	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)		391,848		-5,400	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)		1,661,607		1,663,036	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		96,704		96,550	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,758,311		1,759,586	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 141330 Component CCN: 14Z330		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 12/6/2011 6:27 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		1,299,978		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	06/10/2011	10,712		0		3.01
3.02		04/12/2011	31,061		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	01/21/2011	89,739		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)		-47,966		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)		1,252,012		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		147,621		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,399,633		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2	
		Component CCN: 14Z330		Date/Time Prepared: 12/6/2011 6:27 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)		1,042,709	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		381,432	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		1,213	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)		1,424,141	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,424,141	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)		1,424,141	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		24,508	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)		1,399,633	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
17.00	Reimbursable bad debts (see instructions)		0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		1,399,633	0	19.00
20.00	Interim payments		1,252,012	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		147,621	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		16,131	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 12/6/2011 6:27 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			1,978,494 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,978,494 4.00
5.00	Primary payer payments			1,519 5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)			1,996,745 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 teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,996,745 19.00
20.00	Deductibles (exclude professional component)			238,434 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)			1,758,311 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,758,311 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			0 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))			1,758,311 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,758,311 30.00
31.00	Interim payments			1,661,607 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			96,704 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			25,179 34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 141330 Period: From 07/01/2010 To 06/30/2011 Worksheet G
 Date/Time Prepared: 1/27/2012 9:08 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,059,477	0	0	0	1.00
2.00	Temporary investments	1,251,456	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,790,436	0	0	0	4.00
5.00	Other receivable	549,760	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	813,119	0	0	0	7.00
8.00	Prepaid expenses	273,715	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	801,584	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,539,547	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	11,255,215	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)	11,255,215	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	691,185	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	691,185	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,485,947	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	924,968	0	0	0	37.00
38.00	Salaries, wages, and fees payable	789,733	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	571,074	0	0	0	40.00
41.00	Deferred income	370,998	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,138,708	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,795,481	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,922,696	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,922,696	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,718,177	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	13,767,770	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	13,767,770	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,485,947	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
1/27/2012 9:08 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		11,937,603	
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,830,167			2.00
3.00	Total (sum of line 1 and line 2)		13,767,770		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		13,767,770		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,767,770		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
1/27/2012 9:08 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
		0			0	
2.00						2.00
3.00		0			0	3.00
4.00	0		0			4.00
	0		0			
5.00	0		0			5.00
	0		0			
6.00	0		0			6.00
	0		0			
7.00	0		0			7.00
	0		0			
8.00	0		0			8.00
	0		0			
9.00	0		0			9.00
10.00		0			0	10.00
11.00		0			0	11.00
12.00	0		0			12.00
	0		0			
13.00	0		0			13.00
	0		0			
14.00	0		0			14.00
	0		0			
15.00	0		0			15.00
	0		0			
16.00	0		0			16.00
	0		0			
17.00	0		0			17.00
18.00		0			0	18.00
19.00		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141330

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-2 Parts
Date/Time Prepared:
1/27/2012 9:08 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,748,024		4,748,024	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	2,673,379		2,673,379	8.00
9.00	OTHER LONG TERM CARE	1,608,042		1,608,042	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,029,445		9,029,445	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)	9,029,445		9,029,445	17.00
18.00	Ancillary services	8,948,681	19,618,415	28,567,096	18.00
19.00	Outpatient services	61,094	2,169,373	2,230,467	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	DIET & RETAIL PHARM	15,453	1,891,604	1,907,057	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,054,673	23,679,392	41,734,065	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,702,324		29.00
30.00	BAD DEBTS	1,253,682			30.00
31.00	GAIN/LOSS ON ASSETS -NON OP RV	24,147			31.00
32.00	LEASE ADJUSTMENT	167,845			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)		1,445,674		36.00
37.00	FUND RAISING	3,762			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		3,762		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,144,236		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141330	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/27/2012 9:08 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	41,734,065	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,781,918	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,952,147	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,144,236	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-192,089	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	700,085	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OP REV	1,197,636	24.00
24.01	NON OP OTHER	124,533	24.01
24.02	ROUNDING	2	24.02
24.03		0	24.03
24.04		0	24.04
24.05		0	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	2,022,256	25.00
26.00	Total (line 5 plus line 25)	1,830,167	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,830,167	29.00