

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 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 10/23/2013 1:59 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: 10/23/2013	Time: 1:59 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOPEDALE MEDICAL COMPLEX (141330) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	120,416	-12,220	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	-149,232	0	0	0	5.00
6.00 Swing bed - NF	0				0	6.00
8.00 NURSING FACILITY	0				0	8.00
200.00 Total	0	-28,816	-12,220	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 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 10/23/2013 1:34 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: SECOND STREET	PO Box:	Zip Code: 61747-	1.00
2.00	City: HOPEDALE	State: IL	County: TAZEWELL	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HOPEDALE MEDICAL COMPLEX	141330	37900	1	10/01/2003	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HOPEDALE SWING BED	14Z330	37900		10/01/2003	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2012	06/30/2013	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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid 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 unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid 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	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 10/23/2013 1:34 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete 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 1.00	IME Average 2.00	Direct GME Average 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 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-2
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

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

	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
			3.00
1.00	2.00	3.00	

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
					5.00	
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 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		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y			N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N			N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/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
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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	97,580	0	0	
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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		
		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:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		
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		
				1.00	
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		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

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							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	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under 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)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 10/23/2013 1:34 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for 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		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/23/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 10/23/2013 1:34 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			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.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			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	
		Date	
		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)		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)	08/23/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		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 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	30,661.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	30,661.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	30,661.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	74	27,010		0	20.00
21.00 OTHER LONG TERM CARE	46.00	86	31,390			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		185				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	854	34	1,357			1.00
2.00 HMO	119	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,478	0	1,529			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	28			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,332	34	2,914			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	2,332	34	2,914	0.00	214.09	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY		0	15,747	0.00	33.61	20.00
21.00 OTHER LONG TERM CARE			17,355	0.00	13.70	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	261.40	27.00
28.00 Observation Bed Days		0	345			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 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)			0	246	6	503	1.00
2.00 HMO				28			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	246	6	503	14.00	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	0.00						20.00
21.00 OTHER LONG TERM CARE	0.00					3	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						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 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 10/23/2013 1:34 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.422783	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		228,417	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		52,000	5.00	
6.00	Medicaid charges		1,683,171	6.00	
7.00	Medicaid cost (line 1 times line 6)		711,616	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)		431,199	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)		431,199	19.00	
			1.00		
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	897,811	585,802	1,483,613	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	379,579	247,667	627,246	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)	379,579	247,667	627,246	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)		508,309	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		314,359	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		193,950	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		81,999	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		709,245	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,140,444	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 141330		Period: From 07/01/2012 To 06/30/2013		Worksheet A	
Date/Time Prepared: 10/23/2013 1:34 pm							
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	CAP REL COSTS-BLDG & FIXT		406,729	406,729	417,550	824,279	1.00
1.01 00101	WELLNESS CENTER B&F		60,117	60,117	102,567	162,684	1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP		799,260	799,260	-334,223	465,037	2.00
2.01 00201	WELLNESS CENTER MME		0	0	22,521	22,521	2.01
4.00 00400	EMPLOYEE BENEFITS	170,018	1,922,210	2,092,228	17,749	2,109,977	4.00
5.01 00510	PHYSICIAN BILLING OFFICE	109,218	29,072	138,290	0	138,290	5.01
5.02 00511	HOSPITAL BUSINESS OFFICE	332,550	262,021	594,571	0	594,571	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	950,722	1,673,648	2,624,370	578	2,624,948	5.03
6.00 00600	MAINTENANCE & REPAIRS	359,958	330,264	690,222	0	690,222	6.00
7.01 00701	WELLNESS CENTER PLANT OP	0	62,526	62,526	0	62,526	7.01
7.02 00702	OPERATION OF PLANT ALL	0	481,588	481,588	2,238	483,826	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	149,319	28,820	178,139	0	178,139	8.00
9.00 00900	HOUSEKEEPING	130,210	50,544	180,754	0	180,754	9.00
10.00 01000	DIETARY	527,024	455,859	982,883	-162,464	820,419	10.00
11.00 01100	CAFETERIA	0	0	0	162,464	162,464	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	91,387	91,387	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	196,996	149,573	346,569	0	346,569	14.00
15.00 01500	PHARMACY	164,947	16,050	180,997	-1,945	179,052	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	55,323	227,150	282,473	0	282,473	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	6,046	6,046	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,309,182	306,663	1,615,845	-172,481	1,443,364	30.00
45.00 04500	NURSING FACILITY	1,102,134	294,533	1,396,667	21,267	1,417,934	45.00
46.00 04600	OTHER LONG TERM CARE	323,082	76,288	399,370	21,677	421,047	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	440,510	569,643	1,010,153	-237,156	772,997	50.00
53.00 05300	ANESTHESIOLOGY	338	362,442	362,780	-14,097	348,683	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	337,181	483,943	821,124	2,173	823,297	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	94,345	94,345	0	94,345	58.00
60.00 06000	LABORATORY	289,175	594,003	883,178	0	883,178	60.00
65.00 06500	RESPIRATORY THERAPY	282,880	45,826	328,706	2,488	331,194	65.00
66.00 06600	PHYSICAL THERAPY	490,282	53,920	544,202	-3,606	540,596	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	289,747	289,747	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	475,084	475,084	0	475,084	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	371,907	371,907	0	371,907	73.00
76.00 03020	RENEWED HOPE	101,612	99,170	200,782	0	200,782	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	54,385	1,162,848	1,217,233	46,071	1,263,304	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE		261,021	261,021	-261,021	0	113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	7,877,046	12,207,067	20,084,113	19,530	20,103,643	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	380,037	64,271	444,308	0	444,308	192.00
192.01 19201	SATELLITE OFFICES	243,586	40,472	284,058	0	284,058	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	271,922	1,364,232	1,636,154	0	1,636,154	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	330,957	109,444	440,401	-19,530	420,871	194.07
200.00 20000	TOTAL (SUM OF LINES 118-199)	9,103,548	13,785,486	22,889,034	0	22,889,034	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			
				1.00
1.01	00101	-9,045	815,234	1.01
		-12,482	150,202	2.00
2.00	00200	27,397	492,434	2.00
2.01	00201	0	22,521	2.01
4.00	00400	-132,465	1,977,512	4.00
5.01	00510	0	138,290	5.01
5.02	00511	-2,298	592,273	5.02
5.03	00560	-354,141	2,270,807	5.03
6.00	00600	0	690,222	6.00
7.01	00701	0	62,526	7.01
7.02	00702	-1,482	482,344	7.02
8.00	00800	0	178,139	8.00
9.00	00900	0	180,754	9.00
10.00	01000	-179	820,240	10.00
11.00	01100	-93,022	69,442	11.00
13.00	01300	0	91,387	13.00
14.00	01400	0	346,569	14.00
15.00	01500	0	179,052	15.00
16.00	01600	-1,693	280,780	16.00
17.00	01700	0	6,046	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	0	1,443,364	30.00
45.00	04500	-14,385	1,403,549	45.00
46.00	04600	-26,433	394,614	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	-1,442	771,555	50.00
53.00	05300	-264,064	84,619	53.00
54.00	05400	45,016	868,313	54.00
57.00	05700	0	0	57.00
58.00	05800	-136	94,209	58.00
60.00	06000	0	883,178	60.00
65.00	06500	-1,362	329,832	65.00
66.00	06600	-3,793	536,803	66.00
69.00	06900	0	0	69.00
71.00	07100	0	289,747	71.00
72.00	07200	0	475,084	72.00
73.00	07300	0	371,907	73.00
76.00	03020	-856	199,926	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	-281,943	981,361	91.00
92.00	09200			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	0	0	113.00
118.00		-1,128,808	18,974,835	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
192.00	19200	0	444,308	192.00
192.01	19201	0	284,058	192.01
194.00	07950	0	0	194.00
194.01	07951	0	0	194.01
194.02	07952	0	1,636,154	194.02
194.03	07953	0	0	194.03
194.04	07954	0	0	194.04
194.06	07955	0	0	194.06
194.07	07956	0	420,871	194.07
200.00		-1,128,808	21,760,226	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	79,685	82,779	1.00	
	TOTALS		79,685	82,779		
B - INTEREST EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	176,578	1.00	
2.00	WELLNESS CENTER B&F	1.01	0	18,847	2.00	
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,990	3.00	
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	578	4.00	
5.00	OPERATION OF PLANT ALL	7.02	0	2,238	5.00	
6.00	NURSING FACILITY	45.00	0	21,190	6.00	
7.00	OTHER LONG TERM CARE	46.00	0	21,190	7.00	
8.00	OPERATING ROOM	50.00	0	2,177	8.00	
9.00	ANESTHESIOLOGY	53.00	0	1,003	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,173	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	2,057	11.00	
	TOTALS		0	261,021		
C - ER NURSING RECLASS						
1.00	EMERGENCY	91.00	51,448	0	1.00	
	TOTALS		51,448	0		
D - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	324,692	1.00	
	TOTALS		0	324,692		
E - WELLNESS CENTER DEP						
1.00	WELLNESS CENTER B&F	1.01	0	83,720	1.00	
2.00	WELLNESS CENTER MME	2.01	0	22,521	2.00	
	TOTALS		0	106,241		
F - NURSING ADMIN						
1.00	NURSING ADMINISTRATION	13.00	91,387	0	1.00	
	TOTALS		91,387	0		
G - WELLNESS CENTER RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	12,580	5,169	1.00	
2.00	NURSING FACILITY	45.00	68	28	2.00	
3.00	OTHER LONG TERM CARE	46.00	345	142	3.00	
4.00	RESPIRATORY THERAPY	65.00	833	342	4.00	
5.00	PHYSICAL THERAPY	66.00	16	7	5.00	
	TOTALS		13,842	5,688		
H - SOCIAL SERVICE RECLASS						
1.00	SOCIAL SERVICE	17.00	0	6,046	1.00	
	TOTALS		0	6,046		
I - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	289,747	1.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
	TOTALS		0	289,747		
500.00	Grand Total: Increases		236,362	1,076,214	500.00	

RECLASSIFICATIONS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6

Date/Time Prepared:
10/23/2013 1:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	79,685	82,779	0		1.00
	TOTALS		79,685	82,779			
B - INTEREST EXPENSE RECLASS							
1.00	INTEREST EXPENSE	113.00	0	261,021	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	TOTALS		0	261,021			
C - ER NURSING RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	51,448	0	0		1.00
	TOTALS		51,448	0			
D - BUILDING DEPRECIATION							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	324,692	9		1.00
	TOTALS		0	324,692			
E - WELLNESS CENTER DEP							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	83,720	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,521	9		2.00
	TOTALS		0	106,241			
F - NURSING ADMIN							
1.00	ADULTS & PEDIATRICS	30.00	91,387	0	0		1.00
	TOTALS		91,387	0			
G - WELLNESS CENTER RECLASS							
1.00	WELLNESS CENTER	194.07	13,842	5,688	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		13,842	5,688			
H - SOCIAL SERVICE RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	6,046	0		1.00
	TOTALS		0	6,046			
I - MEDICAL SUPPLIES							
1.00		0.00	0	0	0		1.00
3.00	PHARMACY	15.00	0	1,945	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	23,600	0		4.00
5.00	NURSING FACILITY	45.00	0	19	0		5.00
6.00	OPERATING ROOM	50.00	0	239,333	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	15,100	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	744	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	3,629	0		9.00
10.00	EMERGENCY	91.00	0	5,377	0		10.00
	TOTALS		0	289,747			
500.00	Grand Total : Decreases		236,362	1,076,214			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	752,267	37,998	0	37,998	0	1.00
2.00	Land Improvements	472,426	56,995	0	56,995	0	2.00
3.00	Buildings and Fixtures	18,774,236	250,945	0	250,945	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,196,338	551,749	0	551,749	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,195,267	897,687	0	897,687	0	8.00
9.00	Reconciling Items	-1,856,761	-521,133	0	-521,133	0	9.00
10.00	Total (line 8 minus line 9)	34,052,028	1,418,820	0	1,418,820	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	790,265	0				1.00
2.00	Land Improvements	529,421	0				2.00
3.00	Buildings and Fixtures	19,025,181	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	12,748,087	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	33,092,954	0				8.00
9.00	Reconciling Items	-2,377,894	0				9.00
10.00	Total (line 8 minus line 9)	35,470,848	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	406,729	0	0	0	0	1.00
1.01	WELLNESS CENTER B&F	60,117	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	799,260	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)	1,266,106	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	406,729				1.00
1.01	WELLNESS CENTER B&F	0	60,117				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	799,260				2.00
2.01	WELLNESS CENTER MME	0	0				2.01
3.00	Total (sum of lines 1-2)	0	1,266,106				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	20,344,867	0	20,344,867	0.614779	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	12,748,087	0	12,748,087	0.385221	0	2.00
2.01	WELLNESS CENTER MME	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	33,092,954	0	33,092,954	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	647,701	0	1.00
1.01	WELLNESS CENTER B&F	0	0	0	143,837	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	452,047	36,000	2.00
2.01	WELLNESS CENTER MME	0	0	0	22,521	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,266,106	36,000	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	167,533	0	0	0	815,234	1.00
1.01	WELLNESS CENTER B&F	6,365	0	0	0	150,202	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	4,387	0	0	0	492,434	2.00
2.01	WELLNESS CENTER MME	0	0	0	0	22,521	2.01
3.00	Total (sum of lines 1-2)	178,285	0	0	0	1,480,391	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8

Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst.	A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - WELLNESS CENTER B&F (chapter 2)			0	WELLNESS CENTER B&F	1.01	0	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01 Investment income - WELLNESS CENTER MME (chapter 2)			0	WELLNESS CENTER MME	2.01	0	2.01
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-250,567	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - WELLNESS CENTER B&F			0	WELLNESS CENTER B&F	1.01	0	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01 Depreciation - WELLNESS CENTER MME			0	WELLNESS CENTER MME	2.01	0	27.01
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00

31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			31.00		
				Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.
				*** Cost Center Deleted ***					
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00		
33.00	INVEST INCOME-NEW BLDGS AND FIXTURES	B	-9,045	CAP REL COSTS-BLDG & FIXT	1.00		11 33.00		
33.01	INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-8,603	CAP REL COSTS-MVBLE EQUIP	2.00		11 33.01		
33.02	INVESTMENT INCOME-OTHER	B	-383	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 33.02		
33.03	INTEREST INCOME OFFSET	B	-1,482	OPERATION OF PLANT ALL	7.02		0 33.03		
33.04	TRADE, QUANTITY AND TIME DISCOUNTS	B	-4,264	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 33.04		
33.05	CAFETERIA--EMPLOYEES AND GUESTS	B	-93,022	CAFETERIA	11.00		0 33.05		
33.06	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-1,693	MEDICAL RECORDS & LIBRARY	16.00		0 33.06		
33.08	INTEREST INCOME OFFSET	B	-12,482	WELLNESS CENTER B&F	1.01		11 33.08		
33.09	INTEREST INCOME OFFSET	B	-14,033	NURSING FACILITY	45.00		0 33.09		
33.10	INTEREST INCOME OFFSET	B	-14,033	OTHER LONG TERM CARE	46.00		0 33.10		
33.11	INTEREST INCOME OFFSET	B	-1,442	OPERATING ROOM	50.00		0 33.11		
33.12	INTEREST INCOME OFFSET	B	-664	ANESTHESIOLOGY	53.00		0 33.12		
34.00	INTEREST INCOME OFFSET	B	-1,439	RADIOLOGY-DIAGNOSTIC	54.00		0 34.00		
34.01	INTEREST INCOME OFFSET	B	-1,362	RESPIRATORY THERAPY	65.00		0 34.01		
34.02	EMPLOYEE CHILD CARE REV	B	-131,970	EMPLOYEE BENEFITS	4.00		0 34.02		
34.04	MISC INCOME	B	-4	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 34.04		
34.06			0		0.00		0 34.06		
34.07	OTHER INCOME OLTC	B	-9,788	OTHER LONG TERM CARE	46.00		0 34.07		
34.08			0		0.00		0 34.08		
34.09	TELEPHONE SERVICES	A	-2,298	HOSPITAL BUSINESS OFFICE	5.02		0 34.09		
34.10	TELEPHONE EMP BENEFIT EXPENSE	A	-495	EMPLOYEE BENEFITS	4.00		0 34.10		
34.11	ALCOHOLIC BEVERAGES	A	-472	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 34.11		
34.12	NON-ALLO ADVERTISING SALARIES	A	-37,724	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 34.12		
34.13	ADVERTISING/MARKETING EXPENSE	A	-108,350	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 34.13		
34.14	MARKETING DIET	A	-179	DIETARY	10.00		0 34.14		
34.15	MARKETING NURSING HOME	A	-140	NURSING FACILITY	45.00		0 34.15		
36.00	MARKETING OLTC	A	-2,612	OTHER LONG TERM CARE	46.00		0 36.00		
38.02	MARKETING RAD	A	-55	RADIOLOGY-DIAGNOSTIC	54.00		0 38.02		
38.03	MARKETING - MRI MOBI	A	-136	MRI	58.00		0 38.03		
38.04	MARKETING PT	A	-3,793	PHYSICAL THERAPY	66.00		0 38.04		
41.02			0		0.00		0 41.02		
41.03	CHARITABLE CONTRIBUTIONS	A	-8,720	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 41.03		
41.04	ANESTH ON-CALL TIME	A	-263,400	ANESTHESIOLOGY	53.00		0 41.04		
41.06	PATIENT TELEVISION EXPENSE	A	-3,317	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 41.06		
41.07			0		0.00		0 41.07		
41.08			0		0.00		0 41.08		
41.09			0		0.00		0 41.09		
41.10			0		0.00		0 41.10		
42.00			0		0.00		0 42.00		
43.00	MEDI CAID ASSESSMENT	A	-182,352	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 43.00		
44.00			0		0.00		0 44.00		
44.01			0		0.00		0 44.01		
44.02	ER PHYSICIAN ASSISTANT - SALARIES	A	-25,817	EMERGENCY	91.00		0 44.02		
44.03	ER PHYSICIAN ASSISTANT - BENEFITS	A	-5,559	EMERGENCY	91.00		0 44.03		
44.04	IHA LOBBYING DUES	A	-8,555	OTHER ADMINISTRATIVE AND GENERAL	5.03		0 44.04		
44.05	LEASE ADJUSTMENTS - CSK-2	A	46,510	RADIOLOGY-DIAGNOSTIC	54.00		0 44.05		
44.06	LEASE ADJUSTMENTS - CSK-3	A	36,000	CAP REL COSTS-MVBLE EQUIP	2.00		10 44.06		
44.07	MARKETING - RENEWED HOPE	A	-856	RENEWED HOPE	76.00		0 44.07		
44.08	ADVERTISING	A	-212	NURSING FACILITY	45.00		0 44.08		

Provider CCN: 141330

Period:
 From 07/01/2012
 To 06/30/2013

Worksheet A-8

Date/Time Prepared:
 10/23/2013 1:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
44.09		0			0.00	0	44.09
44.10		0			0.00	0	44.10
45.01		0			0.00	0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	-1,128,808					50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 141330
 Period: From 07/01/2012 To 06/30/2013
 Worksheet A-8-1
 Date/Time Prepared: 10/23/2013 1:34 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	91.00	EMERGENCY	ER PHYSICIAN	229,017	229,017 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MME	4,765	4,765 2.00
3.00	4.00	EMPLOYEE BENEFITS	EMP BENEFITS	64,379	64,379 3.00
4.00	5.01	PHYSICIAN BILLING OFFICE	PHYS BILLING	138,244	138,244 4.00
4.01	5.03	OTHER ADMINISTRATIVE AND GENERAL	A&G ALL	18,102	18,102 4.01
4.02	6.00	MAINTENANCE & REPAIRS	MAINT AND REPAIRS	8,285	8,285 4.02
4.03	7.02	OPERATION OF PLANT ALL	PLANT OP ALL	18,233	18,233 4.03
4.04	192.00	PHYSICIANS' PRIVATE OFFICES	PHYS OFFICES	444,308	444,308 4.04
4.06	192.01	SATELLITE OFFICES	SATELLITE OFFICES	285,541	285,541 4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,210,874	1,210,874 5.00

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

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

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

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

6.00	G		0.00	ROSSI PHYSICIANS	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	RELATED PHYS				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 07/01/2012
To 06/30/2013

Worksheet A-8-1

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8-2

Date/Time Prepared:
10/23/2013 1:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	170,117	10,632	159,485	0	0	1.00
2.00	91.00	EMERGENCY	910,330	239,935	670,395	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,080,447	250,567	829,880			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	10,632		1.00
2.00	91.00	EMERGENCY	0	0	0	239,935		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	250,567		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	WELLNESS CENTER B&F	MVBLE EQUIP	WELLNESS CENTER MME	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	815,234	815,234			1.00
1.01 00101	WELLNESS CENTER B&F	150,202	0	150,202		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	492,434			492,434	2.00
2.01 00201	WELLNESS CENTER MME	22,521			0	2.01
4.00 00400	EMPLOYEE BENEFITS	1,977,512	50,177	29,219	2,490	5,432
5.01 00510	PHYSICIAN BILLING OFFICE	138,290	5,289	0	0	0
5.02 00511	HOSPITAL BUSINESS OFFICE	592,273	16,834	0	22,872	0
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	2,270,807	61,822	5,522	75,508	0
6.00 00600	MAINTENANCE & REPAIRS	690,222	7,253	0	1,046	0
7.01 00701	WELLNESS CENTER PLANT OP	62,526	0	0	0	0
7.02 00702	OPERATION OF PLANT ALL	482,344	4,555	0	46,318	0
8.00 00800	LAUNDRY & LINEN SERVICE	178,139	14,157	0	2,235	0
9.00 00900	HOUSEKEEPING	180,754	3,169	0	0	0
10.00 01000	DIETARY	820,240	16,959	0	1,806	0
11.00 01100	CAFETERIA	69,442	23,513	0	0	0
13.00 01300	NURSING ADMINISTRATION	91,387	3,031	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	346,569	16,303	0	0	0
15.00 01500	PHARMACY	179,052	3,100	0	6,647	0
16.00 01600	MEDICAL RECORDS & LIBRARY	280,780	20,305	638	241	0
17.00 01700	SOCIAL SERVICE	6,046	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,443,364	46,939	0	36,710	0
45.00 04500	NURSING FACILITY	1,403,549	134,087	313	4,268	29
46.00 04600	OTHER LONG TERM CARE	394,614	275,009	942	8,984	149
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	771,555	32,174	0	60,967	0
53.00 05300	ANESTHESIOLOGY	84,619	863	0	618	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	868,313	28,374	0	158,977	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	94,209	0	0	0	0
60.00 06000	LABORATORY	883,178	10,448	0	18,167	0
65.00 06500	RESPIRATORY THERAPY	329,832	4,045	9,077	11,273	431
66.00 06600	PHYSICAL THERAPY	536,803	2,129	30,016	3,119	149
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	289,747	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	475,084	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	371,907	0	0	0	0
76.00 03020	RENEWED HOPE	199,926	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	981,361	8,069	0	449	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)	18,974,835	788,604	75,727	462,695	6,190
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	444,308	0	0	1,603	0
192.01 19201	SATELLITE OFFICES	284,058	0	0	2,161	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	1,636,154	0	0	187	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	26,630	0	0	0
194.07 07956	WELLNESS CENTER	420,871	0	74,475	25,788	16,331
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	21,760,226	815,234	150,202	492,434	22,521

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

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	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	WELLNESS CENTER B&F					1.01	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	WELLNESS CENTER MME					2.01	
4.00	00400	EMPLOYEE BENEFITS	2,064,830				4.00	
5.01	00510	PHYSICIAN BILLING OFFICE	25,542	169,121			5.01	
5.02	00511	HOSPITAL BUSINESS OFFICE	77,233		709,212		5.02	
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	213,514		0	2,627,173	5.03	
6.00	00600	MAINTENANCE & REPAIRS	84,180		0	782,701	6.00	
7.01	00701	WELLNESS CENTER PLANT OP	0	62,526	0	62,526	7.01	
7.02	00702	OPERATION OF PLANT ALL	0	533,217	0	533,217	7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	34,920	229,451	0	229,451	8.00	
9.00	00900	HOUSEKEEPING	30,451	214,374	0	214,374	9.00	
10.00	01000	DIETARY	104,615	943,620	0	943,620	10.00	
11.00	01100	CAFETERIA	18,635	111,590	0	111,590	11.00	
13.00	01300	NURSING ADMINISTRATION	21,372	115,790	0	115,790	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	46,069	408,941	0	408,941	14.00	
15.00	01500	PHARMACY	38,575	227,374	0	227,374	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	12,938	314,902	0	314,902	16.00	
17.00	01700	SOCIAL SERVICE	0	6,046	0	6,046	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	272,762	1,799,775	0	89,451	1,889,226	30.00
45.00	04500	NURSING FACILITY	257,761	1,800,007	0	0	1,800,007	45.00
46.00	04600	OTHER LONG TERM CARE	75,637	755,335	0	0	755,335	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	103,018	967,714	0	167,229	1,134,943	50.00
53.00	05300	ANESTHESIOLOGY	79	86,179	0	35,157	121,336	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,853	1,134,517	0	128,407	1,262,924	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	94,209	0	14,962	109,171	58.00
60.00	06000	LABORATORY	67,626	979,419	0	79,511	1,058,930	60.00
65.00	06500	RESPIRATORY THERAPY	66,349	421,007	0	25,168	446,175	65.00
66.00	06600	PHYSICAL THERAPY	114,661	686,877	0	29,159	716,036	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	289,747	0	23,428	313,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	475,084	0	34,152	509,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	371,907	0	46,177	418,084	73.00
76.00	03020	RENEWED HOPE	23,763	223,689	0	7,409	231,098	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	12,685	1,002,564	0	29,002	1,031,566	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)	1,781,238	18,544,068	0	709,212	18,374,947	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	88,875	534,786	28,122	0	562,908	192.00
192.01	19201	SATELLITE OFFICES	56,965	343,184	18,046	0	361,230	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	63,592	1,699,933	89,391	0	1,789,324	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	26,630	1,400	0	28,030	194.06
194.07	07956	WELLNESS CENTER	74,160	611,625	32,162	0	643,787	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)	2,064,830	21,760,226	169,121	709,212	21,760,226	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

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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						6.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700						17.00
		2,627,173					
		107,473	890,174				
		8,586	96,440	167,552			
		73,217	293,577	0	900,011		
		31,506	11,938	0	40,959	313,854	
		29,436	0	0	9,169	35,293	
		129,569	33,738	0	49,066	376	
		15,323	5,294	0	68,028	0	
		15,899	0	0	8,769	0	
		56,152	5,710	0	47,167	0	
		31,221	8,928	0	8,969	0	
		43,240	5,917	926	58,747	0	
		830	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						30.00
45.00	04500						45.00
46.00	04600						46.00
		259,405	168,173	0	135,805	57,438	
		247,161	0	454	0	159,779	
		103,716	72,148	1,368	0	1,879	
ANCILLARY SERVICE COST CENTERS							
50.00	05000						50.00
53.00	05300						53.00
54.00	05400						54.00
57.00	05700						57.00
58.00	05800						58.00
60.00	06000						60.00
65.00	06500						65.00
66.00	06600						66.00
69.00	06900						69.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
76.00	03020						76.00
		155,840	29,378	0	93,085	5,726	
		16,661	0	0	2,498	0	
		173,413	55,435	0	82,093	4,719	
		0	0	0	0	0	
		14,990	0	0	0	0	
		145,403	11,315	0	30,229	0	
		61,265	5,813	13,172	11,704	622	
		98,320	2,803	43,557	6,158	8,065	
		0	0	0	0	0	
		43,002	0	0	0	0	
		69,924	0	0	0	0	
		57,408	0	0	0	0	
		31,732	0	0	12,991	0	
OUTPATIENT SERVICE COST CENTERS							
91.00	09100						91.00
92.00	09200						92.00
		141,645	3,633	0	23,346	24,489	
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
		2,162,337	810,240	59,477	688,783	298,386	
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200						192.00
192.01	19201						192.01
194.00	07950						194.00
194.01	07951						194.01
194.02	07952						194.02
194.03	07953						194.03
194.04	07954						194.04
194.06	07955						194.06
194.07	07956						194.07
200.00							200.00
201.00							201.00
202.00							202.00
		0	0	0	0	0	
		77,293	25,226	0	0	6,109	
		49,601	7,371	0	134,669	2,956	
		0	0	0	0	0	
		0	43,185	0	0	0	
		245,694	4,152	0	8,232	0	
		0	0	0	0	0	
		0	0	0	68,327	15	
		3,849	0	0	0	0	
		88,399	0	108,075	0	6,388	
		0	0	0	0	0	
		2,627,173	890,174	167,552	900,011	313,854	

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	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	288,272					9.00
10.00	01000		1,156,369				10.00
11.00	01100			200,235			11.00
13.00	01300			1,256	141,714		13.00
14.00	01400			7,248		525,218	14.00
15.00	01500			2,811		1,106	15.00
16.00	01600	2,120		3,385		71	16.00
17.00	01700					0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	51,070	85,616	31,349	126,876	29,021	30.00
45.00	04500	66,791	530,941	40,201		10,795	45.00
46.00	04600	78,845	539,812	16,386		2,454	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000			18,838		46,330	50.00
53.00	05300					2,828	53.00
54.00	05400	11,879		11,016		7,298	54.00
57.00	05700						57.00
58.00	05800						58.00
60.00	06000	11,062		9,557		118,050	60.00
65.00	06500			7,428		11,422	65.00
66.00	06600			12,475		1,368	66.00
69.00	06900						69.00
71.00	07100					101,299	71.00
72.00	07200					166,093	72.00
73.00	07300						73.00
76.00	03020			2,619		346	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100			3,660	14,838	8,007	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		221,767	1,156,369	168,229	141,714	506,488	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200	32,590		12,654		4,856	192.00
192.01	19201					3,190	192.01
194.00	07950						194.00
194.01	07951	5,741					194.01
194.02	07952			6,937		3,407	194.02
194.03	07953						194.03
194.04	07954						194.04
194.06	07955						194.06
194.07	07956	28,174		12,415		7,277	194.07
200.00							200.00
201.00							201.00
202.00		288,272	1,156,369	200,235	141,714	525,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						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						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	280,409					15.00
16.00	01600		429,308				16.00
17.00	01700			6,876			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	54,147	6,876	2,895,002	0	30.00
45.00	04500	0	0	0	2,856,129	0	45.00
46.00	04600	0	0	0	1,571,943	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	101,232	0	1,585,372	0	50.00
53.00	05300	0	21,282	0	164,605	0	53.00
54.00	05400	0	77,728	0	1,686,505	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	9,057	0	133,218	0	58.00
60.00	06000	0	48,130	0	1,432,676	0	60.00
65.00	06500	0	15,235	0	572,836	0	65.00
66.00	06600	0	17,651	0	906,433	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	14,181	0	471,657	0	71.00
72.00	07200	0	20,673	0	765,926	0	72.00
73.00	07300	280,409	27,952	0	783,853	0	73.00
76.00	03020	0	4,485	0	283,271	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	17,555	0	1,268,739	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		280,409	429,308	6,876	17,378,165	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	721,636	0	192.00
192.01	19201	0	0	0	559,017	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	48,926	0	194.01
194.02	07952	0	0	0	2,057,746	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	68,342	0	194.04
194.06	07955	0	0	0	31,879	0	194.06
194.07	07956	0	0	0	894,515	0	194.07
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		280,409	429,308	6,876	21,760,226	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141330

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	WELLNESS CENTER B&F	1.01
2.00	00200	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	30.00
45.00	04500	NURSING FACILITY	45.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	RENEWED HOPE	76.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SATELLITE OFFICES	192.01
194.00	07950	ARC (HOPEDALE HALL)	194.00
194.01	07951	OUTSIDE PROPERTY	194.01
194.02	07952	RETAIL PHARMACY	194.02
194.03	07953	DURABLE MEDICAL EQUIPMENT	194.03
194.04	07954	DUPLEX	194.04
194.06	07955	UNUSED SPACE	194.06
194.07	07956	WELLNESS CENTER	194.07
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

Period:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		BLDG & FIXT	WELLNESS CENTER B&F	MVBLE EQUIP	WELLNESS CENTER MME	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	WELLNESS CENTER B&F					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	WELLNESS CENTER MME					2.01
4.00 00400	EMPLOYEE BENEFITS	0	50,177	29,219	2,490	5,432
5.01 00510	PHYSICIAN BILLING OFFICE	0	5,289	0	0	0
5.02 00511	HOSPITAL BUSINESS OFFICE	0	16,834	0	22,872	0
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	0	61,822	5,522	75,508	0
6.00 00600	MAINTENANCE & REPAIRS	0	7,253	0	1,046	0
7.01 00701	WELLNESS CENTER PLANT OP	0	0	0	0	0
7.02 00702	OPERATION OF PLANT ALL	0	4,555	0	46,318	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	14,157	0	2,235	0
9.00 00900	HOUSEKEEPING	0	3,169	0	0	0
10.00 01000	DIETARY	0	16,959	0	1,806	0
11.00 01100	CAFETERIA	0	23,513	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	3,031	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	16,303	0	0	0
15.00 01500	PHARMACY	0	3,100	0	6,647	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	20,305	638	241	0
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	46,939	0	36,710	0
45.00 04500	NURSING FACILITY	0	134,087	313	4,268	29
46.00 04600	OTHER LONG TERM CARE	0	275,009	942	8,984	149
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	32,174	0	60,967	0
53.00 05300	ANESTHESIOLOGY	0	863	0	618	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	28,374	0	158,977	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
60.00 06000	LABORATORY	0	10,448	0	18,167	0
65.00 06500	RESPIRATORY THERAPY	0	4,045	9,077	11,273	431
66.00 06600	PHYSICAL THERAPY	0	2,129	30,016	3,119	149
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	RENEWED HOPE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	8,069	0	449	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	788,604	75,727	462,695	6,190
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	1,603	0
192.01 19201	SATELLITE OFFICES	0	0	0	2,161	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	187	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	26,630	0	0	0
194.07 07956	WELLNESS CENTER	0	0	74,475	25,788	16,331
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	0	815,234	150,202	492,434	22,521

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet B Part II Date/Time Prepared: 10/23/2013 1:34 pm			
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	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	WELLNESS CENTER MME					2.01
4.00	00400	EMPLOYEE BENEFITS	87,318	87,318			4.00
5.01	00510	PHYSICIAN BILLING OFFICE	5,289	1,080	6,369		5.01
5.02	00511	HOSPITAL BUSINESS OFFICE	39,706	3,266	0	42,972	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	142,852	9,030	0	0	151,882
6.00	00600	MAINTENANCE & REPAIRS	8,299	3,560	0	0	6,213
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	496
7.02	00702	OPERATION OF PLANT ALL	50,873	0	0	0	4,233
8.00	00800	LAUNDRY & LINEN SERVICE	16,392	1,477	0	0	1,821
9.00	00900	HOUSEKEEPING	3,169	1,288	0	0	1,702
10.00	01000	DIETARY	18,765	4,424	0	0	7,490
11.00	01100	CAFETERIA	23,513	788	0	0	886
13.00	01300	NURSING ADMINISTRATION	3,031	904	0	0	919
14.00	01400	CENTRAL SERVICES & SUPPLY	16,303	1,948	0	0	3,246
15.00	01500	PHARMACY	9,747	1,631	0	0	1,805
16.00	01600	MEDICAL RECORDS & LIBRARY	21,184	547	0	0	2,500
17.00	01700	SOCIAL SERVICE	0	0	0	0	48
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	83,649	11,531	0	5,419	15,001
45.00	04500	NURSING FACILITY	138,697	10,901	0	0	14,288
46.00	04600	OTHER LONG TERM CARE	285,084	3,199	0	0	5,996
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	93,141	4,357	0	10,137	9,009
53.00	05300	ANESTHESIOLOGY	1,481	3	0	2,130	963
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,351	3,335	0	7,779	10,025
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	906	867
60.00	06000	LABORATORY	28,615	2,860	0	4,817	8,406
65.00	06500	RESPIRATORY THERAPY	24,826	2,806	0	1,525	3,542
66.00	06600	PHYSICAL THERAPY	35,413	4,849	0	1,767	5,684
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,419	2,486
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,069	4,042
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,798	3,319
76.00	03020	RENEWED HOPE	0	1,005	0	449	1,834
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	8,518	536	0	1,757	8,189
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)	1,333,216	75,325	0	42,972	125,010
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,603	3,759	1,059	0	4,468
192.01	19201	SATELLITE OFFICES	2,161	2,409	680	0	2,867
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	187	2,689	3,366	0	14,204
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	26,630	0	53	0	223
194.07	07956	WELLNESS CENTER	116,594	3,136	1,211	0	5,110
200.00		Cross Foot Adjustments	0				
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,480,391	87,318	6,369	42,972	151,882

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141330		Period: From 07/01/2012 To 06/30/2013		Worksheet B Part II Date/Time Prepared: 10/23/2013 1:34 pm	
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	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
2.00	00200	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	18,072				6.00
7.01	00701	WELLNESS CENTER PLANT OP	1,958	2,454			7.01
7.02	00702	OPERATION OF PLANT ALL	5,961	0	61,067		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	242	0	2,779	22,711	8.00
9.00	00900	HOUSEKEEPING	0	0	622	2,554	9,335
10.00	01000	DIETARY	685	0	3,329	27	0
11.00	01100	CAFETERIA	107	0	4,616	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	595	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	116	0	3,200	0	0
15.00	01500	PHARMACY	181	0	609	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	120	14	3,986	0	69
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,414	0	9,215	4,156	1,654
45.00	04500	NURSING FACILITY	0	7	0	11,563	2,163
46.00	04600	OTHER LONG TERM CARE	1,465	20	0	136	2,553
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	596	0	6,316	414	0
53.00	05300	ANESTHESIOLOGY	0	0	170	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,125	0	5,570	341	385
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	230	0	2,051	0	358
65.00	06500	RESPIRATORY THERAPY	118	193	794	45	0
66.00	06600	PHYSICAL THERAPY	57	638	418	584	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	RENEWED HOPE	0	0	881	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	74	0	1,584	1,772	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)	16,449	872	46,735	21,592	7,182
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	512	0	0	442	1,055
192.01	19201	SATELLITE OFFICES	150	0	9,137	214	0
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	877	0	0	0	186
194.02	07952	RETAIL PHARMACY	84	0	559	0	0
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
194.04	07954	DUPLEX	0	0	4,636	1	0
194.06	07955	UNUSED SPACE	0	0	0	0	0
194.07	07956	WELLNESS CENTER	0	1,582	0	462	912
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	18,072	2,454	61,067	22,711	9,335

ALLOCATION OF CAPITAL RELATED COSTS

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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						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	34,720					10.00
11.00	01100	0	29,910				11.00
13.00	01300	0	188	5,637			13.00
14.00	01400	0	1,083	0	25,896		14.00
15.00	01500	0	420	0	55	14,448	15.00
16.00	01600	0	506	0	4	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,571	4,683	5,047	1,431	0	30.00
45.00	04500	15,941	6,004	0	532	0	45.00
46.00	04600	16,208	2,448	0	121	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,814	0	2,284	0	50.00
53.00	05300	0	0	0	139	0	53.00
54.00	05400	0	1,645	0	360	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	1,428	0	5,820	0	60.00
65.00	06500	0	1,109	0	563	0	65.00
66.00	06600	0	1,863	0	67	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	4,994	0	71.00
72.00	07200	0	0	0	8,191	0	72.00
73.00	07300	0	0	0	0	14,448	73.00
76.00	03020	0	391	0	17	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	547	590	395	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		34,720	25,129	5,637	24,973	14,448	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,890	0	239	0	192.00
192.01	19201	0	0	0	157	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	1,036	0	168	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	1,855	0	359	0	194.07
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		34,720	29,910	5,637	25,896	14,448	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141330

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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	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLNESS CENTER B&F					1.01
2.00	00200	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	28,930				16.00
17.00	01700	SOCIAL SERVICE	0	48			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,650	48	151,469	0	151,469
45.00	04500	NURSING FACILITY	0	0	200,096	0	200,096
46.00	04600	OTHER LONG TERM CARE	0	0	317,230	0	317,230
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,818	0	135,886	0	135,886
53.00	05300	ANESTHESIOLOGY	1,434	0	6,320	0	6,320
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,239	0	223,155	0	223,155
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	610	0	2,383	0	2,383
60.00	06000	LABORATORY	3,244	0	57,829	0	57,829
65.00	06500	RESPIRATORY THERAPY	1,027	0	36,548	0	36,548
66.00	06600	PHYSICAL THERAPY	1,190	0	52,530	0	52,530
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	956	0	9,855	0	9,855
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,393	0	15,695	0	15,695
73.00	07300	DRUGS CHARGED TO PATIENTS	1,884	0	22,449	0	22,449
76.00	03020	RENEWED HOPE	302	0	4,879	0	4,879
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,183	0	25,145	0	25,145
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)	28,930	48	1,261,469	0	1,261,469
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	15,027	0	15,027
192.01	19201	SATELLITE OFFICES	0	0	17,775	0	17,775
194.00	07950	ARC (HOPEDALE HALL)	0	0	0	0	0
194.01	07951	OUTSIDE PROPERTY	0	0	1,063	0	1,063
194.02	07952	RETAIL PHARMACY	0	0	22,293	0	22,293
194.03	07953	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
194.04	07954	DUPLEX	0	0	4,637	0	4,637
194.06	07955	UNUSED SPACE	0	0	26,906	0	26,906
194.07	07956	WELLNESS CENTER	0	0	131,221	0	131,221
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	28,930	48	1,480,391	0	1,480,391

COST ALLOCATION - STATISTICAL BASIS

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Period:
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Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIE)	
		BLDG & FIXT (SQUARE FEET)	WELLNESS CENTER B&F (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	WELLNESS CENTER MME (DOLLAR VALUE)		
		1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	188,823				1.00
1.01	00101	WELLNESS CENTER B&F	0	35,064			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			510,566		2.00
2.01	00201	WELLNESS CENTER MME			0	22,527	2.01
4.00	00400	EMPLOYEE BENEFITS	11,622	6,821	2,582	5,433	8,829,335
5.01	00510	PHYSICIAN BILLING OFFICE	1,225	0	0	0	109,218
5.02	00511	HOSPITAL BUSINESS OFFICE	3,899	0	23,714	0	330,252
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	14,319	1,289	78,288	0	912,998
6.00	00600	MAINTENANCE & REPAIRS	1,680	0	1,084	0	359,958
7.01	00701	WELLNESS CENTER PLANT OP	0	0	0	0	0
7.02	00702	OPERATION OF PLANT ALL	1,055	0	48,023	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	3,279	0	2,317	0	149,319
9.00	00900	HOUSEKEEPING	734	0	0	0	130,210
10.00	01000	DIETARY	3,928	0	1,872	0	447,339
11.00	01100	CAFETERIA	5,446	0	0	0	79,685
13.00	01300	NURSING ADMINISTRATION	702	0	0	0	91,387
14.00	01400	CENTRAL SERVICES & SUPPLY	3,776	0	0	0	196,996
15.00	01500	PHARMACY	718	0	6,892	0	164,947
16.00	01600	MEDICAL RECORDS & LIBRARY	4,703	149	250	0	55,323
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,872	0	38,062	0	1,166,347
45.00	04500	NURSING FACILITY	31,057	73	4,425	29	1,102,202
46.00	04600	OTHER LONG TERM CARE	63,697	220	9,315	149	323,427
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,452	0	63,212	0	440,510
53.00	05300	ANESTHESIOLOGY	200	0	641	0	338
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,572	0	164,830	0	337,181
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	2,420	0	18,836	0	289,175
65.00	06500	RESPIRATORY THERAPY	937	2,119	11,688	431	283,713
66.00	06600	PHYSICAL THERAPY	493	7,007	3,234	149	490,298
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	RENEWED HOPE	0	0	0	0	101,612
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,869	0	466	0	54,241
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)	182,655	17,678	479,731	6,191	7,616,676
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,662	0	380,037
192.01	19201	SATELLITE OFFICES	0	0	2,241	0	243,586
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	194	0	271,922
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	6,168	0	0	0	0
194.07	07956	WELLNESS CENTER	0	17,386	26,738	16,336	317,114
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	815,234	150,202	492,434	22,521	2,064,830
203.00		Unit cost multiplier (Wkst. B, Part I)	4.317451	4.283653	0.964486	0.999734	0.233860
204.00		Cost to be allocated (per Wkst. B, Part II)					87,318
205.00		Unit cost multiplier (Wkst. B, Part II)					0.009890

COST ALLOCATION - STATISTICAL BASIS

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Cost Center Description	Reconciliation	PHYSICIAN	HOSPITAL	Reconciliation	OTHER	
		BILLING OFFICE	BUSINESS OFFICE		ADMINISTRATIVE AND GENERAL	
	5A.01	(ACCUM. COST) 5.01	(GROSS REV) 5.02	5A.03	(ACCUM. COST) 5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	WELLNESS CENTER B&F					1.01
2.00 00200	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	-169,121	3,216,158			5.01
5.02 00511	HOSPITAL BUSINESS OFFICE	-709,212	0	36,536,039		5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	-2,627,173	0	-2,627,173	19,133,053	5.03
6.00 00600	MAINTENANCE & REPAIRS	-782,701	0	0	782,701	6.00
7.01 00701	WELLNESS CENTER PLANT OP	-62,526	0	0	62,526	7.01
7.02 00702	OPERATION OF PLANT ALL	-533,217	0	0	533,217	7.02
8.00 00800	LAUNDRY & LINEN SERVICE	-229,451	0	0	229,451	8.00
9.00 00900	HOUSEKEEPING	-214,374	0	0	214,374	9.00
10.00 01000	DIETARY	-943,620	0	0	943,620	10.00
11.00 01100	CAFETERIA	-111,590	0	0	111,590	11.00
13.00 01300	NURSING ADMINISTRATION	-115,790	0	0	115,790	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	-408,941	0	0	408,941	14.00
15.00 01500	PHARMACY	-227,374	0	0	227,374	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	-314,902	0	0	314,902	16.00
17.00 01700	SOCIAL SERVICE	-6,046	0	0	6,046	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	-1,799,775	0	4,608,288	0	1,889,226
45.00 04500	NURSING FACILITY	-1,800,007	0	0	0	1,800,007
46.00 04600	OTHER LONG TERM CARE	-755,335	0	0	0	755,335
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	-967,714	0	8,614,542	0	1,134,943
53.00 05300	ANESTHESIOLOGY	-86,179	0	1,811,211	0	121,336
54.00 05400	RADIOLOGY-DIAGNOSTIC	-1,134,517	0	6,615,157	0	1,262,924
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	-94,209	0	770,819	0	109,171
60.00 06000	LABORATORY	-979,419	0	4,096,181	0	1,058,930
65.00 06500	RESPIRATORY THERAPY	-421,007	0	1,296,578	0	446,175
66.00 06600	PHYSICAL THERAPY	-686,877	0	1,502,213	0	716,036
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-289,747	0	1,206,929	0	313,175
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	-475,084	0	1,759,432	0	509,236
73.00 07300	DRUGS CHARGED TO PATIENTS	-371,907	0	2,378,898	0	418,084
76.00 03020	RENEWED HOPE	-223,689	0	381,712	0	231,098
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	-1,002,564	0	1,494,079	0	1,031,566
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	-18,544,068	0	36,536,039	-2,627,173	15,747,774
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	534,786	0	0	562,908
192.01 19201	SATELLITE OFFICES	0	343,184	0	0	361,230
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	1,699,933	0	0	1,789,324
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	26,630	0	0	28,030
194.07 07956	WELLNESS CENTER	0	611,625	0	0	643,787
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)		169,121	709,212		2,627,173
203.00	Unit cost multiplier (Wkst. B, Part I)		0.052585	0.019411		0.137311
204.00	Cost to be allocated (per Wkst. B, Part II)		6,369	42,972		151,882
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001980	0.001176		0.007938

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period: From 07/01/2012 To 06/30/2013

Worksheet B-1

Date/Time Prepared: 10/23/2013 1:34 pm

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	8,575					6.00
7.01	00701	929	26,954				7.01
7.02	00702	2,828	0	72,051			7.02
8.00	00800	115	0	3,279	314,387		8.00
9.00	00900	0	0	734	35,353	13,056	9.00
10.00	01000	325	0	3,928	377	0	10.00
11.00	01100	51	0	5,446	0	0	11.00
13.00	01300	0	0	702	0	0	13.00
14.00	01400	55	0	3,776	0	0	14.00
15.00	01500	86	0	718	0	0	15.00
16.00	01600	57	149	4,703	0	96	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,620	0	10,872	57,536	2,313	30.00
45.00	04500	0	73	0	160,049	3,025	45.00
46.00	04600	695	220	0	1,882	3,571	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	283	0	7,452	5,736	0	50.00
53.00	05300	0	0	200	0	0	53.00
54.00	05400	534	0	6,572	4,727	538	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	109	0	2,420	0	501	60.00
65.00	06500	56	2,119	937	623	0	65.00
66.00	06600	27	7,007	493	8,079	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	1,040	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	35	0	1,869	24,531	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		7,805	9,568	55,141	298,893	10,044	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	243	0	0	6,119	1,476	192.00
192.01	19201	71	0	10,781	2,961	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	416	0	0	0	260	194.01
194.02	07952	40	0	659	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	5,470	15	0	194.04
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	17,386	0	6,399	1,276	194.07
200.00							200.00
201.00							201.00
202.00		890,174	167,552	900,011	313,854	288,272	202.00
203.00		103.810379	6.216220	12.491305	0.998305	22.079657	203.00
204.00		18,072	2,454	61,067	22,711	9,335	204.00
205.00		2.107522	0.091044	0.847552	0.072239	0.714997	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSNG HR)	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	116,399					10.00
11.00	01100	0	16,741				11.00
13.00	01300	0	105	60,887			13.00
14.00	01400	0	606	0	1,502,319		14.00
15.00	01500	0	235	0	3,164	100	15.00
16.00	01600	0	283	0	204	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,618	2,621	54,512	83,012	0	30.00
45.00	04500	53,444	3,361	0	30,879	0	45.00
46.00	04600	54,337	1,370	0	7,018	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	1,575	0	132,521	0	50.00
53.00	05300	0	0	0	8,089	0	53.00
54.00	05400	0	921	0	20,874	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	799	0	337,666	0	60.00
65.00	06500	0	621	0	32,671	0	65.00
66.00	06600	0	1,043	0	3,912	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	289,754	0	71.00
72.00	07200	0	0	0	475,084	0	72.00
73.00	07300	0	0	0	0	100	73.00
76.00	03020	0	219	0	991	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	306	6,375	22,903	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		116,399	14,065	60,887	1,448,742	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,058	0	13,891	0	192.00
192.01	19201	0	0	0	9,125	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	580	0	9,746	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	1,038	0	20,815	0	194.07
200.00							200.00
201.00							201.00
202.00		1,156,369	200,235	141,714	525,218	280,409	202.00
203.00		9.934527	11.960755	2.327492	0.349605	2,804.090000	203.00
204.00		34,720	29,910	5,637	25,896	14,448	204.00
205.00		0.298284	1.786632	0.092581	0.017237	144.480000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (ASSIGNED TIME)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	WELLNESS CENTER B&F		1.01
2.00	00200	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	36,536,039	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	4,608,288	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	8,614,542	50.00
53.00	05300	ANESTHESIOLOGY	1,811,211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,615,157	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	770,819	58.00
60.00	06000	LABORATORY	4,096,181	60.00
65.00	06500	RESPIRATORY THERAPY	1,296,578	65.00
66.00	06600	PHYSICAL THERAPY	1,502,213	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,206,929	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,759,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,378,898	73.00
76.00	03020	RENEWED HOPE	381,712	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,494,079	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)	36,536,039	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)	429,308	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011750	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000792	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,895,002		2,895,002	0	0	30.00
45.00	04500 NURSING FACILITY	2,856,129		2,856,129	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	1,571,943		1,571,943	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,585,372		1,585,372	0	0	50.00
53.00	05300 ANESTHESIOLOGY	164,605		164,605	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,686,505		1,686,505	0	0	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	133,218		133,218	0	0	58.00
60.00	06000 LABORATORY	1,432,676		1,432,676	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	572,836	0	572,836	0	0	65.00
66.00	06600 PHYSICAL THERAPY	906,433	0	906,433	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	471,657		471,657	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	765,926		765,926	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	783,853		783,853	0	0	73.00
76.00	03020 RENEWED HOPE	283,271		283,271	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,268,739		1,268,739	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	308,765		308,765	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	17,686,930	0	17,686,930	0	0	200.00
201.00	Less Observation Beds	308,765		308,765			201.00
202.00	Total (see instructions)	17,378,165	0	17,378,165	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

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	4,221,601		4,221,601		30.00
45.00	04500	NURSING FACILITY	3,207,207		3,207,207		45.00
46.00	04600	OTHER LONG TERM CARE	1,360,931		1,360,931		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,245,964	5,368,579	8,614,543	0.184034	50.00
53.00	05300	ANESTHESIOLOGY	967,618	843,593	1,811,211	0.090881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	892,832	5,722,325	6,615,157	0.254946	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	36,068	734,751	770,819	0.172827	58.00
60.00	06000	LABORATORY	732,514	3,363,667	4,096,181	0.349759	60.00
65.00	06500	RESPIRATORY THERAPY	777,933	518,645	1,296,578	0.441806	65.00
66.00	06600	PHYSICAL THERAPY	301,764	1,200,449	1,502,213	0.603398	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	706,960	499,969	1,206,929	0.390791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,560,313	199,119	1,759,432	0.435326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,452,769	926,129	2,378,898	0.329503	73.00
76.00	03020	RENEWED HOPE	0	381,712	381,712	0.742107	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	50,911	1,443,168	1,494,079	0.849178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,093	378,594	386,687	0.798488	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	19,523,478	21,580,700	41,104,178		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,523,478	21,580,700	41,104,178		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 10/23/2013 1:34 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
45.00	04500 NURSING FACILITY			45.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 RENEWED HOPE	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,895,002		2,895,002	0	0	30.00
45.00	04500	NURSING FACILITY	2,856,129		2,856,129	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	1,571,943		1,571,943	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,585,372		1,585,372	0	0	50.00
53.00	05300	ANESTHESIOLOGY	164,605		164,605	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,686,505		1,686,505	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	133,218		133,218	0	0	58.00
60.00	06000	LABORATORY	1,432,676		1,432,676	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	572,836	0	572,836	0	0	65.00
66.00	06600	PHYSICAL THERAPY	906,433	0	906,433	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	471,657		471,657	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	765,926		765,926	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	783,853		783,853	0	0	73.00
76.00	03020	RENEWED HOPE	283,271		283,271	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,268,739		1,268,739	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	308,765		308,765		0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,686,930	0	17,686,930	0	0	200.00
201.00		Less Observation Beds	308,765		308,765		0	201.00
202.00		Total (see instructions)	17,378,165	0	17,378,165	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,221,601		4,221,601		30.00
45.00	04500	NURSING FACILITY	3,207,207		3,207,207		45.00
46.00	04600	OTHER LONG TERM CARE	1,360,931		1,360,931		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,245,964	5,368,579	8,614,543	0.184034	50.00
53.00	05300	ANESTHESIOLOGY	967,618	843,593	1,811,211	0.090881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	892,832	5,722,325	6,615,157	0.254946	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	36,068	734,751	770,819	0.172827	58.00
60.00	06000	LABORATORY	732,514	3,363,667	4,096,181	0.349759	60.00
65.00	06500	RESPIRATORY THERAPY	777,933	518,645	1,296,578	0.441806	65.00
66.00	06600	PHYSICAL THERAPY	301,764	1,200,449	1,502,213	0.603398	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	706,960	499,969	1,206,929	0.390791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,560,313	199,119	1,759,432	0.435326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,452,769	926,129	2,378,898	0.329503	73.00
76.00	03020	RENEWED HOPE	0	381,712	381,712	0.742107	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	50,911	1,443,168	1,494,079	0.849178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,093	378,594	386,687	0.798488	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	19,523,478	21,580,700	41,104,178		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,523,478	21,580,700	41,104,178		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 10/23/2013 1:34 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
45.00	04500 NURSING FACILITY			45.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 RENEWED HOPE	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 10/23/2013 1:34 pm
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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	135,886	8,614,543	0.015774	1,952,624	30,801	50.00
53.00	05300	ANESTHESIOLOGY	6,320	1,811,211	0.003489	573,227	2,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,155	6,615,157	0.033734	476,855	16,086	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	2,383	770,819	0.003092	21,400	66	58.00
60.00	06000	LABORATORY	57,829	4,096,181	0.014118	346,584	4,893	60.00
65.00	06500	RESPIRATORY THERAPY	36,548	1,296,578	0.028188	280,323	7,902	65.00
66.00	06600	PHYSICAL THERAPY	52,530	1,502,213	0.034968	59,275	2,073	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,855	1,206,929	0.008165	354,501	2,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,695	1,759,432	0.008920	866,263	7,727	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,449	2,378,898	0.009437	596,708	5,631	73.00
76.00	03020	RENEWED HOPE	4,879	381,712	0.012782	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	25,145	1,494,079	0.016830	3,042	51	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	386,687	0.000000	0	0	92.00
200.00		Total (lines 50-199)	592,674	32,314,439		5,530,802	80,125	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
10/23/2013 1:34 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	8,614,543	0.000000	0.000000	1,952,624	50.00
53.00	05300 ANESTHESIOLOGY	0	1,811,211	0.000000	0.000000	573,227	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,615,157	0.000000	0.000000	476,855	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	770,819	0.000000	0.000000	21,400	58.00
60.00	06000 LABORATORY	0	4,096,181	0.000000	0.000000	346,584	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,296,578	0.000000	0.000000	280,323	65.00
66.00	06600 PHYSICAL THERAPY	0	1,502,213	0.000000	0.000000	59,275	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,206,929	0.000000	0.000000	354,501	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,759,432	0.000000	0.000000	866,263	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,378,898	0.000000	0.000000	596,708	73.00
76.00	03020 RENEWED HOPE	0	381,712	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	1,494,079	0.000000	0.000000	3,042	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	386,687	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	32,314,439			5,530,802	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 RENEWED HOPE	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 10/23/2013 1:34 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
						1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.184034	0	2,652,539	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.090881	0	354,979	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.254946	0	3,243,452	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.172827	0	303,966	0	0	58.00
60.00	06000	LABORATORY	0.349759	0	1,745,804	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.441806	0	283,637	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.603398	0	530,167	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.390791	0	232,715	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.435326	0	127,241	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329503	0	557,731	8,887	0	73.00
76.00	03020	RENEWED HOPE	0.742107	0	239,610	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.849178	0	807,059	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.798488	0	214,517	0	0	92.00
200.00		Subtotal (see instructions)		0	11,293,417	8,887	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	11,293,417	8,887	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 10/23/2013 1:34 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	488,157	0	50.00
53.00	05300 ANESTHESIOLOGY	32,261	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	826,905	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	52,534	0	58.00
60.00	06000 LABORATORY	610,611	0	60.00
65.00	06500 RESPIRATORY THERAPY	125,313	0	65.00
66.00	06600 PHYSICAL THERAPY	319,902	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	90,943	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	55,391	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	183,774	2,928	73.00
76.00	03020 RENEWED HOPE	177,816	0	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	685,337	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	171,289	0	92.00
200.00	Subtotal (see instructions)	3,820,233	2,928	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (Line 200 +/- Line 201)	3,820,233	2,928	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141330	Period: From 07/01/2012	Worksheet D
		Component CCN: 14Z330	To 06/30/2013	Part V
		Title XVIII	Swing Beds - SNF	Date/Time Prepared: 10/23/2013 1:34 pm
				Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.184034	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.090881	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.254946	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MRI	0.172827	0	0	0	58.00
60.00	06000 LABORATORY	0.349759	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.441806	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.603398	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.390791	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.435326	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329503	0	0	0	73.00
76.00	03020 RENEWED HOPE	0.742107	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.849178	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.798488	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 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 10/23/2013 1:34 pm
	Title XVII I	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 RENEWED HOPE	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 10/23/2013 1:34 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,259	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,702	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)		1,357	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		765	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)		764	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		14	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)		14	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		854	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)		739	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)		739	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)		2,895,002	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		1,678	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		1,678	25.00
26.00	Total swing-bed cost (see instructions)		1,371,765	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,523,237	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,669,595	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,669,595	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.326203	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)		3,441.12	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)		1,523,237	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)		894.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		764,304	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)		764,304	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141330		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 10/23/2013 1:34 pm	
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)					1,532,392	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,296,696	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)					661,383	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					661,383	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,322,766	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)					345	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					894.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					308,765	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141330		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 10/23/2013 1:34 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 10/23/2013 1:34 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,107,035		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.184034	1,952,624	359,349	50.00
53.00	05300 ANESTHESIOLOGY	0.090881	573,227	52,095	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.254946	476,855	121,572	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.172827	21,400	3,698	58.00
60.00	06000 LABORATORY	0.349759	346,584	121,221	60.00
65.00	06500 RESPIRATORY THERAPY	0.441806	280,323	123,848	65.00
66.00	06600 PHYSICAL THERAPY	0.603398	59,275	35,766	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.390791	354,501	138,536	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.435326	866,263	377,107	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329503	596,708	196,617	73.00
76.00	03020 RENEWED HOPE	0.742107	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.849178	3,042	2,583	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.798488	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,530,802	1,532,392	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		5,530,802		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141330	Period: From 07/01/2012	Worksheet D-3
		Component CCN: 14Z330	To 06/30/2013	Date/Time Prepared: 10/23/2013 1:34 pm
		Title XVIII	Swing Beds - SNF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.184034	0	50.00
53.00	05300 ANESTHESIOLOGY	0.090881	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.254946	122,538	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.172827	0	58.00
60.00	06000 LABORATORY	0.349759	222,707	60.00
65.00	06500 RESPIRATORY THERAPY	0.441806	436,180	65.00
66.00	06600 PHYSICAL THERAPY	0.603398	200,682	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.390791	121,647	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.435326	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329503	514,064	73.00
76.00	03020 RENEWED HOPE	0.742107	0	76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.849178	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.798488	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,617,818	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		1,617,818	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141330	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 10/23/2013 1:34 pm
		Title VIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,823,161 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)			3,823,161 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)			3,861,393 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)			46,224 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,893,776 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,921,393 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,921,393 30.00
31.00	Primary payer payments			1,215 31.00
32.00	Subtotal (line 30 minus line 31)			1,920,178 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)			283,299 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			283,299 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			216,659 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,203,477 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	SEQUESTRATION			-9,772 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,193,705 40.00
41.00	Interim payments			2,205,925 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)			-12,220 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,935,176		2,118,262		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		96,579		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	11/02/2012	35,797		0		3.01
3.02		04/16/2013	13,097		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	11/02/2012	6,903		3.50
3.51			0	04/16/2013	2,013		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)		48,894		-8,916		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,984,070		2,205,925		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		120,416		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		12,220		6.02
7.00	Total Medicare program liability (see instructions)		2,104,486		2,193,705		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141330
Component CCN: 14Z330

Period:
From 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
10/23/2013 1:34 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,052,485		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	11/02/2012	14,667		0	3.01
3.02		04/16/2013	5,357		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)		20,024		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)		2,072,509		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		149,232		0	6.02
7.00	Total Medicare program liability (see instructions)		1,923,277		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141330

Period:

Worksheet E-2

Component CCN: 14Z330

From 07/01/2012

Date/Time Prepared:

To 06/30/2013

10/23/2013 1:34 pm

		Title XVIII		Swing Beds - SNF	
		Cost			
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,335,994	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)	646,257	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	1,478	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)	1,982,251	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	1,982,251	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)	1,982,251	0	12.00	
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	51,680	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)	1,930,571	0	15.00	
16.00	SEQUESTRATION	-7,294	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)	1,923,277	0	19.00	
20.00	Interim payments	2,072,509	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)	-149,232	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 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 10/23/2013 1:34 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		2,296,696	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)		2,296,696	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,319,663	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)		2,319,663	19.00
20.00	Deductibles (exclude professional component)		235,464	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,084,199	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,084,199	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		31,060	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		31,060	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,449	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,115,259	28.00
29.00	SEQUESTRATION		-10,773	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,104,486	30.00
31.00	Interim payments		1,984,070	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)		120,416	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 07/01/2012
To 06/30/2013

Worksheet G

Date/Time Prepared:
10/23/2013 1:34 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,887,969	0	0	0	1.00
2.00	Temporary investments	2,190,894	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,428,616	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	797,037	0	0	0	7.00
8.00	Prepaid expenses	73,273	0	0	0	8.00
9.00	Other current assets	326,088	0	0	0	9.00
10.00	Due from other funds	398,119	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,101,996	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	11,112,084	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,112,084	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,396,109	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	716,529	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,112,638	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,326,718	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	554,213	0	0	0	37.00
38.00	Salaries, wages, and fees payable	971,884	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	540,219	0	0	0	40.00
41.00	Deferred income	373,504	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,770,292	0	0	0	43.00
44.00	Other current liabilities	412,453	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,622,565	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,510,695	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	210,472	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,721,167	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,343,732	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,982,986				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	15,982,986	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,326,718	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-1

Date/Time Prepared:
10/23/2013 1:34 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		14,911,102		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,071,884			2.00
3.00	Total (sum of line 1 and line 2)		15,982,986		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	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		15,982,986		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)		15,982,986		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00			0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
10/23/2013 1:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,669,595		4,669,595	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	3,207,207		3,207,207	8.00
9.00	OTHER LONG TERM CARE	1,360,931		1,360,931	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,237,733		9,237,733	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,237,733		9,237,733	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	3,600,548	5,768,774	9,369,322	27.00
27.01	ANESTHESIOLOGY	1,004,565	872,287	1,876,852	27.01
27.02	RADIOLOGY DIAGNOSTIC	892,832	5,722,325	6,615,157	27.02
27.04	MRI	36,068	734,751	770,819	27.04
27.05	LABORATORY	732,514	3,363,667	4,096,181	27.05
27.06	RESPIRATORY THERAPY	1,026,232	553,135	1,579,367	27.06
27.07	PHYSICAL THERAPY	301,764	1,200,569	1,502,333	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	1,560,313	199,119	1,759,432	27.10
27.11	DRUGS	1,469,653	933,143	2,402,796	27.11
27.12	RENEWED HOPE	0	381,712	381,712	27.12
27.14	EMERGENCY ROOM	54,096	2,145,024	2,199,120	27.14
27.15	DIETARY	0	15,483	15,483	27.15
27.16	RETAIL PHARMACY	0	1,875,194	1,875,194	27.16
27.17	PHYSICIAN REVENUE	0	9,866	9,866	27.17
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,916,319	23,775,051	43,691,370	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,889,034		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	GAIN ON ASSETS	5,700			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)		5,700		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,883,334		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141330

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-3

Date/Time Prepared:
10/23/2013 1:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,691,370	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,396,117	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,295,253	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,883,334	4.00
5.00	Net income from service to patients (line 3 minus line 4)	411,919	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,536	6.00
7.00	Income from investments	70,609	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)	1,121,982	24.00
24.01	TRANSFER	55,494	24.01
24.02	ROUNDING	47	24.02
25.00	Total other income (sum of lines 6-24)	1,249,668	25.00
26.00	Total (line 5 plus line 25)	1,661,587	26.00
27.00	CHANGE IN NET UNREAL LOSS ON INVEST	5,178	27.00
27.01		0	27.01
27.02	PROVISION FOR UNCOLLECTIBLE ACCTS	508,309	27.02
27.03	INTEREST RATE SWAP INCOME	76,216	27.03
27.04		0	27.04
27.05		0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	589,703	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,071,884	29.00