

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 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 10/24/2012 2:30 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 10/24/2012 Time: 2:30 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 07/01/2011 and ending 06/30/2012 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 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	157,904	113,678	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	65,421	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	223,325	113,678	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.

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

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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 07/01/2011 and ending 06/30/2012 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.

Encryption Information
 ECR: Date: 10/24/2012 Time: 2:30 pm
 gF7vvpMYfgvkuNpi Fsefbpl RtZny10
 1JqqZ0q0by3Teci QYvLkmH40T2l yJb
 J1J40yQl Sj 0sfsg2
 PI: Date: 10/24/2012 Time: 2:30 pm
 wnWDEby8CFkTkgUVHgVDpt. CcyMI FO
 T: B460MwwyskyRbBWQh1c4ZhzT0j Ou
 Y3ChGXbql : 0: qCyj

(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	157,904	113,678	0	0	1.00
2.00	Subprovider - IPF	0	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	0	4.00
5.00	Swing bed - SNF	0	65,421	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00	NURSING FACILITY	0	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	0	12.00
200.00	Total	0	223,325	113,678	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 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 10/24/2012 11:52 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: SECOND STREET	PO Box:							1.00	
2.00	City: HOPEDALE	State: IL		Zip Code: 61747-		County: TAZEWELL			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HOPEDALE MEDICAL COMPLEX	141330	37900	1	10/01/2003	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HOPEDALE SWING BED	14Z330	37900		10/01/2003	N	0	N	7.00
8.00	Swing Beds - NF						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)					07/01/2011	06/30/2012		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					3		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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 paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the 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 paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.					1				26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 10/24/2012 11:52 am		
		Beginning:	Ending:			
		1.00	2.00			
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	
		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 in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	
		1.00	2.00	3.00	4.00	
				Ratio (col. 3/ (col. 3 + col. 4))	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
10/24/2012 11:52 am

		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	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. 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 that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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	If line 63 is yes, then, for each primary care residency program in which you are training residents, 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 that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		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	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)			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	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N			N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N			N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on 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	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 10/24/2012 11:52 am	
		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	115,876	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	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	2.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N			145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, 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 there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
10/24/2012 11:52 am

		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC	N	N	N	N	161.00	
					1.00		
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						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 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 10/24/2012 11:52 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		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	08/28/2012	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 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 10/24/2012 11:52 am
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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.	N		21.00
		1.00	2.00	
				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.	N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LI NHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LI NHART@MCGLADREY.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/28/2012	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
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
10/24/2012 11:52 am

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	9,150	28,345.00		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	9,150	28,345.00		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	9,150	28,345.00		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	27,084			20.00
21.00 OTHER LONG TERM CARE	46.00	86	31,476			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 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
10/24/2012 11:52 am

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	749	35	1,163		1.00
2.00 HMO		99	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	1,045	0	1,088		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	48		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,794	35	2,299		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	1,794	35	2,299		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	19,218		20.00
21.00 OTHER LONG TERM CARE				16,461		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	322		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 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
10/24/2012 11:52 am

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	208	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	182.93	0.00	0	208	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	23.60	0.00			20.00
21.00 OTHER LONG TERM CARE	0.00	10.64	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	217.17	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 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
10/24/2012 11:52 am

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)	10	428		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)	10	428		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		44		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 07/01/2011 To 06/30/2012	Worksheet S-10 Date/Time Prepared: 10/24/2012 11:52 am
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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)		0.452716	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		781,031	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		1,683,171	6.00	
7.00	Medicaid cost (line 1 times line 6)		761,998	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)		0	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)		0	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	1,202,642	1	1,202,643	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	544,455	0	544,455	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)	544,455	0	544,455	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,449,340	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		153,690	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,295,650	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		586,561	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,131,016	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,131,016	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 141330		Period: From 07/01/2011 To 06/30/2012		Worksheet A	
Date/Time Prepared: 10/24/2012 11:52 am							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT		333,813	333,813	284,308	618,121	1.00
1.01 00101	WELLNESS CENTER B&F		60,117	60,117	116,154	176,271	1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		845,848	845,848	-387,011	458,837	2.00
2.01 00201	WELLNESS CENTER MME		0	0	26,641	26,641	2.01
4.00 00400	EMPLOYEE BENEFITS	157,959	2,084,196	2,242,155	16,477	2,258,632	4.00
5.01 00510	PHYSICIAN BILLING OFFICE	107,815	36,553	144,368	0	144,368	5.01
5.02 00511	HOSPITAL BUSINESS OFFICE	302,130	420,384	722,514	0	722,514	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	821,796	2,027,320	2,849,116	498	2,849,614	5.03
6.00 00600	MAINTENANCE & REPAIRS	338,837	410,632	749,469	0	749,469	6.00
7.01 00701	WELLNESS CENTER PLANT OP	0	58,137	58,137	0	58,137	7.01
7.02 00702	OPERATION OF PLANT ALL	0	405,218	405,218	400	405,618	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	129,971	25,672	155,643	0	155,643	8.00
9.00 00900	HOUSEKEEPING	147,785	52,135	199,920	0	199,920	9.00
10.00 01000	DIETARY	535,943	471,425	1,007,368	-144,171	863,197	10.00
11.00 01100	CAFETERIA	0	0	0	144,085	144,085	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	103,721	103,721	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	186,560	164,387	350,947	0	350,947	14.00
15.00 01500	PHARMACY	198,526	22,452	220,978	3,169	224,147	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	77,652	279,914	357,566	0	357,566	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	6,221	6,221	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,113,709	237,622	1,351,331	-194,319	1,157,012	30.00
45.00 04500	NURSING FACILITY	1,073,839	241,970	1,315,809	19,433	1,335,242	45.00
46.00 04600	OTHER LONG TERM CARE	295,503	107,750	403,253	19,776	423,029	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	424,415	590,992	1,015,407	-307,392	708,015	50.00
53.00 05300	ANESTHESIOLOGY	1,691	308,306	309,997	-15,393	294,604	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	360,020	471,419	831,439	3,108	834,547	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	106,014	106,014	0	106,014	58.00
60.00 06000	LABORATORY	266,631	591,262	857,893	0	857,893	60.00
65.00 06500	RESPIRATORY THERAPY	287,729	44,029	331,758	3,286	335,044	65.00
66.00 06600	PHYSICAL THERAPY	505,656	40,905	546,561	-1,805	544,756	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	359,456	359,456	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	261,793	261,793	0	261,793	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	268,223	268,223	0	268,223	73.00
76.00 03020	RENEWED HOPE	101,115	120,829	221,944	0	221,944	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	108,636	1,109,447	1,218,083	59,758	1,277,841	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE		90,703	90,703	-90,703	0	113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	7,543,918	12,289,467	19,833,385	25,697	19,859,082	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	354,458	108,446	462,904	0	462,904	192.00
192.01 19201	SATELLITE OFFICES	215,150	38,602	253,752	0	253,752	192.01
194.00 07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01 07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02 07952	RETAIL PHARMACY	277,961	1,498,297	1,776,258	-7,563	1,768,695	194.02
194.03 07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04 07954	DUPLEX	0	0	0	0	0	194.04
194.06 07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07 07956	WELLNESS CENTER	327,236	113,451	440,687	-18,134	422,553	194.07
200.00 20000	TOTAL (SUM OF LINES 118-199)	8,718,723	14,048,263	22,766,986	0	22,766,986	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-8,557	609,564	1.00
1.01	00101	WELLNESS CENTER B&F	-12,447	163,824	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	27,862	486,699	2.00
2.01	00201	WELLNESS CENTER MME	0	26,641	2.01
4.00	00400	EMPLOYEE BENEFITS	-148,947	2,109,685	4.00
5.01	00510	PHYSICIAN BILLING OFFICE	0	144,368	5.01
5.02	00511	HOSPITAL BUSINESS OFFICE	-1,885	720,629	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-353,021	2,496,593	5.03
6.00	00600	MAINTENANCE & REPAIRS	-1,045	748,424	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	58,137	7.01
7.02	00702	OPERATION OF PLANT ALL	0	405,618	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	155,643	8.00
9.00	00900	HOUSEKEEPING	0	199,920	9.00
10.00	01000	DIETARY	-154	863,043	10.00
11.00	01100	CAFETERIA	-89,014	55,071	11.00
13.00	01300	NURSING ADMINISTRATION	0	103,721	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	350,947	14.00
15.00	01500	PHARMACY	0	224,147	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,158	354,408	16.00
17.00	01700	SOCIAL SERVICE	0	6,221	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-153	1,156,859	30.00
45.00	04500	NURSING FACILITY	-14,557	1,320,685	45.00
46.00	04600	OTHER LONG TERM CARE	-23,936	399,093	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,809	705,206	50.00
53.00	05300	ANESTHESIOLOGY	-221,358	73,246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,251	878,798	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	106,014	58.00
60.00	06000	LABORATORY	0	857,893	60.00
65.00	06500	RESPIRATORY THERAPY	-1,989	333,055	65.00
66.00	06600	PHYSICAL THERAPY	-3,521	541,235	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	359,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	261,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	268,223	73.00
76.00	03020	RENEWED HOPE	-3,531	218,413	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-339,372	938,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,157,341	18,701,741	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	462,904	192.00
192.01	19201	SATELLITE OFFICES	0	253,752	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	194.01
194.02	07952	RETAIL PHARMACY	0	1,768,695	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	194.03
194.04	07954	DUPLEX	0	0	194.04
194.06	07955	UNUSED SPACE	0	0	194.06
194.07	07956	WELLNESS CENTER	0	422,553	194.07
200.00		TOTAL (SUM OF LINES 118-199)	-1,157,341	21,609,645	200.00

RECLASSIFICATIONS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6
Date/Time Prepared:
10/24/2012 11:52 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	72,643	71,442	1.00	
	TOTALS		72,643	71,442		
B - INTEREST EXPENSE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	11,772	1.00	
2.00	WELLNESS CENTER B&F	1.01	0	17,124	2.00	
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	11,196	3.00	
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	498	4.00	
5.00	OPERATION OF PLANT ALL	7.02	0	400	5.00	
7.00	NURSING FACILITY	45.00	0	19,254	7.00	
8.00	OTHER LONG TERM CARE	46.00	0	19,254	8.00	
9.00	OPERATING ROOM	50.00	0	3,864	9.00	
10.00	ANESTHESIOLOGY	53.00	0	1,496	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,108	11.00	
12.00	RESPIRATORY THERAPY	65.00	0	2,737	12.00	
	TOTALS		0	90,703		
C - ER NURSING RECLASS						
1.00	EMERGENCY	91.00	64,998	0	1.00	
	TOTALS		64,998	0		
D - BUILDING DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	371,566	1.00	
	TOTALS		0	371,566		
E - WELLNESS CENTER DEP						
1.00	WELLNESS CENTER B&F	1.01	0	99,030	1.00	
2.00	WELLNESS CENTER MME	2.01	0	26,641	2.00	
	TOTALS		0	125,671		
F - NURSING ADMIN						
1.00	NURSING ADMINISTRATION	13.00	103,721	0	1.00	
	TOTALS		103,721	0		
G - WELLNESS CENTER RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	11,503	5,081	1.00	
2.00	NURSING FACILITY	45.00	128	57	2.00	
3.00	OTHER LONG TERM CARE	46.00	362	160	3.00	
4.00	RESPIRATORY THERAPY	65.00	567	250	4.00	
5.00	PHYSICAL THERAPY	66.00	18	8	5.00	
	TOTALS		12,578	5,556		
H - SOCIAL SERVICE RECLASS						
1.00	SOCIAL SERVICE	17.00	0	6,221	1.00	
	TOTALS		0	6,221		
I - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	359,456	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	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
	TOTALS		0	359,456		
J - PHARMACY SALARY RECLASS						
1.00	PHARMACY	15.00	7,563	0	1.00	
	TOTALS		7,563	0		
500.00	Grand Total: Increases		261,503	1,030,615	500.00	

RECLASSIFICATIONS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6
Date/Time Prepared:
10/24/2012 11:52 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	72,643	71,442	0		1.00
	TOTALS		72,643	71,442			
B - INTEREST EXPENSE RECLASS							
1.00	INTEREST EXPENSE	113.00	0	90,703	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
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
12.00		0.00	0	0	0		12.00
	TOTALS		0	90,703			
C - ER NURSING RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	64,998	0	0		1.00
	TOTALS		64,998	0			
D - BUILDING DEPRECIATION							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	371,566	9		1.00
	TOTALS		0	371,566			
E - WELLNESS CENTER DEP							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	99,030	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	26,641	9		2.00
	TOTALS		0	125,671			
F - NURSING ADMIN							
1.00	ADULTS & PEDIATRICS	30.00	103,721	0	0		1.00
	TOTALS		103,721	0			
G - WELLNESS CENTER RECLASS							
1.00	WELLNESS CENTER	194.07	12,578	5,556	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		12,578	5,556			
H - SOCIAL SERVICE RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	6,221	0		1.00
	TOTALS		0	6,221			
I - MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS	4.00	0	107	0		1.00
2.00	DIETARY	10.00	0	86	0		2.00
3.00	PHARMACY	15.00	0	4,394	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	19,379	0		4.00
5.00	NURSING FACILITY	45.00	0	6	0		5.00
6.00	OPERATING ROOM	50.00	0	311,256	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	16,889	0		7.00
9.00	RESPIRATORY THERAPY	65.00	0	268	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,831	0		10.00
11.00	EMERGENCY	91.00	0	5,240	0		11.00
	TOTALS		0	359,456			
J - PHARMACY SALARY RECLASS							
1.00	RETAIL PHARMACY	194.02	7,563	0	0		1.00
	TOTALS		7,563	0			
500.00	Grand Total: Decreases		261,503	1,030,615			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
10/24/2012 11:52 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	752,267	0	0	0	0	1.00
2.00	Land Improvements	417,684	54,742	0	54,742	0	2.00
3.00	Buildings and Fixtures	18,513,525	260,711	0	260,711	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	11,774,336	422,002	0	422,002	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,457,812	737,455	0	737,455	0	8.00
9.00	Reconciling Items	-1,826,590	-30,171	0	-30,171	0	9.00
10.00	Total (line 8 minus line 9)	33,284,402	767,626	0	767,626	0	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	333,813	0	0	0	0	1.00
1.01	WELLNESS CENTER B&F	60,117	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	845,848	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)	1,239,778	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	19,998,929	0	19,998,929	0.621176	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	12,196,338	0	12,196,338	0.378824	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	32,195,267	0	32,195,267	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
10/24/2012 11:52 am

		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	472,426	0			2.00	
3.00	Buildings and Fixtures	18,774,236	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	12,196,338	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	32,195,267	0			8.00	
9.00	Reconciling Items	-1,856,761	0			9.00	
10.00	Total (line 8 minus line 9)	34,052,028	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	333,813			1.00	
1.01	WELLNESS CENTER B&F	0	60,117			1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	845,848			2.00	
2.01	WELLNESS CENTER MME	0	0			2.01	
3.00	Total (sum of lines 1-2)	0	1,239,778			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	606,349	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	159,147	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	447,641	36,000	2.00
2.01	WELLNESS CENTER MME	0	0	0	26,641	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,239,778	36,000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
10/24/2012 11:52 am

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	3,215	0	0	0	609,564	1.00
1.01	WELLNESS CENTER B&F	4,677	0	0	0	163,824	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,058	0	0	0	486,699	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	26,641	2.01
3.00	Total (sum of lines 1-2)	10,950	0	0	0	1,286,728	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT		1.00	1.00
1.01 Investment income - WELLNESS CENTER B&F (chapter 2)			OWELLNESS CENTER B&F		1.01	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	2.00
2.01 Investment income - WELLNESS CENTER MME (chapter 2)			OWELLNESS CENTER MME		2.01	2.01
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	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)		0			0.00	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	-250,563				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		0			0.00	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		0			0.00	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		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT		1.00	26.00
26.01 Depreciation - WELLNESS CENTER B&F			OWELLNESS CENTER B&F		1.01	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	27.00
27.01 Depreciation - WELLNESS CENTER MME			OWELLNESS CENTER MME		2.01	27.01
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 INVST INCOME-NEW BLDGS AND FIXTURES	B	-8,557	NEW CAP REL COSTS-BLDG & FIXT		1.00	33.00
33.01 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-8,138	NEW CAP REL COSTS-MVBLE EQUIP		2.00	33.01
33.02 INVESTMENT INCOME-OTHER	B	-362	OTHER ADMINISTRATIVE AND GENERAL		5.03	33.02
33.03 TRADE, QUANTITY AND TIME DISCOUNTS	B	-5,644	OTHER ADMINISTRATIVE AND GENERAL		5.03	33.03
33.04 CAFETERIA--EMPLOYEES AND GUESTS	B	-89,014	CAFETERIA		11.00	33.04
33.05 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-3,158	MEDICAL RECORDS & LIBRARY		16.00	33.05
33.06 INTEREST INCOME OFFSET	B	-12,447	WELLNESS CENTER B&F		1.01	33.06
33.07		0			0.00	33.07
33.08 INTEREST INCOME OFFSET	B	-13,995	NURSING FACILITY		45.00	33.08
33.09 INTEREST INCOME OFFSET	B	-13,995	OTHER LONG TERM CARE		46.00	33.09

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
33.10 INTEREST INCOME OFFSET	B	-2,809	OPERATING ROOM	50.00 33.10
33.11 INTEREST INCOME OFFSET	B	-1,087	ANESTHESIOLOGY	53.00 33.11
33.12 INTEREST INCOME OFFSET	B	-2,259	RADIOLOGY-DIAGNOSTIC	54.00 33.12
34.00 INTEREST INCOME OFFSET	B	-1,989	RESPIRATORY THERAPY	65.00 34.00
34.01 EMPLOYEE CHILD CARE REV	B	-148,309	EMPLOYEE BENEFITS	4.00 34.01
34.02 MISC INCOME	B	-13,105	OTHER ADMINISTRATIVE AND GENERAL	5.03 34.02
34.03		0		0.00 34.03
34.04 OTHER INCOME OLTC	B	-1,973	OTHER LONG TERM CARE	46.00 34.04
34.05		0		0.00 34.05
34.06 OTHER INCOME - MAINTENANCE	B	-1,045	MAINTENANCE & REPAIRS	6.00 34.06
34.07 OTHER INCOME - PRIDE TEAM	B	-426	PHYSICAL THERAPY	66.00 34.07
34.08 TELEPHONE SERVICES	A	-1,885	HOSPITAL BUSINESS OFFICE	5.02 34.08
34.09 TELEPHONE EMP BENEFIT EXPENSE	A	-453	EMPLOYEE BENEFITS	4.00 34.09
34.10 ALCOHOLIC BEVERAGES	A	-461	OTHER ADMINISTRATIVE AND GENERAL	5.03 34.10
34.11 NON-ALLO ADVERTISING SALARIES	A	-9,912	OTHER ADMINISTRATIVE AND GENERAL	5.03 34.11
34.12 ADVERTISING/MARKETING EXPENSE	A	-113,249	OTHER ADMINISTRATIVE AND GENERAL	5.03 34.12
34.13 MARKETING DIET	A	-154	DIETARY	10.00 34.13
34.14 MARKETING NURSING HOME	A	-350	NURSING FACILITY	45.00 34.14
34.15 MARKETING OLTC	A	-7,968	OTHER LONG TERM CARE	46.00 34.15
34.16		0		0.00 34.16
35.00		0		0.00 35.00
36.00 MARKETING PT	A	-3,095	PHYSICAL THERAPY	66.00 36.00
37.00		0		0.00 37.00
38.00		0		0.00 38.00
38.01		0		0.00 38.01
38.02 CHARITABLE CONTRIBUTIONS	A	-18,073	OTHER ADMINISTRATIVE AND GENERAL	5.03 38.02
38.03 ANESTH ON-CALL TIME	A	-219,500	ANESTHESIOLOGY	53.00 38.03
38.04 PATIENT TELEVISION EXPENSE	A	-3,235	OTHER ADMINISTRATIVE AND GENERAL	5.03 38.04
39.00		0		0.00 39.00
39.02		0		0.00 39.02
40.00		0		0.00 40.00
41.00		0		0.00 41.00
41.01		0		0.00 41.01
41.02 MEDI CAID ASSESSMENT	A	-182,352	OTHER ADMINISTRATIVE AND GENERAL	5.03 41.02
41.03 CRNA NURSING SALARY OFFSET	A	-771	ANESTHESIOLOGY	53.00 41.03
41.04 CRNA NURSING EMP BENEFITS OFFSET	A	-185	EMPLOYEE BENEFITS	4.00 41.04
41.05		0		0.00 41.05
41.06 ER PHYSICIAN ASSISTANT - SALARIES	A	-71,611	EMERGENCY	91.00 41.06
41.07 ER PHYSICIAN ASSISTANT - BENEFITS	A	-17,198	EMERGENCY	91.00 41.07
41.08 IHA LOBBYING DUES	A	-6,628	OTHER ADMINISTRATIVE AND GENERAL	5.03 41.08
41.09 LEASE ADJUSTMENTS - CSK-2	A	46,510	RADIOLOGY-DIAGNOSTIC	54.00 41.09
41.10 LEASE ADJUSTMENTS - CSK-3	A	36,000	NEW CAP REL COSTS-MVBLE EQUIP	2.00 41.10
42.00 MARKETING - RENEWED HOPE	A	-2,238	RENEWED HOPE	76.00 42.00
43.00 ADVERTISING	A	-153	ADULTS & PEDIATRICS	30.00 43.00
44.00 ADVERTISING	A	-212	NURSING FACILITY	45.00 44.00
45.01 ADVERTISING	A	-1,293	RENEWED HOPE	76.00 45.01
45.02		0		0.00 45.02
45.03		0		0.00 45.03
45.05		0		0.00 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.)		-1,157,341		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - WELLNESS CENTER B&F (chapter 2)	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
2.01	Investment income - WELLNESS CENTER MME (chapter 2)	0	2.01
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 - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - WELLNESS CENTER B&F	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01	Depreciation - WELLNESS CENTER MME	0	27.01
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	INVEST INCOME-NEW BLDGS AND FIXTURES	11	33.00
33.01	INVESTMENT INCOME-NEW MOVABLE EQUIP	11	33.01
33.02	INVESTMENT INCOME-OTHER	0	33.02
33.03	TRADE, QUANTITY AND TIME DISCOUNTS	0	33.03
33.04	CAFETERIA--EMPLOYEES AND GUESTS	0	33.04
33.05	SALE OF MEDICAL RECORDS & ABSTRACTS	0	33.05
33.06	INTEREST INCOME OFFSET	11	33.06
33.07	INTEREST INCOME OFFSET	0	33.07
33.08	INTEREST INCOME OFFSET	0	33.08
33.09	INTEREST INCOME OFFSET	0	33.09
33.10	INTEREST INCOME OFFSET	0	33.10
33.11	INTEREST INCOME OFFSET	0	33.11
33.12	INTEREST INCOME OFFSET	0	33.12
34.00	INTEREST INCOME OFFSET	0	34.00
34.01	EMPLOYEE CHILD CARE REV	0	34.01
34.02	MISC INCOME	0	34.02
34.03	OTHER INCOME OLTC	0	34.03
34.04	OTHER INCOME OLTC	0	34.04
34.05	OTHER INCOME OLTC	0	34.05
34.06	OTHER INCOME - MAINTENANCE	0	34.06
34.07	OTHER INCOME - PRIDE TEAM	0	34.07
34.08	TELEPHONE SERVICES	0	34.08

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
34.09	TELEPHONE EMP BENEFIT EXPENSE	0	34.09
34.10	ALCOHOLIC BEVERAGES	0	34.10
34.11	NON-ALLO ADVERTISING SALARIES	0	34.11
34.12	ADVERTISING/MARKETING EXPENSE	0	34.12
34.13	MARKETING DIET	0	34.13
34.14	MARKETING NURSING HOME	0	34.14
34.15	MARKETING OLTC	0	34.15
34.16		0	34.16
35.00		0	35.00
36.00	MARKETING PT	0	36.00
37.00		0	37.00
38.00		0	38.00
38.01		0	38.01
38.02	CHARITABLE CONTRIBUTIONS	0	38.02
38.03	ANESTH ON-CALL TIME	0	38.03
38.04	PATIENT TELEVISION EXPENSE	0	38.04
39.00		0	39.00
39.02		0	39.02
40.00		0	40.00
41.00		0	41.00
41.01		0	41.01
41.02	MEDI CAID ASSESSMENT	0	41.02
41.03	CRNA NURSING SALARY OFFSET	0	41.03
41.04	CRNA NURSING EMP BENEFITS OFFSET	0	41.04
41.05		0	41.05
41.06	ER PHYSICIAN ASSISTANT - SALARIES	0	41.06
41.07	ER PHYSICIAN ASSISTANT - BENEFITS	0	41.07
41.08	IHA LOBBYING DUES	0	41.08
41.09	LEASE ADJUSTMENTS - CSK-2	0	41.09
41.10	LEASE ADJUSTMENTS - CSK-3	10	41.10
42.00	MARKETING - RENEWED HOPE	0	42.00
43.00	ADVERTISING	0	43.00
44.00	ADVERTISING	0	44.00
45.01	ADVERTISING	0	45.01
45.02		0	45.02
45.03		0	45.03
45.05		0	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 07/01/2011
To 06/30/2012

Worksheet A-8-1

Date/Time Prepared:
10/24/2012 11:52 am

	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	OTHER ADMINISTRATIVE AND GENERAL	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	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:	FAMILY	0.00	100.00

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

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

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

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-1

Date/Time Prepared:
10/24/2012 11:52 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		234,252	234,252	0	0
2.00		4,836	4,836	0	9
3.00		59,442	59,442	0	0
4.00		144,368	144,368	0	0
4.01		14,556	14,556	0	0
4.02		3,876	3,876	0	0
4.03		19,893	19,893	0	0
4.04		462,904	462,904	0	0
4.06		256,842	256,842	0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,200,969	1,200,969	0	

* 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 PHYSICIANS	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 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
10/24/2012 11:52 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	234,252	14,641	1.00
2.00		91.00	EMERGENCY	849,839	235,922	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
200.00				1,084,091	250,563	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
10/24/2012 11:52 am

	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	219,611	0	0	0	0	1.00
2.00	613,917	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	833,528		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
10/24/2012 11:52 am

	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 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
10/24/2012 11:52 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	14,641	1.00
2.00	0	235,922	2.00
3.00	0	0	3.00
4.00	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	0	0	10.00
200.00	0	250,563	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 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 00100	NEW CAP REL COSTS-BLDG & FIXT	609,564	609,564			1.00
1.01 00101	WELLNESS CENTER B&F	163,824	0	163,824		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	486,699			486,699	2.00
2.01 00201	WELLNESS CENTER MME	26,641			0	26,641 2.01
4.00 00400	EMPLOYEE BENEFITS	2,109,685	37,518	31,869	388	5,298 4.00
5.01 00510	PHYSICIAN BILLING OFFICE	144,368	3,955	0	0	0 5.01
5.02 00511	HOSPITAL BUSINESS OFFICE	720,629	12,587	0	28,345	0 5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	2,496,593	46,225	6,022	72,403	0 5.03
6.00 00600	MAINTENANCE & REPAIRS	748,424	5,423	0	1,792	0 6.00
7.01 00701	WELLNESS CENTER PLANT OP	58,137	0	0	0	0 7.01
7.02 00702	OPERATION OF PLANT ALL	405,618	3,406	0	38,481	0 7.02
8.00 00800	LAUNDRY & LINEN SERVICE	155,643	10,585	0	2,332	0 8.00
9.00 00900	HOUSEKEEPING	199,920	2,370	0	0	0 9.00
10.00 01000	DIETARY	863,043	12,680	0	5,470	0 10.00
11.00 01100	CAFETERIA	55,071	17,581	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	103,721	2,266	0	0	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	350,947	12,190	0	0	0 14.00
15.00 01500	PHARMACY	224,147	2,318	0	4,158	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	354,408	15,182	696	0	0 16.00
17.00 01700	SOCIAL SERVICE	6,221	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,156,859	35,097	0	37,478	0 30.00
45.00 04500	NURSING FACILITY	1,320,685	100,259	341	4,541	59 45.00
46.00 04600	OTHER LONG TERM CARE	399,093	205,628	1,028	5,103	167 46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	705,206	24,057	0	53,335	0 50.00
53.00 05300	ANESTHESIOLOGY	73,246	646	0	7,240	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	878,798	21,216	0	190,300	0 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	106,014	0	0	0	0 58.00
60.00 06000	LABORATORY	857,893	7,812	0	10,965	0 60.00
65.00 06500	RESPIRATORY THERAPY	333,055	3,025	9,900	11,707	846 65.00
66.00 06600	PHYSICAL THERAPY	541,235	1,592	32,738	5,357	5,900 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,456	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	261,793	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	268,223	0	0	0	0 73.00
76.00 03020	RENEWED HOPE	218,413	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	938,469	6,034	0	846	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,701,741	589,652	82,594	480,241	12,270 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	462,904	0	0	1,691	0 192.00
192.01 19201	SATELLITE OFFICES	253,752	0	0	2,255	0 192.01
194.00 07950	ARC (HOPEDALE HALL)	0	0	0	0	0 194.00
194.01 07951	OUTSIDE PROPERTY	0	0	0	0	0 194.01
194.02 07952	RETAIL PHARMACY	1,768,695	0	0	195	0 194.02
194.03 07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0 194.03
194.04 07954	DUPLEX	0	0	0	0	0 194.04
194.06 07955	UNUSED SPACE	0	19,912	0	0	0 194.06
194.07 07956	WELLNESS CENTER	422,553	0	81,230	2,317	14,371 194.07
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	21,609,645	609,564	163,824	486,699	26,641 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
10/24/2012 11:52 am

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	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	WELLNESS CENTER B&F					1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	WELLNESS CENTER MME					2.01	
4.00	00400	EMPLOYEE BENEFITS	2,184,758				4.00	
5.01	00510	PHYSICIAN BILLING OFFICE	27,928	176,251			5.01	
5.02	00511	HOSPITAL BUSINESS OFFICE	77,775	839,336	0	839,336	5.02	
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	210,310	2,831,553	0	0	5.03	
6.00	00600	MAINTENANCE & REPAIRS	87,772	843,411	0	0	6.00	
7.01	00701	WELLNESS CENTER PLANT OP	0	58,137	0	0	7.01	
7.02	00702	OPERATION OF PLANT ALL	0	447,505	0	0	7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	33,668	202,228	0	0	8.00	
9.00	00900	HOUSEKEEPING	38,282	240,572	0	0	9.00	
10.00	01000	DIETARY	120,013	1,001,206	0	0	10.00	
11.00	01100	CAFETERIA	18,817	91,469	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	26,868	132,855	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	48,327	411,464	0	0	14.00	
15.00	01500	PHARMACY	53,385	284,008	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	20,115	390,401	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	6,221	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	244,790	1,474,224	0	93,072	1,567,296	30.00
45.00	04500	NURSING FACILITY	278,203	1,704,088	0	0	1,704,088	45.00
46.00	04600	OTHER LONG TERM CARE	76,641	687,660	0	0	687,660	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	109,940	892,538	0	219,132	1,111,670	50.00
53.00	05300	ANESTHESIOLOGY	238	81,370	0	46,069	127,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,260	1,183,574	0	163,292	1,346,866	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	106,014	0	20,366	126,380	58.00
60.00	06000	LABORATORY	69,068	945,738	0	98,394	1,044,132	60.00
65.00	06500	RESPIRATORY THERAPY	74,680	433,213	0	25,603	458,816	65.00
66.00	06600	PHYSICAL THERAPY	130,990	717,812	0	35,904	753,716	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	359,456	0	31,697	391,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	261,793	0	16,232	278,025	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	268,223	0	44,817	313,040	73.00
76.00	03020	RENEWED HOPE	26,193	244,606	0	12,529	257,135	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	18,391	963,740	0	32,229	995,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,885,654	18,280,666	0	839,336	18,104,415	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	91,819	556,414	29,459	0	585,873	192.00
192.01	19201	SATELLITE OFFICES	55,732	311,739	16,505	0	328,244	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	70,044	1,838,934	97,362	0	1,936,296	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	DUPLEX	0	0	0	0	0	194.04
194.06	07955	UNUSED SPACE	0	19,912	1,054	0	20,966	194.06
194.07	07956	WELLNESS CENTER	81,509	601,980	31,871	0	633,851	194.07
200.00		Cross Foot Adjustments		0			0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,184,758	21,609,645	176,251	839,336	21,609,645	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	WELLNESS CENTER PLANT OP	OPERATION OF PLANT ALL	LAUNDRY & LINEN SERVICE	
		5.03	6.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00560						5.03
6.00	00600	2,831,553					6.00
7.01	00701	127,178	970,589				7.01
7.02	00702	8,766	92,446	159,349			7.02
8.00	00800	67,479	360,336	0	875,320		8.00
9.00	00900	30,494	20,842	0	39,835	293,399	9.00
10.00	01000	36,276	0	0	8,917	23,948	10.00
11.00	01100	150,972	50,113	0	47,720	212	11.00
13.00	01300	13,793	9,819	0	66,161	0	13.00
14.00	01400	20,033	0	0	8,528	0	14.00
15.00	01500	62,045	4,909	0	45,873	0	15.00
16.00	01600	42,826	4,632	0	8,723	0	16.00
17.00	01700	58,869	4,817	881	57,135	0	17.00
	01700	938	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	236,333	182,761	0	132,081	38,970	30.00
45.00	04500	256,959	0	432	0	159,491	45.00
46.00	04600	103,692	86,054	1,301	0	2,279	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	167,629	31,865	0	90,531	27,605	50.00
53.00	05300	19,217	0	0	2,430	0	53.00
54.00	05400	203,094	28,808	0	79,841	5,036	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	19,057	0	0	0	0	58.00
60.00	06000	157,445	7,225	0	29,400	0	60.00
65.00	06500	69,185	6,484	12,527	11,383	758	65.00
66.00	06600	113,653	2,316	41,425	5,989	7,724	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	58,982	0	0	0	0	71.00
72.00	07200	41,923	0	0	0	0	72.00
73.00	07300	47,203	0	0	0	0	73.00
76.00	03020	38,773	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	150,182	4,168	0	22,706	10,132	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,302,996	897,595	56,566	657,253	276,155	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	88,344	20,657	0	0	5,998	192.00
192.01	19201	49,496	3,427	0	130,974	4,369	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	45,297	0	0	0	194.01
194.02	07952	291,978	3,613	0	8,006	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	79,087	0	194.04
194.06	07955	3,161	0	0	0	0	194.06
194.07	07956	95,578	0	102,783	0	6,877	194.07
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,831,553	970,589	159,349	875,320	293,399	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00560						5.03
6.00	00600						6.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900	309,713					9.00
10.00	01000		1,250,223				10.00
11.00	01100			181,242			11.00
13.00	01300				163,479		13.00
14.00	01400			7,234		531,525	14.00
15.00	01500			3,804		3,622	15.00
16.00	01600	2,173		3,577		115	16.00
17.00	01700					0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	69,232	78,559	26,510	137,119	44,352	30.00
45.00	04500	73,658	540,142	31,613		13,801	45.00
46.00	04600	84,786	631,522	14,253		3,735	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000			10,743		62,350	50.00
53.00	05300			27		5,475	53.00
54.00	05400	13,878		10,716		14,249	54.00
57.00	05700						57.00
58.00	05800						58.00
60.00	06000	14,140		8,131		160,870	60.00
65.00	06500			6,296		13,141	65.00
66.00	06600			11,748		1,503	66.00
69.00	06900						69.00
71.00	07100					165,595	71.00
72.00	07200						72.00
73.00	07300						73.00
76.00	03020			2,599		6,087	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100			5,104	26,360	8,411	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		257,867	1,250,223	144,418	163,479	503,306	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200	46,295		14,226		8,177	192.00
192.01	19201					7,844	192.01
194.00	07950						194.00
194.01	07951	5,551					194.01
194.02	07952			7,140		5,328	194.02
194.03	07953						194.03
194.04	07954						194.04
194.06	07955						194.06
194.07	07956			15,458		6,870	194.07
200.00							200.00
201.00							201.00
202.00		309,713	1,250,223	181,242	163,479	531,525	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	WELLNESS CENTER MME					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PHYSICIAN BILLING OFFICE					5.01
5.02	00511	HOSPITAL BUSINESS OFFICE					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.01	00701	WELLNESS CENTER PLANT OP					7.01
7.02	00702	OPERATION OF PLANT ALL					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	347,615				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	517,968			16.00
17.00	01700	SOCIAL SERVICE	0	0	7,159		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	57,434	7,159		30.00
45.00	04500	NURSING FACILITY	0	0	0	2,780,184	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	1,615,282	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	135,242	0	1,637,635	50.00
53.00	05300	ANESTHESIOLOGY	0	28,429	0	183,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,767	0	1,803,255	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,568	0	158,005	58.00
60.00	06000	LABORATORY	0	60,719	0	1,482,062	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,800	0	594,390	65.00
66.00	06600	PHYSICAL THERAPY	0	22,156	0	960,230	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,560	0	635,290	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,017	0	329,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	347,615	27,657	0	735,515	73.00
76.00	03020	RENEWED HOPE	0	7,731	0	312,325	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	19,888	0	1,242,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	347,615	517,968	7,159	17,047,881	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	769,570	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	524,354	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	50,848	194.01
194.02	07952	RETAIL PHARMACY	0	0	0	2,252,361	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	194.03
194.04	07954	DUPLEX	0	0	0	79,087	194.04
194.06	07955	UNUSED SPACE	0	0	0	24,127	194.06
194.07	07956	WELLNESS CENTER	0	0	0	861,417	194.07
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	347,615	517,968	7,159	21,609,645	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part I Date/Time Prepared: 10/24/2012 11:52 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 WELLNESS CENTER B&F		1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201 WELLNESS CENTER MME		2.01
4.00	00400 EMPLOYEE BENEFITS		4.00
5.01	00510 PHYSICIAN BILLING OFFICE		5.01
5.02	00511 HOSPITAL BUSINESS OFFICE		5.02
5.03	00560 OTHER ADMINISTRATIVE AND GENERAL		5.03
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.01	00701 WELLNESS CENTER PLANT OP		7.01
7.02	00702 OPERATION OF PLANT ALL		7.02
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	2,577,806	30.00
45.00	04500 NURSING FACILITY	2,780,184	45.00
46.00	04600 OTHER LONG TERM CARE	1,615,282	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,637,635	50.00
53.00	05300 ANESTHESIOLOGY	183,017	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,803,255	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	158,005	58.00
60.00	06000 LABORATORY	1,482,062	60.00
65.00	06500 RESPIRATORY THERAPY	594,390	65.00
66.00	06600 PHYSICAL THERAPY	960,230	66.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	635,290	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	329,965	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	735,515	73.00
76.00	03020 RENEWED HOPE	312,325	76.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	1,242,920	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,047,881	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	769,570	192.00
192.01	19201 SATELLITE OFFICES	524,354	192.01
194.00	07950 ARC (HOPEDALE HALL)	0	194.00
194.01	07951 OUTSIDE PROPERTY	50,848	194.01
194.02	07952 RETAIL PHARMACY	2,252,361	194.02
194.03	07953 DURABLE MEDICAL EQUIPMENT	0	194.03
194.04	07954 DUPLEX	79,087	194.04
194.06	07955 UNUSED SPACE	24,127	194.06
194.07	07956 WELLNESS CENTER	861,417	194.07
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	21,609,645	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
10/24/2012 11:52 am

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 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	WELLNESS CENTER B&F					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	WELLNESS CENTER MME					2.01
4.00 00400	EMPLOYEE BENEFITS	0	37,518	31,869	388	5,298
5.01 00510	PHYSICIAN BILLING OFFICE	0	3,955	0	0	0
5.02 00511	HOSPITAL BUSINESS OFFICE	0	12,587	0	28,345	0
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	0	46,225	6,022	72,403	0
6.00 00600	MAINTENANCE & REPAIRS	0	5,423	0	1,792	0
7.01 00701	WELLNESS CENTER PLANT OP	0	0	0	0	0
7.02 00702	OPERATION OF PLANT ALL	0	3,406	0	38,481	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	10,585	0	2,332	0
9.00 00900	HOUSEKEEPING	0	2,370	0	0	0
10.00 01000	DIETARY	0	12,680	0	5,470	0
11.00 01100	CAFETERIA	0	17,581	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	2,266	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	12,190	0	0	0
15.00 01500	PHARMACY	0	2,318	0	4,158	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	15,182	696	0	0
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	35,097	0	37,478	0
45.00 04500	NURSING FACILITY	0	100,259	341	4,541	59
46.00 04600	OTHER LONG TERM CARE	0	205,628	1,028	5,103	167
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	24,057	0	53,335	0
53.00 05300	ANESTHESIOLOGY	0	646	0	7,240	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	21,216	0	190,300	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	0	7,812	0	10,965	0
65.00 06500	RESPIRATORY THERAPY	0	3,025	9,900	11,707	846
66.00 06600	PHYSICAL THERAPY	0	1,592	32,738	5,357	5,900
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	RENEWED HOPE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	6,034	0	846	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	589,652	82,594	480,241	12,270
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,691	0
192.01 19201	SATELLITE OFFICES	0	0	0	2,255	0
194.00 07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01 07951	OUTSIDE PROPERTY	0	0	0	0	0
194.02 07952	RETAIL PHARMACY	0	0	0	195	0
194.03 07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
194.04 07954	DUPLEX	0	0	0	0	0
194.06 07955	UNUSED SPACE	0	19,912	0	0	0
194.07 07956	WELLNESS CENTER	0	0	81,230	2,317	14,371
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	0	609,564	163,824	486,699	26,641

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 10/24/2012 11:52 am
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Cost Center Description		Subtotal	EMPLOYEE BENEFITS	PHYSICIAN BILLING OFFICE	HOSPITAL BUSINESS OFFICE	OTHER ADMINISTRATIVE AND GENERAL	
		2A	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	WELLNESS CENTER MME					2.01
4.00	00400	EMPLOYEE BENEFITS	75,073	75,073			4.00
5.01	00510	PHYSICIAN BILLING OFFICE	3,955	960	4,915		5.01
5.02	00511	HOSPITAL BUSINESS OFFICE	40,932	2,672	0	43,604	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	124,650	7,227	0	0	131,877
6.00	00600	MAINTENANCE & REPAIRS	7,215	3,016	0	0	5,923
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	408
7.02	00702	OPERATION OF PLANT ALL	41,887	0	0	0	3,143
8.00	00800	LAUNDRY & LINEN SERVICE	12,917	1,157	0	0	1,420
9.00	00900	HOUSEKEEPING	2,370	1,315	0	0	1,690
10.00	01000	DIETARY	18,150	4,124	0	0	7,031
11.00	01100	CAFETERIA	17,581	647	0	0	642
13.00	01300	NURSING ADMINISTRATION	2,266	923	0	0	933
14.00	01400	CENTRAL SERVICES & SUPPLY	12,190	1,661	0	0	2,890
15.00	01500	PHARMACY	6,476	1,834	0	0	1,995
16.00	01600	MEDICAL RECORDS & LIBRARY	15,878	691	0	0	2,742
17.00	01700	SOCIAL SERVICE	0	0	0	0	44
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	72,575	8,411	0	4,834	11,007
45.00	04500	NURSING FACILITY	105,200	9,561	0	0	11,968
46.00	04600	OTHER LONG TERM CARE	211,926	2,633	0	0	4,829
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,392	3,778	0	11,391	7,807
53.00	05300	ANESTHESIOLOGY	7,886	8	0	2,393	895
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,516	3,205	0	8,481	9,459
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,058	888
60.00	06000	LABORATORY	18,777	2,373	0	5,110	7,333
65.00	06500	RESPIRATORY THERAPY	25,478	2,566	0	1,330	3,222
66.00	06600	PHYSICAL THERAPY	45,587	4,501	0	1,865	5,293
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,646	2,747
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	843	1,953
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,328	2,198
76.00	03020	RENEWED HOPE	0	900	0	651	1,806
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,880	632	0	1,674	6,995
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,164,757	64,795	0	43,604	107,261
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,691	3,155	821	0	4,115
192.01	19201	SATELLITE OFFICES	2,255	1,915	460	0	2,305
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0
194.02	07952	RETAIL PHARMACY	195	2,407	2,716	0	13,597
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
194.04	07954	DUPLEX	0	0	0	0	0
194.06	07955	UNUSED SPACE	19,912	0	29	0	147
194.07	07956	WELLNESS CENTER	97,918	2,801	889	0	4,452
200.00		Cross Foot Adjustments	0				
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,286,728	75,073	4,915	43,604	131,877

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 10/24/2012 11:52 am
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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	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	WELLNESS CENTER B&F					1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	WELLNESS CENTER MME					2.01	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.01	00510	PHYSICIAN BILLING OFFICE					5.01	
5.02	00511	HOSPITAL BUSINESS OFFICE					5.02	
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03	
6.00	00600	MAINTENANCE & REPAIRS	16,154				6.00	
7.01	00701	WELLNESS CENTER PLANT OP	1,539	1,947			7.01	
7.02	00702	OPERATION OF PLANT ALL	5,998	0	51,028		7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	347	0	2,322	18,163	8.00	
9.00	00900	HOUSEKEEPING	0	0	520	1,482	7,377	9.00
10.00	01000	DIETARY	834	0	2,782	13	0	10.00
11.00	01100	CAFETERIA	163	0	3,857	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	497	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82	0	2,674	0	0	14.00
15.00	01500	PHARMACY	77	0	509	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80	11	3,331	0	52	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,042	0	7,698	2,412	1,649	30.00
45.00	04500	NURSING FACILITY	0	5	0	9,875	1,754	45.00
46.00	04600	OTHER LONG TERM CARE	1,432	16	0	141	2,019	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	530	0	5,278	1,709	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	142	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479	0	4,654	312	331	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	120	0	1,714	0	337	60.00
65.00	06500	RESPIRATORY THERAPY	108	153	664	47	0	65.00
66.00	06600	PHYSICAL THERAPY	39	506	349	478	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	69	0	1,324	627	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,939	691	38,315	17,096	6,142	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	344	0	0	371	1,103	192.00
192.01	19201	SATELLITE OFFICES	57	0	7,635	270	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	754	0	0	0	132	194.01
194.02	07952	RETAIL PHARMACY	60	0	467	0	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	DUPLEX	0	0	4,611	0	0	194.04
194.06	07955	UNUSED SPACE	0	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	1,256	0	426	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)	16,154	1,947	51,028	18,163	7,377	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 10/24/2012 11:52 am
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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	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	WELLNESS CENTER MME					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PHYSICIAN BILLING OFFICE					5.01
5.02	00511	HOSPITAL BUSINESS OFFICE					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.01	00701	WELLNESS CENTER PLANT OP					7.01
7.02	00702	OPERATION OF PLANT ALL					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	32,934				10.00
11.00	01100	CAFETERIA	0	22,890			11.00
13.00	01300	NURSING ADMINISTRATION	0	261	4,880		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	914	0	20,411	14.00
15.00	01500	PHARMACY	0	480	0	139	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	452	0	4	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,069	3,348	4,093	1,703	30.00
45.00	04500	NURSING FACILITY	14,229	3,992	0	530	45.00
46.00	04600	OTHER LONG TERM CARE	16,636	1,800	0	143	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,357	0	2,394	50.00
53.00	05300	ANESTHESIOLOGY	0	3	0	210	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,353	0	547	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,027	0	6,178	60.00
65.00	06500	RESPIRATORY THERAPY	0	795	0	505	65.00
66.00	06600	PHYSICAL THERAPY	0	1,484	0	58	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	328	0	234	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	645	787	323	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,934	18,239	4,880	19,327	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,797	0	314	192.00
192.01	19201	SATELLITE OFFICES	0	0	0	301	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	0	902	0	205	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	194.03
194.04	07954	DUPLEX	0	0	0	0	194.04
194.06	07955	UNUSED SPACE	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	1,952	0	264	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)	32,934	22,890	4,880	20,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLNESS CENTER B&F						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	WELLNESS CENTER MME						2.01
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PHYSICIAN BILLING OFFICE						5.01
5.02	00511	HOSPITAL BUSINESS OFFICE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.01	00701	WELLNESS CENTER PLANT OP						7.01
7.02	00702	OPERATION OF PLANT ALL						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,241					16.00
17.00	01700	SOCIAL SERVICE	0	44				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,578	44	125,463	0	125,463	30.00
45.00	04500	NURSING FACILITY	0	0	157,114	0	157,114	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	241,575	0	241,575	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,064	0	117,700	0	117,700	50.00
53.00	05300	ANESTHESIOLOGY	1,276	0	12,813	0	12,813	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,522	0	244,859	0	244,859	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	564	0	2,510	0	2,510	58.00
60.00	06000	LABORATORY	2,725	0	45,694	0	45,694	60.00
65.00	06500	RESPIRATORY THERAPY	709	0	35,577	0	35,577	65.00
66.00	06600	PHYSICAL THERAPY	994	0	61,154	0	61,154	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	878	0	11,630	0	11,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	450	0	3,246	0	3,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,241	0	17,277	0	17,277	73.00
76.00	03020	RENEWED HOPE	347	0	4,266	0	4,266	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	893	0	20,849	0	20,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,241	44	1,101,727	0	1,101,727	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	13,711	0	13,711	192.00
192.01	19201	SATELLITE OFFICES	0	0	15,198	0	15,198	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	886	0	886	194.01
194.02	07952	RETAIL PHARMACY	0	0	20,549	0	20,549	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	DUPLEX	0	0	4,611	0	4,611	194.04
194.06	07955	UNUSED SPACE	0	0	20,088	0	20,088	194.06
194.07	07956	WELLNESS CENTER	0	0	109,958	0	109,958	194.07
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,241	44	1,286,728	0	1,286,728	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
10/24/2012 11:52 am

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	00100	NEW CAP REL COSTS-BLDG & FIXT	188,823					1.00
1.01	00101	WELLNESS CENTER B&F	0	35,064				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			483,640			2.00
2.01	00201	WELLNESS CENTER MME			0	26,649		2.01
4.00	00400	EMPLOYEE BENEFITS	11,622	6,821	386	5,300	8,434,054	4.00
5.01	00510	PHYSICIAN BILLING OFFICE	1,225	0	0	0	107,815	5.01
5.02	00511	HOSPITAL BUSINESS OFFICE	3,899	0	28,167	0	300,245	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	14,319	1,289	71,948	0	811,884	5.03
6.00	00600	MAINTENANCE & REPAIRS	1,680	0	1,781	0	338,837	6.00
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ALL	1,055	0	38,239	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	3,279	0	2,317	0	129,971	8.00
9.00	00900	HOUSEKEEPING	734	0	0	0	147,785	9.00
10.00	01000	DIETARY	3,928	0	5,436	0	463,300	10.00
11.00	01100	CAFETERIA	5,446	0	0	0	72,643	11.00
13.00	01300	NURSING ADMINISTRATION	702	0	0	0	103,721	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,776	0	0	0	186,560	14.00
15.00	01500	PHARMACY	718	0	4,132	0	206,089	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,703	149	0	0	77,652	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,872	0	37,242	0	944,990	30.00
45.00	04500	NURSING FACILITY	31,057	73	4,512	59	1,073,967	45.00
46.00	04600	OTHER LONG TERM CARE	63,697	220	5,071	167	295,865	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,452	0	53,000	0	424,415	50.00
53.00	05300	ANESTHESIOLOGY	200	0	7,194	0	920	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,572	0	189,105	0	360,020	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,420	0	10,896	0	266,631	60.00
65.00	06500	RESPIRATORY THERAPY	937	2,119	11,633	846	288,296	65.00
66.00	06600	PHYSICAL THERAPY	493	7,007	5,323	5,902	505,674	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	101,115	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,869	0	841	0	70,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	182,655	17,678	477,223	12,274	7,279,390	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,680	0	354,458	192.00
192.01	19201	SATELLITE OFFICES	0	0	2,241	0	215,150	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0	194.01
194.02	07952	RETAIL PHARMACY	0	0	194	0	270,398	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	194.03
194.04	07954	DUPLEX	0	0	0	0	0	194.04
194.06	07955	UNUSED SPACE	6,168	0	0	0	0	194.06
194.07	07956	WELLNESS CENTER	0	17,386	2,302	14,375	314,658	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)	609,564	163,824	486,699	26,641	2,184,758	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.228230	4.672142	1.006325	0.999700	0.259040	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					75,073	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.008901	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period: From 07/01/2011 To 06/30/2012

Worksheet B-1

Date/Time Prepared: 10/24/2012 11:52 am

Cost Center Description		Reconciliation	PHYSICIAN BILLING OFFICE (ACCUM. COST)	HOSPITAL BUSINESS OFFICE (GROSS REV)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5A.01	5.01	5.02	5A.03	5.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	WELLNESS CENTER MME					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PHYSICIAN BILLING OFFICE	-176,251	3,328,979			5.01
5.02	00511	HOSPITAL BUSINESS OFFICE	-839,336	0	34,085,201		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-2,831,553	0	0	-2,831,553	18,778,092
6.00	00600	MAINTENANCE & REPAIRS	-843,411	0	0	0	843,411
7.01	00701	WELLNESS CENTER PLANT OP	-58,137	0	0	0	58,137
7.02	00702	OPERATION OF PLANT ALL	-447,505	0	0	0	447,505
8.00	00800	LAUNDRY & LINEN SERVICE	-202,228	0	0	0	202,228
9.00	00900	HOUSEKEEPING	-240,572	0	0	0	240,572
10.00	01000	DIETARY	-1,001,206	0	0	0	1,001,206
11.00	01100	CAFETERIA	-91,469	0	0	0	91,469
13.00	01300	NURSING ADMINISTRATION	-132,855	0	0	0	132,855
14.00	01400	CENTRAL SERVICES & SUPPLY	-411,464	0	0	0	411,464
15.00	01500	PHARMACY	-284,008	0	0	0	284,008
16.00	01600	MEDICAL RECORDS & LIBRARY	-390,401	0	0	0	390,401
17.00	01700	SOCIAL SERVICE	-6,221	0	0	0	6,221
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	-1,474,224	0	3,779,579	0	1,567,296
45.00	04500	NURSING FACILITY	-1,704,088	0	0	0	1,704,088
46.00	04600	OTHER LONG TERM CARE	-687,660	0	0	0	687,660
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	-892,538	0	8,899,243	0	1,111,670
53.00	05300	ANESTHESIOLOGY	-81,370	0	1,870,812	0	127,439
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,183,574	0	6,631,147	0	1,346,866
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-106,014	0	827,056	0	126,380
60.00	06000	LABORATORY	-945,738	0	3,995,692	0	1,044,132
65.00	06500	RESPIRATORY THERAPY	-433,213	0	1,039,732	0	458,816
66.00	06600	PHYSICAL THERAPY	-717,812	0	1,458,011	0	753,716
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-359,456	0	1,287,207	0	391,153
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	-261,793	0	659,173	0	278,025
73.00	07300	DRUGS CHARGED TO PATIENTS	-268,223	0	1,819,995	0	313,040
76.00	03020	RENEWED HOPE	-244,606	0	508,774	0	257,135
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	-963,740	0	1,308,780	0	995,969
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-18,280,666	0	34,085,201	-2,831,553	15,272,862
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	556,414	0	0	585,873
192.01	19201	SATELLITE OFFICES	0	311,739	0	0	328,244
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	0	0	0	0
194.02	07952	RETAIL PHARMACY	0	1,838,934	0	0	1,936,296
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
194.04	07954	DUPLEX	0	0	0	0	0
194.06	07955	UNUSED SPACE	0	19,912	0	0	20,966
194.07	07956	WELLNESS CENTER	0	601,980	0	0	633,851
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		176,251	839,336		2,831,553
203.00		Unit cost multiplier (Wkst. B, Part I)		0.052944	0.024625		0.150790
204.00		Cost to be allocated (per Wkst. B, Part II)		4,915	43,604		131,877
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001476	0.001279		0.007023

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		MAINTENANCE & REPAIRS (MAINT TIME)	WELLNESS CENTER PLANT OP (SQUARE FEET)	OPERATION OF PLANT ALL (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.00	7.01	7.02	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00560						5.03
6.00	00600	10,478					6.00
7.01	00701	998	26,954				7.01
7.02	00702	3,890	0	72,051			7.02
8.00	00800	225	0	3,279	312,872		8.00
9.00	00900	0	0	734	25,537	11,828	9.00
10.00	01000	541	0	3,928	226	0	10.00
11.00	01100	106	0	5,446	0	0	11.00
13.00	01300	0	0	702	0	0	13.00
14.00	01400	53	0	3,776	0	0	14.00
15.00	01500	50	0	718	0	0	15.00
16.00	01600	52	149	4,703	0	83	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,973	0	10,872	41,556	2,644	30.00
45.00	04500	0	73	0	170,078	2,813	45.00
46.00	04600	929	220	0	2,430	3,238	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	344	0	7,452	29,437	0	50.00
53.00	05300	0	0	200	0	0	53.00
54.00	05400	311	0	6,572	5,370	530	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	78	0	2,420	0	540	60.00
65.00	06500	70	2,119	937	808	0	65.00
66.00	06600	25	7,007	493	8,237	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	45	0	1,869	10,805	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		9,690	9,568	54,101	294,484	9,848	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	223	0	0	6,396	1,768	192.00
192.01	19201	37	0	10,781	4,659	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	489	0	0	0	212	194.01
194.02	07952	39	0	659	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	6,510	0	0	194.04
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	17,386	0	7,333	0	194.07
200.00							200.00
201.00							201.00
202.00		970,589	159,349	875,320	293,399	309,713	202.00
203.00		92.631132	5.911887	12.148617	0.937760	26.184731	203.00
204.00		16,154	1,947	51,028	18,163	7,377	204.00
205.00		1.541706	0.072234	0.708221	0.058052	0.623690	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
10/24/2012 11:52 am

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	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00560						5.03
6.00	00600						6.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	115,444					10.00
11.00	01100	0	13,530				11.00
13.00	01300	0	154	49,087			13.00
14.00	01400	0	540	0	1,153,429		14.00
15.00	01500	0	284	0	7,860	100	15.00
16.00	01600	0	267	0	249	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,254	1,979	41,172	96,245	0	30.00
45.00	04500	49,876	2,360	0	29,949	0	45.00
46.00	04600	58,314	1,064	0	8,105	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	802	0	135,302	0	50.00
53.00	05300	0	2	0	11,881	0	53.00
54.00	05400	0	800	0	30,921	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	607	0	349,093	0	60.00
65.00	06500	0	470	0	28,517	0	65.00
66.00	06600	0	877	0	3,262	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	359,349	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	100	73.00
76.00	03020	0	194	0	13,208	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	381	7,915	18,252	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		115,444	10,781	49,087	1,092,193	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,062	0	17,745	0	192.00
192.01	19201	0	0	0	17,022	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	533	0	11,561	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	1,154	0	14,908	0	194.07
200.00							200.00
201.00							201.00
202.00		1,250,223	181,242	163,479	531,525	347,615	202.00
203.00		10.829692	13.395565	3.330393	0.460822	3,476.150000	203.00
204.00		32,934	22,890	4,880	20,411	11,510	204.00
205.00		0.285281	1.691796	0.099415	0.017696	115.100000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	WELLNESS CENTER B&F		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	WELLNESS CENTER MME		2.01
4.00	00400	EMPLOYEE BENEFITS		4.00
5.01	00510	PHYSICIAN BILLING OFFICE		5.01
5.02	00511	HOSPITAL BUSINESS OFFICE		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL		5.03
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.01	00701	WELLNESS CENTER PLANT OP		7.01
7.02	00702	OPERATION OF PLANT ALL		7.02
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,085,201	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,779,579	30.00
45.00	04500	NURSING FACILITY	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,899,243	50.00
53.00	05300	ANESTHESIOLOGY	1,870,812	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,631,147	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	827,056	58.00
60.00	06000	LABORATORY	3,995,692	60.00
65.00	06500	RESPIRATORY THERAPY	1,039,732	65.00
66.00	06600	PHYSICAL THERAPY	1,458,011	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,287,207	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	659,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,819,995	73.00
76.00	03020	RENEWED HOPE	508,774	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,308,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,085,201	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	SATELLITE OFFICES	0	192.01
194.00	07950	ARC (HOPEDALE HALL)	0	194.00
194.01	07951	OUTSIDE PROPERTY	0	194.01
194.02	07952	RETAIL PHARMACY	0	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	194.03
194.04	07954	DUPLEX	0	194.04
194.06	07955	UNUSED SPACE	0	194.06
194.07	07956	WELLNESS CENTER	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)	517,968	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.015196	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,241	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000682	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,577,806		2,577,806	0	0	30.00
45.00	04500	NURSING FACILITY	2,780,184		2,780,184	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	1,615,282		1,615,282	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,637,635		1,637,635	0	0	50.00
53.00	05300	ANESTHESIOLOGY	183,017		183,017	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,803,255		1,803,255	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	158,005		158,005	0	0	58.00
60.00	06000	LABORATORY	1,482,062		1,482,062	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	594,390	0	594,390	0	0	65.00
66.00	06600	PHYSICAL THERAPY	960,230	0	960,230	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	635,290		635,290	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	329,965		329,965	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	735,515		735,515	0	0	73.00
76.00	03020	RENEWED HOPE	312,325		312,325	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,242,920		1,242,920	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	321,881		321,881	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,369,762	0	17,369,762	0	0	200.00
201.00		Less Observation Beds	321,881		321,881			201.00
202.00		Total (see instructions)	17,047,881	0	17,047,881	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,422,725		3,422,725		30.00
45.00	04500	NURSING FACILITY	2,668,935		2,668,935		45.00
46.00	04600	OTHER LONG TERM CARE	1,613,775		1,613,775		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,965,940	5,933,303	8,899,243	0.184020	50.00
53.00	05300	ANESTHESIOLOGY	849,146	1,021,666	1,870,812	0.097828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	677,347	5,953,800	6,631,147	0.271937	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,132	814,924	827,056	0.191045	58.00
60.00	06000	LABORATORY	566,241	3,429,451	3,995,692	0.370915	60.00
65.00	06500	RESPIRATORY THERAPY	490,247	549,485	1,039,732	0.571676	65.00
66.00	06600	PHYSICAL THERAPY	202,210	1,255,801	1,458,011	0.658589	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	712,261	574,946	1,287,207	0.493541	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	476,518	182,655	659,173	0.500574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,615	658,380	1,819,995	0.404130	73.00
76.00	03020	RENEWED HOPE	0	508,774	508,774	0.613878	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	35,499	1,273,281	1,308,780	0.949678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,313	346,541	356,854	0.901996	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,864,904	22,503,007	38,367,911		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,864,904	22,503,007	38,367,911		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 10/24/2012 11:52 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
45.00	04500 NURSING FACILITY			45.00
46.00	04600 OTHER LONG TERM CARE			46.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 RENEWED HOPE	0.000000		76.00
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part II Date/Time Prepared: 10/24/2012 11:52 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	117,700	8,899,243	0.013226	1,577,314	20,862	50.00
53.00	05300 ANESTHESIOLOGY	12,813	1,870,812	0.006849	464,662	3,182	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	244,859	6,631,147	0.036926	351,468	12,978	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,510	827,056	0.003035	8,608	26	58.00
60.00	06000 LABORATORY	45,694	3,995,692	0.011436	311,926	3,567	60.00
65.00	06500 RESPIRATORY THERAPY	35,577	1,039,732	0.034217	179,730	6,150	65.00
66.00	06600 PHYSICAL THERAPY	61,154	1,458,011	0.041943	47,685	2,000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,630	1,287,207	0.009035	352,254	3,183	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,246	659,173	0.004924	249,322	1,228	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17,277	1,819,995	0.009493	510,960	4,851	73.00
76.00	03020 RENEWED HOPE	4,266	508,774	0.008385	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	20,849	1,308,780	0.015930	67	1	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	356,854	0.000000	0	0	92.00
200.00	Total (lines 50-199)	577,575	30,662,476		4,053,996	58,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
10/24/2012 11:52 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,899,243	0.000000	0.000000	1,577,314	50.00
53.00	05300	ANESTHESIOLOGY	0	1,870,812	0.000000	0.000000	464,662	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,631,147	0.000000	0.000000	351,468	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	827,056	0.000000	0.000000	8,608	58.00
60.00	06000	LABORATORY	0	3,995,692	0.000000	0.000000	311,926	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,039,732	0.000000	0.000000	179,730	65.00
66.00	06600	PHYSICAL THERAPY	0	1,458,011	0.000000	0.000000	47,685	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,287,207	0.000000	0.000000	352,254	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	659,173	0.000000	0.000000	249,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,819,995	0.000000	0.000000	510,960	73.00
76.00	03020	RENEWED HOPE	0	508,774	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	1,308,780	0.000000	0.000000	67	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	356,854	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	30,662,476			4,053,996	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
10/24/2012 11:52 am

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	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
10/24/2012 11:52 am

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	05000 OPERATING ROOM	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 RENEWED HOPE	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 10/24/2012 11:52 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			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 05000 OPERATING ROOM	0.184020	0	2,538,258	0		50.00
53.00 05300 ANESTHESIOLOGY	0.097828	0	418,965	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.271937	0	3,092,337	0		54.00
57.00 05700 CT SCAN	0.000000	0	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.191045	0	269,734	0		58.00
60.00 06000 LABORATORY	0.370915	0	1,756,787	0		60.00
65.00 06500 RESPIRATORY THERAPY	0.571676	0	299,853	0		65.00
66.00 06600 PHYSICAL THERAPY	0.658589	0	582,239	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.493541	0	285,472	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.500574	0	122,893	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.404130	0	477,386	365		73.00
76.00 03020 RENEWED HOPE	0.613878	0	425,812	0		76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.949678	0	494,790	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.901996	0	242,436	0		92.00
200.00 Subtotal (see instructions)		0	11,006,962	365		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	11,006,962	365		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 10/24/2012 11:52 am
	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	05000	OPERATING ROOM	0	467,090	0	50.00
53.00	05300	ANESTHESIOLOGY	0	40,987	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	840,921	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	51,531	0	58.00
60.00	06000	LABORATORY	0	651,619	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	171,419	0	65.00
66.00	06600	PHYSICAL THERAPY	0	383,456	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,892	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	61,517	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	192,926	148	73.00
76.00	03020	RENEWED HOPE	0	261,397	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	469,891	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	218,676	0	92.00
200.00		Subtotal (see instructions)	0	3,952,322	148	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,952,322	148	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141330	Period: From 07/01/2011	Worksheet D Part V Date/Time Prepared: 10/24/2012 11:52 am
		Component CCN: 14Z330	To 06/30/2012	
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	05000	OPERATING ROOM	0.184020	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.097828	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.271937	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.191045	0	0	0	58.00
60.00	06000	LABORATORY	0.370915	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.571676	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.658589	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.493541	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.500574	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404130	0	0	0	73.00
76.00	03020	RENEWED HOPE	0.613878	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.949678	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.901996	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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330 Component CCN: 14Z330	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 10/24/2012 11:52 am
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	05000	OPERATING ROOM	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020	RENEWED HOPE	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		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 07/01/2011 To 06/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 10/24/2012 11:52 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,485	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,163	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		544	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)		544	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		22	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		26	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		749	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)		0	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)		1,045	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		119.88	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		119.88	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,577,806	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)		2,637	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		3,117	25.00
26.00	Total swing-bed cost (see instructions)		1,093,351	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,484,455	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,836,755	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,836,755	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.386904	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)		3,299.02	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)		1,484,455	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)		999.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		748,723	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)		748,723	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141330		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 10/24/2012 11:52 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Cost 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)					1,188,000	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,936,723	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)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,044,613	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,044,613	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)					322	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					999.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					321,881	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet D-1

Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description	Cost	Title XVIII		Hospital	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 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 10/24/2012 11:52 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		963,210		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.184020	1,577,314	290,257	50.00
53.00	05300 ANESTHESIOLOGY	0.097828	464,662	45,457	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.271937	351,468	95,577	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.191045	8,608	1,645	58.00
60.00	06000 LABORATORY	0.370915	311,926	115,698	60.00
65.00	06500 RESPIRATORY THERAPY	0.571676	179,730	102,747	65.00
66.00	06600 PHYSICAL THERAPY	0.658589	47,685	31,405	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.493541	352,254	173,852	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.500574	249,322	124,804	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.404130	510,960	206,494	73.00
76.00	03020 RENEWED HOPE	0.613878	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.949678	67	64	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.901996	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,053,996	1,188,000	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)		4,053,996		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 141330	Period: From 07/01/2011	Worksheet D-3
	Component CCN: 14Z330	To 06/30/2012	Date/Time Prepared: 10/24/2012 11:52 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.184020	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.097828	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.271937	77,952	21,198	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.191045	0	0	58.00
60.00	06000 LABORATORY	0.370915	151,830	56,316	60.00
65.00	06500 RESPIRATORY THERAPY	0.571676	180,203	103,018	65.00
66.00	06600 PHYSICAL THERAPY	0.658589	132,949	87,559	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.493541	74,460	36,749	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.500574	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.404130	353,004	142,660	73.00
76.00	03020 RENEWED HOPE	0.613878	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.949678	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.901996	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		970,398	447,500	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)		970,398		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 10/24/2012 11:52 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,952,470 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)			3,952,470 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)			3,991,995 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)			43,880 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,835,576 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)			2,112,539 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)			2,112,539 30.00
31.00	Primary payer payments			174 31.00
32.00	Subtotal (line 30 minus line 31)			2,112,365 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)			138,463 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			138,463 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			138,463 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,250,828 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)			2,250,828 40.00
41.00	Interim payments			2,137,150 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)			113,678 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 10/24/2012 11:52 am
	Title XVIII	Hospital	Cost
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
10/24/2012 11:52 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,413,783		1,650,427		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		48,142		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	02/03/2012	21,064	06/01/2012	499,009		3.01
3.02		06/01/2012	172,646		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	02/03/2012	60,428		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)		193,710		438,581		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)		1,607,493		2,137,150		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		157,904		113,678		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,765,397		2,250,828		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 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
10/24/2012 11:52 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,147,354		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	02/03/2012	60,959		0	3.01
3.02		06/01/2012	197,761		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		258,720		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)		1,406,074		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		65,421		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,471,495		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 07/01/2011 To 06/30/2012	Worksheet E-2	
		Component CCN: 14Z330		Date/Time Prepared: 10/24/2012 11:52 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,055,059	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)		451,975	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		1,045	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)		1,507,034	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,507,034	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)		1,507,034	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		35,539	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)		1,471,495	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)		1,471,495	0	19.00
20.00	Interim payments		1,406,074	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)		65,421	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141330	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 10/24/2012 11:52 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		1,936,723	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)		1,936,723	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,956,090	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)		1,956,090	19.00
20.00	Deductibles (exclude professional component)		205,920	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,750,170	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,750,170	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		15,227	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		15,227	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		15,227	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,765,397	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)		1,765,397	30.00
31.00	Interim payments		1,607,493	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)		157,904	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet G

Date/Time Prepared:
10/24/2012 11:52 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	5,666,980	0	0	0	1.00
2.00	Temporary investments	1,165,508	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,548,078	0	0	0	4.00
5.00	Other receivable	275,470	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	778,416	0	0	0	7.00
8.00	Prepaid expenses	115,051	0	0	0	8.00
9.00	Other current assets	248,788	0	0	0	9.00
10.00	Due from other funds	417,043	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,215,334	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	10,486,241	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)	10,486,241	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	973,721	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	462,560	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,436,281	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,137,856	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	406,246	0	0	0	37.00
38.00	Salaries, wages, and fees payable	965,193	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	728,049	0	0	0	40.00
41.00	Deferred income	388,192	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,495,640	0	0	0	43.00
44.00	Other current liabilities	291,946	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,275,266	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,751,293	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	266,580	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,017,873	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,293,139	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	14,844,717	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)	14,844,717	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,137,856	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
10/24/2012 11:52 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		13,669,311	
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,175,334			2.00
3.00	Total (sum of line 1 and line 2)		14,844,645		0	3.00
4.00	ROUNDING	72		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)		72		0	10.00
11.00	Subtotal (line 3 plus line 10)		14,844,717		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)		14,844,717		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
10/24/2012 11:52 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						4.00
	0			0		
5.00						5.00
	0			0		
6.00						6.00
	0			0		
7.00						7.00
	0			0		
8.00						8.00
	0			0		
9.00						9.00
	0			0		
10.00			0		0	10.00
			0		0	
11.00						11.00
12.00						12.00
	0			0		
13.00						13.00
	0			0		
14.00						14.00
	0			0		
15.00						15.00
	0			0		
16.00						16.00
	0			0		
17.00						17.00
	0			0		
18.00			0		0	18.00
			0		0	
19.00						19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-2 Parts

Date/Time Prepared:
10/24/2012 11:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,836,755		3,836,755	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	2,668,935		2,668,935	8.00
9.00	OTHER LONG TERM CARE	1,613,775		1,613,775	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,119,465		8,119,465	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,119,465		8,119,465	17.00
18.00	Ancillary services	1	1	2	18.00
19.00	Outpatient services	0	1	1	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	OPERATING ROOM	3,361,882	6,394,680	9,756,562	27.00
27.01	ANESTHESIOLOGY	881,460	1,058,813	1,940,273	27.01
27.02	RADIOLOGY DIAGNOSTIC	677,347	5,953,800	6,631,147	27.02
27.03		0	0	0	27.03
27.04	MRI	12,132	814,924	827,056	27.04
27.05	LABORATORY	566,241	3,429,451	3,995,692	27.05
27.06	RESPIRATORY THERAPY	688,426	580,801	1,269,227	27.06
27.07	PHYSICAL THERAPY	202,210	1,256,496	1,458,706	27.07
27.08	EKG	0	0	0	27.08
27.09	MEDICAL SUPPLIES	0	0	0	27.09
27.10	IMPL. DEV. CHARGED TO PATIENT	476,518	182,655	659,173	27.10
27.11	DRUGS	1,201,959	675,254	1,877,213	27.11
27.12	RENEWED HOPE	0	508,774	508,774	27.12
27.13		0	0	0	27.13
27.14	EMERGENCY ROOM	38,110	1,950,084	1,988,194	27.14
27.15	DIETARY	0	17,523	17,523	27.15
27.16	RETAIL PHARMACY	0	1,886,566	1,886,566	27.16
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,225,751	24,709,823	40,935,574	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,766,986		29.00
30.00	PROVISION FOR BAD DEBTS	1,449,340			30.00
31.00	LONG LIVED ASSET IMPAIRMENT	0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,449,340		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,216,326		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141330

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-3

Date/Time Prepared:
10/24/2012 11:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	40,935,574	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,835,769	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,099,805	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,216,326	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-116,521	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	920	6.00
7.00	Income from investments	65,640	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 (SPECIFY)	1,202,544	24.00
24.01	TEMPORARY RESTRICTED ASSETS	42,131	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	1,311,235	25.00
26.00	Total (line 5 plus line 25)	1,194,714	26.00
27.00	CHANGE IN NET UNREAL LOSS ON INVEST	19,380	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	19,380	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,175,334	29.00