

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT  
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

- PROVIDER USE ONLY
1.  ELECTRONICALLY FILED COST REPORT
  2.  MANUALLY SUBMITTED COST REPORT
  3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
  4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
- DATE: \_\_\_\_\_ TIME: \_\_\_\_\_
- CONTRACTOR USE ONLY
5.  COST REPORT STATUS
  6. DATE RECEIVED: \_\_\_\_\_
  7. CONTRACTOR NO: \_\_\_\_\_
  8.  INITIAL REPORT FOR THIS PROVIDER CCN
  9.  FINAL REPORT FOR THIS PROVIDER CCN
  10. NPR DATE: \_\_\_\_\_
  11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_
  12.  IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.
- 1 - AS SUBMITTED
  - 2 - SETTLED WITHOUT AUDIT
  - 3 - SETTLED WITH AUDIT
  - 4 - REOPENED
  - 5 - AMENDED

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. JOSEPH'S HOSPITAL (14-0145) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) \_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		94,727	-252		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			43,186		10
10.01 HEALTH CLINIC - RHC II			16,197		10.01
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		94,727	59,131		200

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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS 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 THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 9515 HOLY CROSS LANE  
 2 CITY: BREESE

STATE: IL

P.O.BOX:  
 ZIP CODE: 62230

COUNTY: CILNTON

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			3
							6	7	8	
3	HOSPITAL	ST. JOSEPH'S HOSPITAL	14-0145	41180	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	RHC-BREESE	14-8503	41180		01/01/2009	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	RHC-GERMANTOWN	14-8502	41180		01/01/2009	N	O	N	15.01
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2010				TO: 06/30/2011				20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.									1	2
23	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.									1	N 23

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPHS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1,026	146					24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	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.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	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
61	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)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	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)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	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)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME		PROGRAM CODE			
1		2			
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	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)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	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
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. 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.			71
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	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 AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. 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.			76
<b>LONG TERM CARE HOSPITAL PPS</b>				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
<b>TEFRA PROVIDERS</b>				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N N 90
91	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
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	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
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N 2 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 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.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	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 EACH THERAPY.		PHY- OCCUP- SICAL ATIONAL N	RESPI- RATORY 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N	2	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	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.	2		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		1,000,000 3,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	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.	Y	14H005	140
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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	NAME: HOSPITAL SISTERS HEALTH SYSTEM CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 00131	141
142	STREET: 4936 LAVERNA ROAD P.O. BOX:		142
143	CITY: SPRINGFIELD STATE: IL	ZIP CODE: 62707	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149

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)	PART A	PART B	
155 HOSPITAL	1	2	
156 SUBPROVIDER - IPF	N	N	155
157 SUBPROVIDER - IRF	N	N	156
158 SUBPROVIDER - (OTHER)	N	N	157
159 SNF	N	N	158
160 HHA	N	N	159
161 CMHC	N	N	160

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		165		
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

		Y/N	DATE		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
1	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)	1 N	2	1	
		Y/N	DATE	V/I	
2	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.	1 N	2	3 2	
3	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)	N		3	
<b>FINANCIAL DATA AND REPORTS</b>					
		Y/N	TYPE	DATE	
4	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.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5	
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2	6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	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	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
<b>PS&amp;R REPORT DATA</b>					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	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)	1 N	2	3 N	4 16
17	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	12/12/2011	Y	12/12/2011 17
18	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 THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	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
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

- |    |   |    |
|----|---|----|
| 22 | HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.  | 22 |
| 23 | HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | 23 |
| 24 | WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.                | 24 |
| 25 | HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.                               | 25 |
| 26 | WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.                                | 26 |
| 27 | HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.                                     | 27 |

INTEREST EXPENSE

- |    |   |    |
|----|---|----|
| 28 | WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.                                     | 28 |
| 29 | 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. | 29 |
| 30 | HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.  | 30 |
| 31 | HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.  | 31 |

PURCHASED SERVICES

- |    |   |    |
|----|---|----|
| 32 | HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. | 32 |
| 33 | IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.                                       | 33 |

PROVIDER-BASED PHYSICIANS

- |    |  |    |
|----|--|----|
| 34 | ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.   | 34 |
| 35 | 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. | 35 |

HOME OFFICE COSTS

- |    | Y/N  | DATE |    |
|----|--|------|----|
|    | 1  | 2    |    |
| 36 | WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?   |      | 36 |
| 37 | IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  |      | 37 |
| 38 | IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. |      | 38 |
| 39 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.   |      | 39 |
| 40 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  |      | 40 |





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	13,835,764	13,835,764	612,540.00	22.59	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B		48,234	48,234			3
4	PHYSICIAN-PART A						4
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B		73,732	73,732	775.00	95.14	5
6	NON-PHYSICIAN-PART B		2,247	2,247	118.00	19.04	6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		172,310	172,310	6,948.00	24.80	10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		36,991	36,991	1,202.00	30.77	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES		158,942	158,942	936.00	169.81	12
13	CONTRACT LABOR: PHYSICIAN-PART A		419,069	419,069	3,377.00	124.10	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,017,331	1,017,331	11,465.00	88.73	14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		5,890,053	5,890,053			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		74,961	74,961			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B		20,983	20,983			21
22	PHYSICIAN PART A						22
23	PHYSICIAN PART B		32,076	32,076			23
24	WAGE-RELATED COSTS (RHC/FQHC)		978	978			24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		77,290	77,290	2,067.00	37.39	26
27	ADMINISTRATIVE & GENERAL		1,821,063	-20,911	1,800,152	89,253.00	20.17
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		652,174		652,174	14,340.00	45.48
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		508,123		508,123	23,250.00	21.85
31	LAUNDRY & LINEN SERVICE		101,874	4,182	106,056	10,051.00	10.55
32	HOUSEKEEPING		380,149	16,729	396,878	34,945.00	11.36
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		463,058	-364,514	98,544	7,068.00	13.94
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA			364,514	364,514	29,203.00	12.48
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		484,803		484,803	12,546.00	38.64
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY						40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		629,335		629,335	35,561.00	17.70
42	SOCIAL SERVICE		71,382		71,382	2,099.00	34.01
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	14,363,725		14,363,725	625,987.00	22.95	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	172,310		172,310	6,948.00	24.80	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	14,191,415		14,191,415	619,039.00	22.92	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,632,333		1,632,333	16,980.00	96.13	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5,890,053		5,890,053		41.50%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	21,713,801		21,713,801	636,019.00	34.14	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,189,251		5,189,251	260,383.00	19.93	7

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
01/30/2012 13:47

RHC I  
COMPONENT NO: 14-8503

WORKSHEET S-8

HOSPITAL-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER  
STATISTICAL DATA

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 9401 HOLY CROSS 1  
2 CITY: BREESE STATE: ILLINOIS ZIP CODE: 62230 COUNTY: CLINTON 2  
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD DATE  
1 2  
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 4  
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 5  
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) 6  
7 APPALACHIAN REGIONAL COMMISSION 7  
8 LOOK-ALIKES 8

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 1 2  
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0730	1730	0730	1830	0730	1830	0730	1730	0730	1700			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2  
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 12  
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW. N 13

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS) Y/N V XVIII XIX 15

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
01/30/2012 13:47

RHC II  
COMPONENT NO: 14-8502

WORKSHEET S-8

HOSPITAL-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER  
STATISTICAL DATA

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 205 MUNSTER STR 1  
2 CITY: GERMANTOWN STATE: ILLINOIS ZIP CODE: 62245 COUNTY: CLINTON 2  
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD DATE  
1 2  
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 4  
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 5  
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) 6  
7 APPALACHIAN REGIONAL COMMISSION 7  
8 LOOK-ALIKES 8

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 1 2  
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0830	1830	0800	1700	0800	1600	0800	1700					11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2  
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 12  
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW. N 13

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS) Y/N V XVIII XIX 15

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)		0.433062	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)				
2	NET REVENUE FROM MEDICAID		2,601,714	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID			5
6	MEDICAID CHARGES		10,082,842	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)		4,366,496	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)		1,764,782	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)				
9	NET REVENUE FROM STAND-ALONE SCHIP			9
10	STAND-ALONE SCHIP CHARGES			10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)			11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)			12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)				
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)			13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)			14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)			15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)			16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)				
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)		1,764,782	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	501,729	128,652	630,381	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	217,280	55,714	272,994	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	13,158	14,538	27,696	22
23	COST OF CHARITY CARE	204,122	41,176	245,298	23
24	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
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)				25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			3,076,963	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			89,324	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			2,987,639	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,293,833	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,539,131	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			3,303,913	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,417,823	1,417,823		1
2	00200		1,944,179	1,944,179	-22,797	2
3	00300					3
4	00400	77,290	6,315,839	6,393,129		4
5.01	00540	65,460	66,475	131,935		5.01
5.02	00550	23,394	151,773	175,167		5.02
5.03	00560	130,521	20,625	151,146	-20,911	5.03
5.04	00570	327,692	3,868	331,560	48,307	5.04
5.05	00581	325,419	289,677	615,096	-48,307	5.05
5.06	00590	948,577	8,430,659	9,379,236		5.06
6	00600					6
7	00700	508,123	1,190,069	1,698,192		7
8	00800	101,874	17,880	119,754	4,182	8
9	00900	380,149	58,351	438,500	16,729	9
10	01000	463,058	204,603	667,661	-531,586	10
11	01100				531,586	11
12	01200					12
13	01300	484,803	13,783	498,586		13
14	01400					14
15	01500					15
16	01600	629,335	126,339	755,674		16
17	01700	71,382	11,295	82,677		17
19	01900				626,310	19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,723,651	155,407	1,879,058	-57,922	30
31	03100	18,056	740	18,796	809	31
43	04300	222,510	61,273	283,783	19,422	43
ANCILLARY SERVICE COST CENTERS						
50	05000	1,420,950	212,901	1,633,851	-6,371	50
51	05100	2,708	1,396	4,104	260	51
52	05200	387,273	21,110	408,383	37,692	52
53	05300	48,234	984,979	1,033,213	-626,310	53
54	05400	1,054,830	255,852	1,310,682	-13,561	54
57	05700	97,237	124,754	221,991	8,232	57
58	05800	73,889	91,802	165,691	5,329	58
60	06000	1,047,149	1,285,957	2,333,106		60
62.30	06250					62.30
63	06300		130,741	130,741		63
65	06500	354,167	215,871	570,038		65
66	06600	949,319	422,235	1,371,554		66
69	06900	47,118	42,160	89,278		69
70	07000	56,256	17,269	73,525		70
71	07100	26,570	1,056,992	1,083,562	6,110	71
73	07300	347,156	1,074,012	1,421,168		73
76.97	07697	94,971	3,220	98,191		76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	45,612	2,122,787	2,168,399		88
88.01	08801	30,368	420,943	451,311		88.01
91	09100	908,216	1,580,532	2,488,748		91
91.01	09101	170,137	386,402	556,539		91.01
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300		183,988	183,988		113
118		13,663,454	31,116,561	44,780,015	-22,797	118
NONREIMBURSABLE COST CENTERS						
192	19200	172,310	773,441	945,751	22,797	192
200		13,835,764	31,890,002	45,725,766		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,395,026		1,395,026	1
2	00200	1,944,179		1,944,179	2
3	00300				3
4	00400	6,393,129	-1,595,097	4,798,032	4
5.01	00540	131,935		131,935	5.01
5.02	00550	175,167	1,051,113	1,226,280	5.02
5.03	00560	130,235	-12,730	117,505	5.03
5.04	00570	379,867		379,867	5.04
5.05	00581	566,789	-977	565,812	5.05
5.06	00590	9,379,236	-5,455,683	3,923,553	5.06
6	00600				6
7	00700	1,698,192		1,698,192	7
8	00800	123,936	-706	123,230	8
9	00900	455,229		455,229	9
10	01000	136,075	-1,266	134,809	10
11	01100	531,586	-141,272	390,314	11
12	01200				12
13	01300	498,586	-5,036	493,550	13
14	01400				14
15	01500				15
16	01600	755,674	-32,126	723,548	16
17	01700	82,677	-38,977	43,700	17
19	01900	626,310	-626,310		19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,821,136		1,821,136	30
31	03100	19,605		19,605	31
43	04300	303,205	-10,684	292,521	43
ANCILLARY SERVICE COST CENTERS					
50	05000	1,627,480	-36,000	1,591,480	50
51	05100	4,364		4,364	51
52	05200	446,075		446,075	52
53	05300	406,903	-362,137	44,766	53
54	05400	1,297,121	-1,271	1,295,850	54
57	05700	230,223		230,223	57
58	05800	171,020		171,020	58
60	06000	2,333,106	-67,043	2,266,063	60
62.30	06250				62.30
63	06300	130,741		130,741	63
65	06500	570,038	-23,377	546,661	65
66	06600	1,371,554	-182,140	1,189,414	66
69	06900	89,278	-33,084	56,194	69
70	07000	73,525		73,525	70
71	07100	1,089,672		1,089,672	71
73	07300	1,421,168	-4,827	1,416,341	73
76.97	07697	98,191	-24,566	73,625	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800	2,168,399	-134,473	2,033,926	88
88.01	08801	451,311	-256	451,055	88.01
91	09100	2,488,748	-1,452,318	1,036,430	91
91.01	09101	556,539	-326,531	230,008	91.01
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
113	11300	183,988	-183,988		113
118		44,757,218	-9,701,762	35,055,456	118
NONREIMBURSABLE COST CENTERS					
192	19200	968,548	-364,921	603,627	192
200		45,725,766	-10,066,683	35,659,083	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 NON-PHYSICIAN CRNA	A	NONPHYSICIAN ANESTHETISTS	19		48,234	578,076 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					48,234	578,076 500
1 TRENTON BLDG DEPR	B	PHYSICIANS' PRIVATE OFFICES	192			22,797 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B						22,797 500
1 CAFETERIA COST	C	CAFETERIA	11		364,514	167,072 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					364,514	167,072 500
1 MANAGER SALARY COST	D	ADMITTING	5.04		48,307	1
2		LAUNDRY & LINEN SERVICE	8		4,182	2
3		HOUSEKEEPING	9		16,729	3
4		INTENSIVE CARE UNIT	31		809	4
5		NURSERY	43		19,422	5
6		RECOVERY ROOM	51		260	6
7		DELIVERY ROOM & LABOR ROOM	52		37,692	7
8		COMPUTED TOMOGRAPHY (CT) SCAN	57		8,232	8
9		MAGNETIC RESONANCE IMAGING (M	58		5,329	9
10		MEDICAL SUPPLIES CHRGED TO PA	71		6,110	10
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					147,072	500
GRAND TOTAL (INCREASES)					559,820	767,945

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 NON-PHYSICIAN CRNA	A	ANESTHESIOLOGY	53	48,234	578,076	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				48,234	578,076	500
1 TRENTON BLDG DEPR	B	CAP REL COSTS-BLDG & FIXT	1		22,797	9 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					22,797	500
1 CAFETERIA COST	C	DIETARY	10	364,514	167,072	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				364,514	167,072	500
1 MANAGER SALARY COST	D	PURCHASING	5.03	20,911		1
2		BUSINESS OFFICE	5.05	48,307		2
3		ADULTS & PEDIATRICS	30	57,922		3
4		OPERATING ROOM	50	6,371		4
5		RADIOLOGY-DIAGNOSTIC	54	13,561		5
6						6
7						7
8						8
9						9
10						10
500 TOTAL RECLASSIFICATIONS CODE LETTER - D				147,072		500
GRAND TOTAL (DECREASES)				559,820	767,945	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	921,436	15,000		15,000		936,436	1
2 LAND IMPROVEMENTS	2,989,698					2,989,698	2
3 BUILDINGS AND FIXTURES	12,474,704	24,752		24,752		12,499,456	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	9,703,785	65,214		65,214		9,768,999	5
6 MOVABLE EQUIPMENT	19,044,852	1,369,501		1,369,501		20,414,353	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	45,134,475	1,474,467		1,474,467		46,608,942	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	45,134,475	1,474,467		1,474,467		46,608,942	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,417,823						1,417,823 1
2 CAP REL COSTS-MVBLE EQUIP	1,944,179						1,944,179 2
3 TOTAL (SUM OF LINES 1-2)	3,362,002						3,362,002 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,395,026						1,395,026 1
2 CAP REL COSTS-MVBLE EQUIP	1,944,179						1,944,179 2
3 TOTAL	3,339,205						3,339,205 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-5,971	PURCHASING	5.03	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)	B	-4,827	DRUGS CHARGED TO PATIENTS	73	5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	B	-977	BUSINESS OFFICE	5.05	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,371,682			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-6,759	PURCHASING	5.03	11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-331,301			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-141,272	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-32,126	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-1,266	DIETARY	10	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST	A	-626,310	NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 MEDICAL RECORD FEES	B	-400	RURAL HEALTH CLINIC (RHC)	88	33
34 CCHRC BRESEE RENTAL INCOME	B	-90,928	RURAL HEALTH CLINIC (RHC)	88	34
35 CCHRC ADVERTISING	A	-1,173	RURAL HEALTH CLINIC (RHC)	88	35
36 CCHRC ADVERTISING	A	-256	RHC II	88.01	36
37 CCHRC HOSPITAL VISITS	A	-34,981	RURAL HEALTH CLINIC (RHC)	88	37
38 HEALTH FAIR REVENUE	B	-7,560	LABORATORY	60	38
39 MISCELLANEOUS REVENUE	B	-18,625	INFORMATION SYSTEMS	5.02	39
39.01 MISCELLANEOUS REVENUE	B	-9,770	ADMIN & GENERAL	5.06	39.01
39.02 MISCELLANEOUS REVENUE	B	-5,036	NURSING ADMINISTRATION	13	39.02
39.03 MISCELLANEOUS REVENUE	B	-38,977	SOCIAL SERVICE	17	39.03
39.04 MISCELLANEOUS REVENUE	B	-4,525	EMPLOYEE BENEFITS	4	39.04
39.05 MISCELLANEOUS REVENUE	B	-1,271	RADIOLOGY-DIAGNOSTIC	54	39.05
39.06 MISCELLANEOUS REVENUE	B	-24,566	CARDIAC REHABILITATION	76.97	39.06
39.07 MISCELLANEOUS REVENUE	B	-123,160	PHYSICAL THERAPY	66	39.07
39.08 MISCELLANEOUS REVENUE	B	-706	LAUNDRY & LINEN SERVICE	8	39.08
39.09 MISCELLANEOUS REVENUE	B	-834	NURSERY	43	39.09
39.10 MISCELLANEOUS REVENUE	B	-1,000	OPERATING ROOM	50	39.10
40					40
41 NON-ALLOW INTEREST	A	-183,988	INTEREST EXPENSE	113	41
42 MEDICAID TAX	A	-686,808	ADMIN & GENERAL	5.06	42
43 PHYSICIAN RECRUITMENT	A	-157,275	ADMIN & GENERAL	5.06	43
43.01 PHYSICIAN LEGAL FEES	A	-6,255	ADMIN & GENERAL	5.06	43.01
43.02 NON-ALLOW LOBBYING COST	A	-21,212	ADMIN & GENERAL	5.06	43.02
44 BAD DEBT EXPENSE	A	-3,069,972	ADMIN & GENERAL	5.06	44
44.01 BAD DEBT EXPENSE	A	-6,991	RURAL HEALTH CLINIC (RHC)	88	44.01
45 ADVERTISING COST	A	-308,894	ADMIN & GENERAL	5.06	45
45.01 ADVERTISING COST	A	-38	PHYSICAL THERAPY	66	45.01
46 MEDICAL GROUP EXPENSE	A	-364,921	PHYSICIANS' PRIVATE OFFICES	192	46
47 EMPLOYEE SELF INSURANCE PAYMENTS	A	-1,372,698	EMPLOYEE BENEFITS	4	47

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
01/30/2012 13:47

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
				COST CENTER 3	LINE NO. 4	
48	NON ALLOWABLE MEDICARE EXPENSE	A	-1,372	ADMIN & GENERAL	5.06	48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-10,066,683			50

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

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5.06	ADMIN & GENERAL	CONTRACTED SERVICES HSHS	849,635	2,032,800	-1,183,165	1
2	5.02	INFORMATION SYSTEMS	CONTRACTED SERVICES CCC	1,069,738		1,069,738	2
3	4	EMPLOYEE BENEFITS	HEALTH & DENTAL PREMIUMS	4,065,012	4,282,886	-217,874	3
4	88	RURAL HEALTH CLINIC (RHC)	RURAL HEALTH CLINIC SERV	1,984,588	1,984,588		4
4.01	88.01	RHC II	RURAL HEALTH CLINIC SERV	378,760	378,760		4.01
5		TOTALS (SUM OF LINES 1-4)		8,347,733	8,679,034	-331,301	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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 REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				TYPE OF BUSINESS	
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP			
1	2	3	4	5	6		
6	B		HOSPITAL SISTERS HEALTH SYSTEM	100.00	CORPORATE OFFICE		6
7	G		HSHS MEDICAL GROUP		PHYSICIAN PRACTICES		7
8							8
9							9
10							10

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE 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.
  - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY: FINANCIAL

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	VARIOUS	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2		3	4	5	6	7	8	9	
1	5.06 ADMIN & GENERAL	VARIOUS	20,354		20,354	171,400	114	9,394	470	1
2	43 NURSERY	VARIOUS	31,440		31,440	171,400	262	21,590	1,080	2
3	50 OPERATING ROOM	VARIOUS	35,000	35,000		204,100				3
4	53 ANESTHESIOLOGY	VARIOUS	380,266	346,266	34,000	171,400	220	18,129	906	4
5	54 RADIOLOGY-DIAGNOSTIC	VARIOUS	6,000		6,000	171,400	368	30,325	1,516	5
6	60 LABORATORY	VARIOUS	130,715		130,715	219,500	675	71,232	3,562	6
7	65 RESPIRATORY THERAPY	VARIOUS	74,550		74,550	171,400	621	51,173	2,559	7
8	66 PHYSICAL THERAPY	VARIOUS	109,785	35,775	74,010	171,400	617	50,843	2,542	8
9	69 ELECTROCARDIOLOGY	VARIOUS	33,084	33,084		171,400				9
10	91 EMERGENCY	VARIOUS	1,493,520	1,445,520	48,000	171,400	500	41,202	2,060	10
11	91.01 PRIORITY CARE CARLYLE	VARIOUS	326,531	326,531		171,400				11
200	TOTAL		2,641,245	2,222,176	419,069		3,377	293,888	14,695	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
1	5.06 ADMIN & GENERAL	VARIOUS					9,394	10,960	10,960	1
2	43 NURSERY	VARIOUS					21,590	9,850	9,850	2
3	50 OPERATING ROOM	VARIOUS							35,000	3
4	53 ANESTHESIOLOGY	VARIOUS					18,129	15,871	362,137	4
5	54 RADIOLOGY-DIAGNOSTIC	VARIOUS					30,325			5
6	60 LABORATORY	VARIOUS					71,232	59,483	59,483	6
7	65 RESPIRATORY THERAPY	VARIOUS					51,173	23,377	23,377	7
8	66 PHYSICAL THERAPY	VARIOUS					50,843	23,167	58,942	8
9	69 ELECTROCARDIOLOGY	VARIOUS							33,084	9
10	91 EMERGENCY	VARIOUS					41,202	6,798	1,452,318	10
11	91.01 PRIORITY CARE CARLYLE	VARIOUS							326,531	11
200	TOTAL						293,888	149,506	2,371,682	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ALLOCATION	CAP	CAP	EMPLOYEE	COMMUNICAT	
	(FROM WKST A, COL.7) 0	BLDGS & FIXTURES 1	MOVABLE EQUIPMENT 2	BENEFITS 4		
GENERAL SERVICE COST CENTERS					5.01	
1 CAP REL COSTS-BLDG & FIXT	1,395,026	1,395,026				1
2 CAP REL COSTS-MVBLE EQUIP	1,944,179		1,944,179			2
4 EMPLOYEE BENEFITS	4,798,032	3,491	6,718	4,808,241		4
5.01 COMMUNICATIONS	131,935	2,174	15,253	22,877	172,239	5.01
5.02 INFORMATION SYSTEMS	1,226,280	15,030	298,904	8,176	9,267	5.02
5.03 PURCHASING	117,505	39,997	2,601	38,306	1,598	5.03
5.04 ADMITTING	379,867	10,020	4,946	131,402	1,278	5.04
5.05 BUSINESS OFFICE	565,812	10,452	9,230	96,844	9,587	5.05
5.06 ADMIN & GENERAL	3,923,553	276,480	26,332	331,504	15,019	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,698,192	76,140	46,647	177,576	6,711	7
8 LAUNDRY & LINEN SERVICE	123,230	20,904	5,119	37,064	320	8
9 HOUSEKEEPING	455,229	8,592	5,252	138,699	1,917	9
10 DIETARY	134,809	24,388	13,383	34,439	3,196	10
11 CAFETERIA	390,314	14,967	329	127,389		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	493,550	6,717	1,055	169,426	1,917	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	723,548	12,041	21,160	219,937	11,504	16
17 SOCIAL SERVICE	43,700	1,380	2,401	24,946	1,917	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,821,136	162,956	71,021	582,126	14,699	30
31 INTENSIVE CARE UNIT	19,605	14,563	160	6,593	1,917	31
43 NURSERY	292,521	5,742	14,579	84,549		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,591,480	77,632	145,946	494,360	9,267	50
51 RECOVERY ROOM	4,364	6,174	616	1,037		51
52 DELIVERY ROOM & LABOR ROOM	446,075	15,588	26,250	148,515		52
53 ANESTHESIOLOGY	44,766	3,860	24,310	16,857	320	53
54 RADIOLOGY-DIAGNOSTIC	1,295,850	48,275	370,534	363,898	7,669	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	230,223		239,104	36,859		57
58 MAGNETIC RESONANCE IMAGING (MRI)	171,020		186,985	27,685		58
60 LABORATORY	2,266,063	27,858	111,055	365,952	4,793	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	130,741					63
65 RESPIRATORY THERAPY	546,661	9,065	12,629	123,773	2,556	65
66 PHYSICAL THERAPY	1,189,414	104,570	45,357	331,763	8,628	66
69 ELECTROCARDIOLOGY	56,194		4,368	16,467		69
70 ELECTROENCEPHALOGRAPHY	73,525	4,878	7,962	19,660		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,089,672	6,132	5,073	11,421		71
73 DRUGS CHARGED TO PATIENTS	1,416,341	5,616	80,599	121,322	1,598	73
76.97 CARDIAC REHABILITATION	73,625	11,414	11,019	33,190	1,278	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,033,926	56,602	33,089	15,940	16,617	88
88.01 RHC II	451,055	7,526	2,366	10,613		88.01
91 EMERGENCY	1,036,430	100,341	28,087	317,399	9,267	91
91.01 PRIORITY CARE CARLYLE	230,008	10,452	10,857	59,459		91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	35,055,456	1,202,017	1,891,296	4,748,023	142,840	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	603,627	193,009	52,883	60,218	29,399	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	35,659,083	1,395,026	1,944,179	4,808,241	172,239	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	INFORMATIO	PURCHASING	ADMITTING	BUS OFFICE	SUBTOTAL	
	SYSTEMS					
	5.02	5.03	5.04	5.05	(COLS.0-4)	
					4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS	1,557,657					5.02
5.03 PURCHASING		200,007				5.03
5.04 ADMITTING		83	527,596			5.04
5.05 BUSINESS OFFICE	1,557,657	2,376		2,251,958		5.05
5.06 ADMIN & GENERAL		2,735			4,575,623	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		2,701			2,007,967	7
8 LAUNDRY & LINEN SERVICE		1,029			187,666	8
9 HOUSEKEEPING		2,582			612,271	9
10 DIETARY		2,166			212,381	10
11 CAFETERIA		9,901			542,900	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		30			672,695	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		703			988,893	16
17 SOCIAL SERVICE		36			74,380	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		8,252	27,818	118,726	2,806,734	30
31 INTENSIVE CARE UNIT		37	244	1,041	44,160	31
43 NURSERY		1,659	4,307	18,383	421,740	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		5,846	58,527	249,793	2,632,851	50
51 RECOVERY ROOM		85	4,667	19,918	36,861	51
52 DELIVERY ROOM & LABOR ROOM		974	9,887	42,198	689,487	52
53 ANESTHESIOLOGY		1,826	34,972	149,262	276,173	53
54 RADIOLOGY-DIAGNOSTIC		3,315	58,017	247,617	2,395,175	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		637	49,864	212,819	769,506	57
58 MAGNETIC RESONANCE IMAGING (MRI)		245	17,535	74,838	478,308	58
60 LABORATORY		44,003	104,686	446,982	3,371,392	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.		7,944	3,549	15,146	157,380	63
65 RESPIRATORY THERAPY		7,198	16,051	68,504	786,437	65
66 PHYSICAL THERAPY		3,534	22,833	97,452	1,803,551	66
69 ELECTROCARDIOLOGY		334	9,240	39,438	126,041	69
70 ELECTROENCEPHALOGRAPHY		249	3,235	13,808	123,317	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		60,049	16,310	69,611	1,258,268	71
73 DRUGS CHARGED TO PATIENTS		17,725	30,096	128,448	1,801,745	73
76.97 CARDIAC REHABILITATION		102	939	4,009	135,576	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		686			2,156,860	88
88.01 RHC II		344			471,904	88.01
91 EMERGENCY		3,897	49,112	209,608	1,754,141	91
91.01 PRIORITY CARE CARLYLE		2,795	3,929	16,770	334,270	91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,557,657	196,078	525,818	2,244,371	34,706,653	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		3,929	1,778	7,587	952,430	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,557,657	200,007	527,596	2,251,958	35,659,083	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
	A & G	7	8	9	10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL	4,575,623					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	295,581	2,303,548				7
8 LAUNDRY & LINEN SERVICE	27,625	50,096	265,387			8
9 HOUSEKEEPING	90,129	20,589	17,731	740,720		9
10 DIETARY	31,263	58,445	544	3,156	305,789	10
11 CAFETERIA	79,917	35,868	2,541	20,795		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	99,023	16,097		5,785		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	145,569	28,855		6,999		16
17 SOCIAL SERVICE	10,949	3,306		1,740		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	413,162	390,512	99,434	315,076	305,789	30
31 INTENSIVE CARE UNIT	6,501	34,900	590	3,560		31
43 NURSERY	62,082	13,760	2,716	10,842		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	387,566	186,039	49,858	86,699		50
51 RECOVERY ROOM	5,426	14,795				51
52 DELIVERY ROOM & LABOR ROOM	101,495	37,355	14,360	21,482		52
53 ANESTHESIOLOGY	40,654	9,251				53
54 RADIOLOGY-DIAGNOSTIC	352,579	115,688	22,287	48,467		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	113,274					57
58 MAGNETIC RESONANCE IMAGING (MRI)	70,409					58
60 LABORATORY	496,296	66,761	141	39,000		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	23,167					63
65 RESPIRATORY THERAPY	115,767	21,725	1,117	11,004		65
66 PHYSICAL THERAPY	265,490	250,595	12,379	63,193		66
69 ELECTROCARDIOLOGY	18,554					69
70 ELECTROENCEPHALOGRAPHY	18,153	11,689				70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	185,222	14,695				71
73 DRUGS CHARGED TO PATIENTS	265,224	13,459		5,017		73
76.97 CARDIAC REHABILITATION	19,957	27,352		6,797		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	317,498	135,642				88
88.01 RHC II	69,466	18,034				88.01
91 EMERGENCY	258,217	240,459	27,546	91,108		91
91.01 PRIORITY CARE CARLYLE	49,206	25,048				91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	4,435,421	1,841,015	251,244	740,720	305,789	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	140,202	462,533	14,143			192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,575,623	2,303,548	265,387	740,720	305,789	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	682,021					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	20,867	814,467				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	59,174		1,229,490			16
17 SOCIAL SERVICE	3,495		5,655	99,525		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	127,587	318,749	377,232	89,180	5,243,455	30
31 INTENSIVE CARE UNIT	1,004	2,507	3,659		96,881	31
43 NURSERY	12,838	32,074	61,874		617,926	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	83,708	209,128	67,861		3,703,710	50
51 RECOVERY ROOM	138	346	1,331		58,897	51
52 DELIVERY ROOM & LABOR ROOM	24,881	62,159	665		951,884	52
53 ANESTHESIOLOGY			8,982		335,060	53
54 RADIOLOGY-DIAGNOSTIC	64,780		136,388		3,135,364	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	6,367		109,443		998,590	57
58 MAGNETIC RESONANCE IMAGING (MRI)	4,118		44,243		597,078	58
60 LABORATORY	68,932		155,682		4,198,204	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			665		181,212	63
65 RESPIRATORY THERAPY	24,223		1,663		961,936	65
66 PHYSICAL THERAPY	71,389		33,265		2,499,862	66
69 ELECTROCARDIOLOGY	3,045		3,327		150,967	69
70 ELECTROENCEPHALOGRAPHY	3,460		1,331		157,950	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,807		4,657		1,466,649	71
73 DRUGS CHARGED TO PATIENTS	14,119		6,320		2,105,884	73
76.97 CARDIAC REHABILITATION	6,471		333		196,486	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	969		6,653		2,617,622	88
88.01 RHC II			998		560,402	88.01
91 EMERGENCY	65,852	164,519	194,935	10,345	2,807,122	91
91.01 PRIORITY CARE CARLYLE		24,985	1,663		435,172	91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	671,224	814,467	1,228,825	99,525	34,078,313	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	10,797		665		1,580,770	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	682,021	814,467	1,229,490	99,525	35,659,083	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5.01 COMMUNICATIONS			5.01
5.02 INFORMATION SYSTEMS			5.02
5.03 PURCHASING			5.03
5.04 ADMITTING			5.04
5.05 BUSINESS OFFICE			5.05
5.06 ADMIN & GENERAL			5.06
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	5,243,455		30
31 INTENSIVE CARE UNIT	96,881		31
43 NURSERY	617,926		43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	3,703,710		50
51 RECOVERY ROOM	58,897		51
52 DELIVERY ROOM & LABOR ROOM	951,884		52
53 ANESTHESIOLOGY	335,060		53
54 RADIOLOGY-DIAGNOSTIC	3,135,364		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	998,590		57
58 MAGNETIC RESONANCE IMAGING (MRI)	597,078		58
60 LABORATORY	4,198,204		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63 BLOOD STORING, PROCESSING & TRANS.	181,212		63
65 RESPIRATORY THERAPY	961,936		65
66 PHYSICAL THERAPY	2,499,862		66
69 ELECTROCARDIOLOGY	150,967		69
70 ELECTROENCEPHALOGRAPHY	157,950		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,466,649		71
73 DRUGS CHARGED TO PATIENTS	2,105,884		73
76.97 CARDIAC REHABILITATION	196,486		76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC (RHC)	2,617,622		88
88.01 RHC II	560,402		88.01
91 EMERGENCY	2,807,122		91
91.01 PRIORITY CARE CARLYLE	435,172		91.01
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113 INTEREST EXPENSE			113
118 SUBTOTALS (SUM OF LINES 1-117)	34,078,313		118
NONREIMBURSABLE COST CENTERS			
192 PHYSICIANS' PRIVATE OFFICES	1,580,770		192
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)	35,659,083		202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5.01		3,491	6,718	10,209	10,209	4
5.01		2,174	15,253	17,427	49	5.01
5.02	376,768	15,030	298,904	690,702	17	5.02
5.03		39,997	2,601	42,598	81	5.03
5.04		10,020	4,946	14,966	279	5.04
5.05	609	10,452	9,230	20,291	206	5.05
5.06	31,783	276,480	26,332	334,595	704	5.06
6						6
7	4,920	76,140	46,647	127,707	377	7
8		20,904	5,119	26,023	79	8
9		8,592	5,252	13,844	294	9
10		24,388	13,383	37,771	73	10
11		14,967	329	15,296	270	11
12						12
13		6,717	1,055	7,772	360	13
14						14
15						15
16		12,041	21,160	33,201	467	16
17		1,380	2,401	3,781	53	17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	2,001	162,956	71,021	235,978	1,235	30
31		14,563	160	14,723	14	31
43		5,742	14,579	20,321	180	43
ANCILLARY SERVICE COST CENTERS						
50	1,000	77,632	145,946	224,578	1,050	50
51		6,174	616	6,790	2	51
52		15,588	26,250	41,838	315	52
53		3,860	24,310	28,170	36	53
54		48,275	370,534	418,809	773	54
57			239,104	239,104	78	57
58			186,985	186,985	59	58
60		27,858	111,055	138,913	777	60
62.30						62.30
63						63
65		9,065	12,629	21,694	263	65
66		104,570	45,357	149,927	704	66
69			4,368	4,368	35	69
70	540	4,878	7,962	13,380	42	70
71	67,260	6,132	5,073	78,465	24	71
73		5,616	80,599	86,215	258	73
76.97		11,414	11,019	22,433	70	76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88		56,602	33,089	89,691	34	88
88.01	15,153	7,526	2,366	25,045	23	88.01
91		100,341	28,087	128,428	674	91
91.01		10,452	10,857	21,309	126	91.01
92						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113						113
118	500,034	1,202,017	1,891,296	3,593,347	10,081	118
NONREIMBURSABLE COST CENTERS						
192		193,009	52,883	245,892	128	192
200						200
201						201
202	500,034	1,395,026	1,944,179	3,839,239	10,209	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	COMMUNICAT 5.01	INFORMATIO SYSTEMS 5.02	PURCHASING 5.03	ADMITTING 5.04	BUS OFFICE 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS	17,476					5.01
5.02 INFORMATION SYSTEMS	940	691,659				5.02
5.03 PURCHASING	162		42,841			5.03
5.04 ADMITTING	130		18	15,393		5.04
5.05 BUSINESS OFFICE	973	691,659	509		713,638	5.05
5.06 ADMIN & GENERAL	1,524		586			5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	681		578			7
8 LAUNDRY & LINEN SERVICE	32		220			8
9 HOUSEKEEPING	195		553			9
10 DIETARY	324		464			10
11 CAFETERIA			2,121			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	195		6			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,167		151			16
17 SOCIAL SERVICE	195		8			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 ADULTS & PEDIATRICS	1,491		1,767	811	37,625	30
31 INTENSIVE CARE UNIT	195		8	7	330	31
43 NURSERY			355	126	5,826	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	940		1,252	1,706	79,160	50
51 RECOVERY ROOM			18	136	6,312	51
52 DELIVERY ROOM & LABOR ROOM			209	288	13,373	52
53 ANESTHESIOLOGY	32		391	1,019	47,302	53
54 RADIOLOGY-DIAGNOSTIC	778		710	1,691	78,471	54
57 COMPUTED TOMOGRAPHY (CT) SCAN			136	1,454	67,443	57
58 MAGNETIC RESONANCE IMAGING (MRI)			53	511	23,717	58
60 LABORATORY	486		9,425	3,066	141,633	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			1,702	103	4,800	63
65 RESPIRATORY THERAPY	259		1,542	468	21,709	65
66 PHYSICAL THERAPY	875		757	666	30,883	66
69 ELECTROCARDIOLOGY			72	269	12,498	69
70 ELECTROENCEPHALOGRAPHY			53	94	4,376	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			12,862	475	22,060	71
73 DRUGS CHARGED TO PATIENTS	162		3,796	877	40,706	73
76.97 CARDIAC REHABILITATION	130		22	27	1,270	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,686		147			88
88.01 RHC II			74			88.01
91 EMERGENCY	940		835	1,432	66,426	91
91.01 PRIORITY CARE CARLYLE			599	115	5,314	91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	14,492	691,659	41,999	15,341	711,234	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2,984		842	52	2,404	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	17,476	691,659	42,841	15,393	713,638	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	OPERATION OF PLANT		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
	A & G	7	8	9	10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL	337,409					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	21,796	151,139				7
8 LAUNDRY & LINEN SERVICE	2,037	3,287	31,678			8
9 HOUSEKEEPING	6,646	1,351	2,116	24,999		9
10 DIETARY	2,305	3,835	65	107	44,944	10
11 CAFETERIA	5,893	2,353	303	702		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	7,302	1,056		195		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	10,734	1,893		236		16
17 SOCIAL SERVICE	807	217		59		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	30,467	25,622	11,871	10,634	44,944	30
31 INTENSIVE CARE UNIT	479	2,290	70	120		31
43 NURSERY	4,578	903	324	366		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	28,580	12,206	5,951	2,926		50
51 RECOVERY ROOM	400	971				51
52 DELIVERY ROOM & LABOR ROOM	7,484	2,451	1,714	725		52
53 ANESTHESIOLOGY	2,998	607				53
54 RADIOLOGY-DIAGNOSTIC	26,000	7,590	2,660	1,636		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	8,353					57
58 MAGNETIC RESONANCE IMAGING (MRI)	5,192					58
60 LABORATORY	36,595	4,380	17	1,316		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	1,708					63
65 RESPIRATORY THERAPY	8,537	1,425	133	371		65
66 PHYSICAL THERAPY	19,578	16,442	1,478	2,133		66
69 ELECTROCARDIOLOGY	1,368					69
70 ELECTROENCEPHALOGRAPHY	1,339	767				70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	13,658	964				71
73 DRUGS CHARGED TO PATIENTS	19,558	883		169		73
76.97 CARDIAC REHABILITATION	1,472	1,795		229		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	23,413	8,900				88
88.01 RHC II	5,123	1,183				88.01
91 EMERGENCY	19,041	15,777	3,288	3,075		91
91.01 PRIORITY CARE CARLYLE	3,629	1,643				91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	327,070	120,791	29,990	24,999	44,944	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	10,339	30,348	1,688			192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	337,409	151,139	31,678	24,999	44,944	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	26,938					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	824	17,710				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,337		50,186			16
17 SOCIAL SERVICE	138		231	5,489		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,039	6,931	15,397	4,918	434,730	30
31 INTENSIVE CARE UNIT	40	55	149		18,480	31
43 NURSERY	507	697	2,526		36,709	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,306	4,547	2,770		368,972	50
51 RECOVERY ROOM	5	8	54		14,696	51
52 DELIVERY ROOM & LABOR ROOM	983	1,352	27		70,759	52
53 ANESTHESIOLOGY			367		80,922	53
54 RADIOLOGY-DIAGNOSTIC	2,559		5,567		547,244	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	251		4,467		321,286	57
58 MAGNETIC RESONANCE IMAGING (MRI)	163		1,806		218,486	58
60 LABORATORY	2,723		6,355		345,686	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			27		8,340	63
65 RESPIRATORY THERAPY	957		68		57,426	65
66 PHYSICAL THERAPY	2,820		1,358		227,621	66
69 ELECTROCARDIOLOGY	120		136		18,866	69
70 ELECTROENCEPHALOGRAPHY	137		54		20,242	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	150		190		128,848	71
73 DRUGS CHARGED TO PATIENTS	558		258		153,440	73
76.97 CARDIAC REHABILITATION	256		14		27,718	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	38		272		124,181	88
88.01 RHC II			41		31,489	88.01
91 EMERGENCY	2,601	3,577	7,957	571	254,622	91
91.01 PRIORITY CARE CARLYLE		543	68		33,346	91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	26,512	17,710	50,159	5,489	3,544,109	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	426		27		295,130	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	26,938	17,710	50,186	5,489	3,839,239	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	I&R COST &	TOTAL	
	POST STEP- DOWN ADJS 25		
GENERAL SERVICE COST CENTERS			
1			1
2			2
4			4
5.01			5.01
5.02			5.02
5.03			5.03
5.04			5.04
5.05			5.05
5.06			5.06
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
19			19
20			20
21			21
22			22
23			23
INPATIENT ROUTINE SERV COST CENTERS			
30		434,730	30
31		18,480	31
43		36,709	43
ANCILLARY SERVICE COST CENTERS			
50		368,972	50
51		14,696	51
52		70,759	52
53		80,922	53
54		547,244	54
57		321,286	57
58		218,486	58
60		345,686	60
62.30			62.30
63		8,340	63
65		57,426	65
66		227,621	66
69		18,866	69
70		20,242	70
71		128,848	71
73		153,440	73
76.97		27,718	76.97
76.98			76.98
76.99			76.99
OUTPATIENT SERVICE COST CENTERS			
88		124,181	88
88.01		31,489	88.01
91		254,622	91
91.01		33,346	91.01
92			92
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113			113
118		3,544,109	118
NONREIMBURSABLE COST CENTERS			
192		295,130	192
200			200
201			201
202		3,839,239	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	COMMUNICAT PHONES	INFORMATIO SYSTEMS TIME SPENT	
	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	200,202					1
2 CAP REL COSTS-MVBLE EQUIP		1,944,179				2
4 EMPLOYEE BENEFITS	501	6,718	13,758,473			4
5.01 COMMUNICATIONS	312	15,253	65,460	539		5.01
5.02 INFORMATION SYSTEMS	2,157	298,904	23,395	29	100	5.02
5.03 PURCHASING	5,740	2,601	109,610	5		5.03
5.04 ADMITTING	1,438	4,946	375,998	4		5.04
5.05 BUSINESS OFFICE	1,500	9,230	277,113	30	100	5.05
5.06 ADMIN & GENERAL	39,678	26,332	948,576	47		5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	10,927	46,647	508,123	21		7
8 LAUNDRY & LINEN SERVICE	3,000	5,119	106,056	1		8
9 HOUSEKEEPING	1,233	5,252	396,878	6		9
10 DIETARY	3,500	13,383	98,545	10		10
11 CAFETERIA	2,148	329	364,514			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	964	1,055	484,802	6		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,728	21,160	629,335	36		16
17 SOCIAL SERVICE	198	2,401	71,382	6		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	23,386	71,021	1,665,728	46		30
31 INTENSIVE CARE UNIT	2,090	160	18,865	6		31
43 NURSERY	824	14,579	241,932			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,141	145,946	1,414,580	29		50
51 RECOVERY ROOM	886	616	2,968			51
52 DELIVERY ROOM & LABOR ROOM	2,237	26,250	424,965			52
53 ANESTHESIOLOGY	554	24,310	48,234	1		53
54 RADIOLOGY-DIAGNOSTIC	6,928	370,534	1,041,270	24		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		239,104	105,469			57
58 MAGNETIC RESONANCE IMAGING (MRI)		186,985	79,218			58
60 LABORATORY	3,998	111,055	1,047,149	15		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	1,301	12,629	354,167	8		65
66 PHYSICAL THERAPY	15,007	45,357	949,318	27		66
69 ELECTROCARDIOLOGY		4,368	47,118			69
70 ELECTROENCEPHALOGRAPHY	700	7,962	56,256			70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	880	5,073	32,680			71
73 DRUGS CHARGED TO PATIENTS	806	80,599	347,156	5		73
76.97 CARDIAC REHABILITATION	1,638	11,019	94,971	4		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,123	33,089	45,612	52		88
88.01 RHC II	1,080	2,366	30,368			88.01
91 EMERGENCY	14,400	28,087	908,216	29		91
91.01 PRIORITY CARE CARLYLE	1,500	10,857	170,137			91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	172,503	1,891,296	13,586,164	447	100	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	27,699	52,883	172,309	92		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,395,026	1,944,179	4,808,241	172,239	1,557,657	202
203 UNIT COST MULT-WS B PT I	6.968092	1.000000	0.349475	319.552876	15,576.570000	203
204 COST TO BE ALLOC PER B PT II			10,209	17,476	691,659	204
205 UNIT COST MULT-WS B PT II			0.000742	32.423006	6,916.590000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING	ADMITTING	BUS OFFICE	RECON-	A & G	
	SUPPLY EXP 5.03	REVENUE 5.04	REVENUE 5.05	CILIATION 5A.06	ACCUM COST 5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING	3,291,573					5.03
5.04 ADMITTING	1,368	89,947,239				5.04
5.05 BUSINESS OFFICE	39,101		89,947,239			5.05
5.06 ADMIN & GENERAL	45,005			-4,575,623	31,083,460	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	44,445				2,007,967	7
8 LAUNDRY & LINEN SERVICE	16,931				187,666	8
9 HOUSEKEEPING	42,497				612,271	9
10 DIETARY	35,652				212,381	10
11 CAFETERIA	162,939				542,900	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	499				672,695	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	11,565				988,893	16
17 SOCIAL SERVICE	592				74,380	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	135,802	4,742,212	4,742,212		2,806,734	30
31 INTENSIVE CARE UNIT	608	41,577	41,577		44,160	31
43 NURSERY	27,309	734,259	734,259		421,740	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	96,208	9,977,362	9,977,362		2,632,851	50
51 RECOVERY ROOM	1,396	795,589	795,589		36,861	51
52 DELIVERY ROOM & LABOR ROOM	16,028	1,685,475	1,685,475		689,487	52
53 ANESTHESIOLOGY	30,050	5,961,892	5,961,892		276,173	53
54 RADIOLOGY-DIAGNOSTIC	54,560	9,890,443	9,890,443		2,395,175	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	10,483	8,500,511	8,500,511		769,506	57
58 MAGNETIC RESONANCE IMAGING (MRI)	4,036	2,989,235	2,989,235		478,308	58
60 LABORATORY	724,172	17,852,019	17,852,019		3,371,392	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	130,741	604,973	604,973		157,380	63
65 RESPIRATORY THERAPY	118,458	2,736,213	2,736,213		786,437	65
66 PHYSICAL THERAPY	58,155	3,892,492	3,892,492		1,803,551	66
69 ELECTROCARDIOLOGY	5,494	1,575,250	1,575,250		126,041	69
70 ELECTROENCEPHALOGRAPHY	4,091	551,530	551,530		123,317	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	988,264	2,780,444	2,780,444		1,258,268	71
73 DRUGS CHARGED TO PATIENTS	291,699	5,130,520	5,130,520		1,801,745	73
76.97 CARDIAC REHABILITATION	1,679	160,113	160,113		135,576	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	11,284				2,156,860	88
88.01 RHC II	5,662				471,904	88.01
91 EMERGENCY	64,140	8,372,280	8,372,280		1,754,141	91
91.01 PRIORITY CARE CARLYLE	46,002	669,826	669,826		334,270	91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,226,915	89,644,215	89,644,215	-4,575,623	30,131,030	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	64,658	303,024	303,024		952,430	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	200,007	527,596	2,251,958		4,575,623	202
203 UNIT COST MULT-WS B PT I	0.060763	0.005866	0.025036		0.147204	203
204 COST TO BE ALLOC PER B PT II	42,841	15,393	713,638		337,409	204
205 UNIT COST MULT-WS B PT II	0.013015	0.000171	0.007934		0.010855	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	HOURS OF	MEALS	MEALS	
	FEET	POUNDS OF	SERVICE	SERVED	SERVED	
	7	LAUNDRY	9	10	11	
		8				
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	137,949					7
8 LAUNDRY & LINEN SERVICE	3,000	303,984				8
9 HOUSEKEEPING	1,233	20,310	18,309			9
10 DIETARY	3,500	623	78	19,544		10
11 CAFETERIA	2,148	2,910	514		19,709	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	964		143		603	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,728		173		1,710	16
17 SOCIAL SERVICE	198		43		101	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	23,386	113,897	7,788	19,544	3,687	30
31 INTENSIVE CARE UNIT	2,090	676	88		29	31
43 NURSERY	824	3,111	268		371	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,141	57,109	2,143		2,419	50
51 RECOVERY ROOM	886				4	51
52 DELIVERY ROOM & LABOR ROOM	2,237	16,448	531		719	52
53 ANESTHESIOLOGY	554					53
54 RADIOLOGY-DIAGNOSTIC	6,928	25,528	1,198		1,872	54
57 COMPUTED TOMOGRAPHY (CT) SCAN					184	57
58 MAGNETIC RESONANCE IMAGING (MRI)					119	58
60 LABORATORY	3,998	162	964		1,992	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	1,301	1,279	272		700	65
66 PHYSICAL THERAPY	15,007	14,179	1,562		2,063	66
69 ELECTROCARDIOLOGY					88	69
70 ELECTROENCEPHALOGRAPHY	700				100	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	880				110	71
73 DRUGS CHARGED TO PATIENTS	806		124		408	73
76.97 CARDIAC REHABILITATION	1,638		168		187	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,123				28	88
88.01 RHC II	1,080					88.01
91 EMERGENCY	14,400	31,552	2,252		1,903	91
91.01 PRIORITY CARE CARLYLE	1,500					91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	110,250	287,784	18,309	19,544	19,397	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	27,699	16,200			312	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,303,548	265,387	740,720	305,789	682,021	202
203 UNIT COST MULT-WS B PT I	16.698548	0.873030	40.456606	15.646183	34.604546	203
204 COST TO BE ALLOC PER B PT II	151,139	31,678	24,999	44,944	26,938	204
205 UNIT COST MULT-WS B PT II	1.095615	0.104209	1.365394	2.299632	1.366787	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5.01 COMMUNICATIONS				5.01
5.02 INFORMATION SYSTEMS				5.02
5.03 PURCHASING				5.03
5.04 ADMITTING				5.04
5.05 BUSINESS OFFICE				5.05
5.06 ADMIN & GENERAL				5.06
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION	9,421			13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY		3,696		16
17 SOCIAL SERVICE		17	558	17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	3,687	1,134	500	30
31 INTENSIVE CARE UNIT	29	11		31
43 NURSERY	371	186		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	2,419	204		50
51 RECOVERY ROOM	4	4		51
52 DELIVERY ROOM & LABOR ROOM	719	2		52
53 ANESTHESIOLOGY		27		53
54 RADIOLOGY-DIAGNOSTIC		410		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		329		57
58 MAGNETIC RESONANCE IMAGING (MRI)		133		58
60 LABORATORY		468		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRANS.		2		63
65 RESPIRATORY THERAPY		5		65
66 PHYSICAL THERAPY		100		66
69 ELECTROCARDIOLOGY		10		69
70 ELECTROENCEPHALOGRAPHY		4		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		14		71
73 DRUGS CHARGED TO PATIENTS		19		73
76.97 CARDIAC REHABILITATION		1		76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)		20		88
88.01 RHC II		3		88.01
91 EMERGENCY	1,903	586	58	91
91.01 PRIORITY CARE CARLYLE	289	5		91.01
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	9,421	3,694	558	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES		2		192
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	814,467	1,229,490	99,525	202
203 UNIT COST MULT-WS B PT I	86.452287	332.654221	178.360215	203
204 COST TO BE ALLOC PER B PT II	17,710	50,186	5,489	204
205 UNIT COST MULT-WS B PT II	1.879843	13.578463	9.836918	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,243,455		5,243,455		5,243,455	30
31 INTENSIVE CARE UNIT	96,881		96,881		96,881	31
43 NURSERY	617,926		617,926	9,850	627,776	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,703,710		3,703,710		3,703,710	50
51 RECOVERY ROOM	58,897		58,897		58,897	51
52 DELIVERY ROOM & LABOR ROOM	951,884		951,884		951,884	52
53 ANESTHESIOLOGY	335,060		335,060	15,871	350,931	53
54 RADIOLOGY-DIAGNOSTIC	3,135,364		3,135,364		3,135,364	54
57 COMPUTED TOMOGRAPHY (CT) SC	998,590		998,590		998,590	57
58 MAGNETIC RESONANCE IMAGING	597,078		597,078		597,078	58
60 LABORATORY	4,198,204		4,198,204	59,483	4,257,687	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	181,212		181,212		181,212	63
65 RESPIRATORY THERAPY	961,936		961,936	23,377	985,313	65
66 PHYSICAL THERAPY	2,499,862		2,499,862	23,167	2,523,029	66
69 ELECTROCARDIOLOGY	150,967		150,967		150,967	69
70 ELECTROENCEPHALOGRAPHY	157,950		157,950		157,950	70
71 MEDICAL SUPPLIES CHRGED TO	1,466,649		1,466,649		1,466,649	71
73 DRUGS CHARGED TO PATIENTS	2,105,884		2,105,884		2,105,884	73
76.97 CARDIAC REHABILITATION	196,486		196,486		196,486	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,617,622		2,617,622		2,617,622	88
88.01 RHC II	560,402		560,402		560,402	88.01
91 EMERGENCY	2,807,122		2,807,122	6,798	2,813,920	91
91.01 PRIORITY CARE CARLYLE	435,172		435,172		435,172	91.01
92 OBSERVATION BEDS	545,790		545,790		545,790	92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	34,624,103		34,624,103	138,546	34,762,649	200
201 LESS OBSERVATION BEDS	545,790		545,790		545,790	201
202 TOTAL (SEE INSTRUCTIONS)	34,078,313		34,078,313	138,546	34,216,859	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,060,582		4,060,582			30
31 INTENSIVE CARE UNIT	41,577		41,577			31
43 NURSERY	718,306		718,306			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,705,561	7,971,178	9,676,739	0.382744	0.382744	0.382744 50
51 RECOVERY ROOM	162,677	609,250	771,927	0.076299	0.076299	0.076299 51
52 DELIVERY ROOM & LABOR ROOM	1,307,641	334,596	1,642,237	0.579626	0.579626	0.579626 52
53 ANESTHESIOLOGY	386,571	1,123,235	1,509,806	0.221923	0.221923	0.221923 53
54 RADIOLOGY-DIAGNOSTIC	912,099	8,753,087	9,665,186	0.324398	0.324398	0.324398 54
57 COMPUTED TOMOGRAPHY (CT) SC	1,277,428	7,087,564	8,364,992	0.119377	0.119377	0.119377 57
58 MAGNETIC RESONANCE IMAGING	74,842	2,817,202	2,892,044	0.206455	0.206455	0.206455 58
60 LABORATORY	2,718,677	14,822,812	17,541,489	0.239330	0.239330	0.242721 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	269,485	323,357	592,842	0.305667	0.305667	0.305667 63
65 RESPIRATORY THERAPY	1,938,361	772,215	2,710,576	0.354883	0.354883	0.363507 65
66 PHYSICAL THERAPY	113,939	3,691,422	3,805,361	0.656932	0.656932	0.663020 66
69 ELECTROCARDIOLOGY	179,163	1,302,971	1,482,134	0.101858	0.101858	0.101858 69
70 ELECTROENCEPHALOGRAPHY	1,972	541,212	543,184	0.290785	0.290785	0.290785 70
71 MEDICAL SUPPLIES CHRGED TO	682,374	2,006,787	2,689,161	0.545393	0.545393	0.545393 71
73 DRUGS CHARGED TO PATIENTS	2,338,834	2,668,324	5,007,158	0.420575	0.420575	0.420575 73
76.97 CARDIAC REHABILITATION	151	159,962	160,113	1.227171	1.227171	1.227171 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY	776,395	4,469,316	5,245,711	0.535127	0.535127	0.536423 91
91.01 PRIORITY CARE CARLYLE	1,732	232,447	234,179	1.858288	1.858288	1.858288 91.01
92 OBSERVATION BEDS	36,228	560,306	596,534	0.914935	0.914935	0.914935 92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	19,704,595	60,247,243	79,951,838			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	19,704,595	60,247,243	79,951,838			202

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 01/30/2012 13:47

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED ADJUSTMENT	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)		(COL. 1 MINUS COL. 2)		(COL. 3 + COL. 4)		(COL. 5 x COL. 6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	434,730		434,730	5,428	80.09	2,701	216,323	30
31 INTENSIVE CARE UNIT	18,480		18,480	18	1,026.67	18	18,480	31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	36,709		36,709	1,116	32.89			43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	489,919		489,919	6,562		2,719	234,803	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
	(FROM WKST B, PT. II, COL. 26)	(FROM WKST C, PT. I, COL. 8)	(COL.1 + COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	368,972	9,676,739	0.038130	549,331	20,946	50
51 RECOVERY ROOM	14,696	771,927	0.019038	60,964	1,161	51
52 DELIVERY ROOM & LABOR ROOM	70,759	1,642,237	0.043087	7,280	314	52
53 ANESTHESIOLOGY	80,922	1,509,806	0.053598	97,005	5,199	53
54 RADIOLOGY-DIAGNOSTIC	547,244	9,665,186	0.056620	697,831	39,511	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	321,286	8,364,992	0.038408	857,581	32,938	57
58 MAGNETIC RESONANCE IMAGING (M	218,486	2,892,044	0.075547	58,131	4,392	58
60 LABORATORY	345,686	17,541,489	0.019707	1,826,386	35,993	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T	8,340	592,842	0.014068	159,364	2,242	63
65 RESPIRATORY THERAPY	57,426	2,710,576	0.021186	1,573,062	33,327	65
66 PHYSICAL THERAPY	227,621	3,805,361	0.059816	98,602	5,898	66
69 ELECTROCARDIOLOGY	18,866	1,482,134	0.012729	167,368	2,130	69
70 ELECTROENCEPHALOGRAPHY	20,242	543,184	0.037265	1,962	73	70
71 MEDICAL SUPPLIES CHRGED TO PA	128,848	2,689,161	0.047914	439,748	21,070	71
73 DRUGS CHARGED TO PATIENTS	153,440	5,007,158	0.030644	1,330,216	40,763	73
76.97 CARDIAC REHABILITATION	27,718	160,113	0.173115	150	26	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	124,181					88
88.01 RHC II	31,489					88.01
91 EMERGENCY	254,622	5,245,711	0.048539	553,155	26,850	91
91.01 PRIORITY CARE CARLYLE	33,346	234,179	0.142395	1,073	153	91.01
92 OBSERVATION BEDS	45,251	596,534	0.075857	22,943	1,740	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	3,099,441	75,131,373	75,131,373	8,502,152	274,726	200

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KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	5,428		2,701		30
31 INTENSIVE CARE UNIT	18		18		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	1,116				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	6,562		2,719		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY						91
91.01 PRIORITY CARE CARLYLE						91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[XX] HOSPITAL (14-0145) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] NF	[ ] ICF/MR	[ ] PPS [ ] TEFRA				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13		
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	9,676,739		549,331		2,805,176		50	
51	RECOVERY ROOM	771,927		60,964		181,161		51	
52	DELIVERY ROOM & LABOR ROOM	1,642,237		7,280		1,021		52	
53	ANESTHESIOLOGY	1,509,806		97,005		380,242		53	
54	RADIOLOGY-DIAGNOSTIC	9,665,186		697,831		2,570,720		54	
57	COMPUTED TOMOGRAPHY (CT) SCA	8,364,992		857,581		2,336,713		57	
58	MAGNETIC RESONANCE IMAGING (	2,892,044		58,131		768,748		58	
60	LABORATORY	17,541,489		1,826,386		678,409		60	
62.30	BLOOD CLOTTING FOR HEMOPHILI							62.30	
63	BLOOD STORING, PROCESSING &	592,842		159,364		88,550		63	
65	RESPIRATORY THERAPY	2,710,576		1,573,062		341,082		65	
66	PHYSICAL THERAPY	3,805,361		98,602		1,295,735		66	
69	ELECTROCARDIOLOGY	1,482,134		167,368		720,397		69	
70	ELECTROENCEPHALOGRAPHY	543,184		1,962		199,326		70	
71	MEDICAL SUPPLIES CHRGED TO P	2,689,161		439,748		692,535		71	
73	DRUGS CHARGED TO PATIENTS	5,007,158		1,330,216		1,276,159		73	
76.97	CARDIAC REHABILITATION	160,113		150		99,730		76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
88	RURAL HEALTH CLINIC (RHC)							88	
88.01	RHC II							88.01	
91	EMERGENCY	5,245,711		553,155		1,062,118		91	
91.01	PRIORITY CARE CARLYLE	234,179		1,073		55,042		91.01	
92	OBSERVATION BEDS	596,534		22,943		184,892		92	
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (SUM OF LINES 50-199)	75,131,373		8,502,152		15,737,756		200	

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.382744	2,805,176			1,073,664			50
51 RECOVERY ROOM	0.076299	181,161			13,822			51
52 DELIVERY ROOM & LABOR ROOM	0.579626	1,021			592			52
53 ANESTHESIOLOGY	0.221923	380,242			84,384			53
54 RADIOLOGY-DIAGNOSTIC	0.324398	2,570,720	168		833,936	54		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.119377	2,336,713			278,950			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206455	768,748			158,712			58
60 LABORATORY	0.239330	678,409	-3,510		162,364	-840		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63 BLOOD STORING, PROCESSING & TRA	0.305667	88,550			27,067			63
65 RESPIRATORY THERAPY	0.354883	341,082	19,198		121,044	6,813		65
66 PHYSICAL THERAPY	0.656932	1,295,735			851,210			66
69 ELECTROCARDIOLOGY	0.101858	720,397			73,378			69
70 ELECTROENCEPHALOGRAPHY	0.290785	199,326			57,961			70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.545393	692,535	2,031		377,704	1,108		71
73 DRUGS CHARGED TO PATIENTS	0.420575	1,276,159	-522	8,559	536,721	-220	3,600	73
76.97 CARDIAC REHABILITATION	1.227171	99,730			122,386			76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
88.01 RHC II								88.01
91 EMERGENCY	0.535127	1,062,118			568,368			91
91.01 PRIORITY CARE CARLYLE	1.858288	55,042			102,284			91.01
92 OBSERVATION BEDS	0.914935	184,892			169,164			92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)		15,737,756	17,365	8,559	5,613,711	6,915	3,600	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		15,737,756	17,365	8,559	5,613,711	6,915	3,600	202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS							30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (M					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
63 BLOOD STORING, PROCESSING & T					63
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGED TO PA					71
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
91 EMERGENCY					91
91.01 PRIORITY CARE CARLYLE					91.01
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK [ ] TITLE V  
APPLICABLE [ ] TITLE XVIII-PT A  
BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
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 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
51	RECOVERY ROOM					51
52	DELIVERY ROOM & LABOR ROOM					52
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
57	COMPUTED TOMOGRAPHY (CT) SCAN					57
58	MAGNETIC RESONANCE IMAGING (M					58
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
63	BLOOD STORING, PROCESSING & T					63
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
69	ELECTROCARDIOLOGY					69
70	ELECTROENCEPHALOGRAPHY					70
71	MEDICAL SUPPLIES CHRGED TO PA					71
73	DRUGS CHARGED TO PATIENTS					73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)					88
88.01	RHC II					88.01
91	EMERGENCY					91
91.01	PRIORITY CARE CARLYLE					91.01
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0145)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM COSTS (COL. 9 x COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50 OPERATING ROOM	9,676,739						50			
51 RECOVERY ROOM	771,927						51			
52 DELIVERY ROOM & LABOR ROOM	1,642,237						52			
53 ANESTHESIOLOGY	1,509,806						53			
54 RADIOLOGY-DIAGNOSTIC	9,665,186						54			
57 COMPUTED TOMOGRAPHY (CT) SCA	8,364,992						57			
58 MAGNETIC RESONANCE IMAGING (	2,892,044						58			
60 LABORATORY	17,541,489						60			
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30			
63 BLOOD STORING, PROCESSING &	592,842						63			
65 RESPIRATORY THERAPY	2,710,576						65			
66 PHYSICAL THERAPY	3,805,361						66			
69 ELECTROCARDIOLOGY	1,482,134						69			
70 ELECTROENCEPHALOGRAPHY	543,184						70			
71 MEDICAL SUPPLIES CHRGED TO P	2,689,161						71			
73 DRUGS CHARGED TO PATIENTS	5,007,158						73			
76.97 CARDIAC REHABILITATION	160,113						76.97			
76.98 HYPERBARIC OXYGEN THERAPY							76.98			
76.99 LITHOTRIPSY							76.99			
OUTPATIENT SERVICE COST CENTERS										
88 RURAL HEALTH CLINIC (RHC)							88			
88.01 RHC II							88.01			
91 EMERGENCY	5,245,711						91			
91.01 PRIORITY CARE CARLYLE	234,179						91.01			
92 OBSERVATION BEDS	596,534						92			
OTHER REIMBURSABLE COST CENTERS										
200 TOTAL (SUM OF LINES 50-199)	75,131,373						200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [ ] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.382744						50
51 RECOVERY ROOM	0.076299						51
52 DELIVERY ROOM & LABOR ROOM	0.579626						52
53 ANESTHESIOLOGY	0.221923						53
54 RADIOLOGY-DIAGNOSTIC	0.324398						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.119377						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206455						58
60 LABORATORY	0.239330						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63 BLOOD STORING, PROCESSING & TRA	0.305667						63
65 RESPIRATORY THERAPY	0.354883						65
66 PHYSICAL THERAPY	0.656932						66
69 ELECTROCARDIOLOGY	0.101858						69
70 ELECTROENCEPHALOGRAPHY	0.290785						70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.545393						71
73 DRUGS CHARGED TO PATIENTS	0.420575						73
76.97 CARDIAC REHABILITATION	1.227171						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
91 EMERGENCY	0.535127						91
91.01 PRIORITY CARE CARLYLE	1.858288						91.01
92 OBSERVATION BEDS	0.914935						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,428	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,428	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	469	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,959	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,701	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,243,455	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,243,455	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,553,910	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	320,987	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,232,923	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1.475405	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	684.41	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	651.93	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	32.48	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	47.92	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	22,474	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,220,981	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 966.00 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,609,166 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 2,609,166 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	96,881	18	5,382.28	18	96,881	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,848,434	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					5,554,481	49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 234,803 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 274,726 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 509,529 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 5,044,952 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 565 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 966.00 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 545,790 89

	COST	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	434,730	5,243,455	0.082909	545,790	45,251	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,428	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,428	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	469	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,959	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	590	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	1,116	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	436	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,243,455	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,243,455	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,553,910	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	320,987	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,232,923	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1.475405	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	684.41	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	651.93	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	32.48	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	47.92	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	22,474	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,220,981	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0145)	[ ]	SUB (OTHER)	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF			[XX]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)				961.86 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)				567,497 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)				40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)				567,497 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42	NURSERY (TITLES V AND XIX ONLY)	617,926	1,116	553.70	436 241,413 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	96,881	18	5,382.28	43
44	CORONARY CARE UNIT				44
45	BURN INTENSIVE CARE UNIT				45
46	SURGICAL INTENSIVE CARE UNIT				46
47	OTHER SPECIAL CARE (SPECIFY)				47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)				48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)				808,910 49

PASS-THROUGH COST ADJUSTMENTS					
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)				50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)				51
52	TOTAL PROGRAM EXCLUDABLE COST				52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)				53

TARGET AMOUNT AND LIMIT COMPUTATION					
54	PROGRAM DISCHARGES				54
55	TARGET AMOUNT PER DISCHARGE				55
56	TARGET AMOUNT (LINE 54 x LINE 55)				56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT				57
58	BONUS PAYMENT (SEE INSTRUCTIONS)				58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET				59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET				60
61	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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E				61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)				62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)				63

PROGRAM INPATIENT ROUTINE SWING BED COST					
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)				64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)				65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)				66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)				67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)				68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)				69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)				565 87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)				88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)				89

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	1	2	3	4
90	CAPITAL-RELATED COST			90
91	NURSING SCHOOL COST			91
92	ALLIED HEALTH COST			92
93	ALL OTHER MEDICAL EDUCATION			93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] S/B SNF [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		2,395,769			30
31 INTENSIVE CARE UNIT		24,182			31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.382744	549,331	210,253		50
51 RECOVERY ROOM	0.076299	60,964	4,651		51
52 DELIVERY ROOM & LABOR ROOM	0.579626	7,280	4,220		52
53 ANESTHESIOLOGY	0.232434	97,005	22,547		53
54 RADIOLOGY-DIAGNOSTIC	0.324398	697,831	226,375		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.119377	857,581	102,375		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206455	58,131	12,001		58
60 LABORATORY	0.242721	1,826,386	443,302		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRA	0.305667	159,364	48,712		63
65 RESPIRATORY THERAPY	0.363507	1,573,062	571,819		65
66 PHYSICAL THERAPY	0.663020	98,602	65,375		66
69 ELECTROCARDIOLOGY	0.101858	167,368	17,048		69
70 ELECTROENCEPHALOGRAPHY	0.290785	1,962	571		70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.545393	439,748	239,835		71
73 DRUGS CHARGED TO PATIENTS	0.420575	1,330,216	559,456		73
76.97 CARDIAC REHABILITATION	1.227171	150	184		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
91 EMERGENCY	0.536423	553,155	296,725		91
91.01 PRIORITY CARE CARLYLE	1.858288	1,073	1,994		91.01
92 OBSERVATION BEDS	0.914935	22,943	20,991		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		8,502,152	2,848,434		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		8,502,152			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0145) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.382744			50
51 RECOVERY ROOM	0.076299			51
52 DELIVERY ROOM & LABOR ROOM	0.579626			52
53 ANESTHESIOLOGY	0.221923			53
54 RADIOLOGY-DIAGNOSTIC	0.324398			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.119377			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206455			58
60 LABORATORY	0.239330			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.305667			63
65 RESPIRATORY THERAPY	0.354883			65
66 PHYSICAL THERAPY	0.656932			66
69 ELECTROCARDIOLOGY	0.101858			69
70 ELECTROENCEPHALOGRAPHY	0.290785			70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.545393			71
73 DRUGS CHARGED TO PATIENTS	0.420575			73
76.97 CARDIAC REHABILITATION	1.227171			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
91 EMERGENCY	0.535127			91
91.01 PRIORITY CARE CARLYLE	1.858288			91.01
92 OBSERVATION BEDS	0.914935			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

CHECK [XX] HOSPITAL (14-0145)  
 APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	4,510,281	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	32,940	2
3	MANAGED CARE SIMULATED PAYMENTS	43,375	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	55.45	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0141	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1921	31
32	SUM OF LINES 30 AND 31	0.2062	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0623	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	280,991	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)	768	40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	4,824,212	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	4,824,212	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	367,935	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK [XX] HOSPITAL (14-0145)  
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	5,192,147	59
60	PRIMARY PAYER PAYMENTS	13,695	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	5,178,452	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	606,036	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	9,163	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	31,902	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	22,331	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	31,902	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	4,585,584	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.96	LOW VOLUME PAYMENT ADJUSTMENT - 1	438,018	70.96
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	5,023,602	71
72	INTERIM PAYMENTS	4,928,875	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	94,727	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	36,984	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (14-0145) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,867,670		2,978,104	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 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.	.01 01/21/2011	61,205		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE			3.50
	.51		01/21/2011	9,463	3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		61,205		-9,463	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		4,928,875		2,968,641	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .03				
	PROVIDER .04				
	TO .05				
	PROGRAM .06				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

8 NAME OF CONTRACTOR: \_\_\_\_\_ CONTRACTOR NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
01/30/2012 13:47

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK  
APPLICABLE BOX

HOSPITAL (14-0145)       CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,655 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,719 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,881 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	79,951,838 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	630,381 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-0145) [ ] SNF [ ] PPS  
 APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
 BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
 [ ] SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	808,910	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	808,910	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	808,910	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES		8
9	ANCILLARY SERVICE CHARGES		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	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)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	808,910	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29	SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>CURRENT ASSETS</b>				
1 CASH ON HAND AND IN BANKS	1,309,759			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	15,581,562			4
5 OTHER RECEIVABLES	366,953			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-9,511,780			6
7 INVENTORY	595,496			7
8 PREPAID EXPENSES	297,718			8
9 OTHER CURRENT ASSETS	3,050,000			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	11,689,708			11
<b>FIXED ASSETS</b>				
12 LAND	1,432,837			12
13 LAND IMPROVEMENTS	3,463,354			13
14 ACCUMULATED DEPRECIATION	-1,727,702			14
15 BUILDINGS	17,381,931			15
16 ACCUMULATED DEPRECIATION	-6,844,565			16
17 LEASEHOLD IMPROVEMENTS	163,480			17
18 ACCUMULATED AMORTIZATION	-58,093			18
19 FIXED EQUIPMENT	12,215,354			19
20 ACCUMULATED DEPRECIATION	-8,024,037			20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	20,652,103			23
24 ACCUMULATED DEPRECIATION	-15,076,599			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	23,578,063			30
<b>OTHER ASSETS</b>				
31 INVESTMENTS	70,724,000			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	146,842			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	70,870,842			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	106,138,613			36
<b>LIABILITIES AND FUND BALANCES</b>				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>CURRENT LIABILITIES</b>				
37 ACCOUNTS PAYABLE	994,252			37
38 SALARIES, WAGES & FEES PAYABLE	2,074,120			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	3,050,000			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	316,452			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,434,824			45
<b>LONG-TERM LIABILITIES</b>				
46 MORTGAGE PAYABLE	8,200,000			46
47 NOTES PAYABLE				47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	7,608,042			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	15,808,042			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	22,242,866			51
<b>CAPITAL ACCOUNTS</b>				
52 GENERAL FUND BALANCE	83,895,747			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	83,895,747			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	106,138,613			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		69,531,656							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		12,637,740							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		82,169,396							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 CHANGE IN TEMP RESTRICTED AS	167,884								5
6 NET ASSETS RELEASED	1,807,260								6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		1,975,144							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		84,144,540							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 CUM EFFECT/CHANGE IN ACCT PR	248,793								13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		248,793							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		83,895,747							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	4,673,214		4,673,214	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	4,673,214		4,673,214	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	41,403		41,403	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	41,403		41,403	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	4,714,617		4,714,617	17
18 ANCILLARY SERVICES	17,380,062	59,837,326	77,217,388	18
19 OUTPATIENT SERVICES		7,103,020	7,103,020	19
20 RHC		3,270,605	3,270,605	20
20.01 RHC II				20.01
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
27.01 OBSERVATION BEDS	36,975	572,216	609,191	27.01
27.02 PHYSICIAN SERVICES		303,023	303,023	27.02
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	22,131,654	71,086,190	93,217,844	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		45,725,766	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38 ROUNDING		-6	38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-6	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		45,725,760	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	93,217,844	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	45,517,521	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	47,700,323	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	45,725,760	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,974,563	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,250	6
7	INCOME FROM INVESTMENTS	9,780,558	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	977	8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	5,971	10
11	REBATES AND REFUNDS OF EXPENSES	4,827	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	706	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	141,272	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	32,526	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,266	21
22	RENTAL OF HOSPITAL SPACE	451,745	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS REVENUE)	234,049	24
24.01	OTHER (SALE OF SCRAP)	8,030	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	10,663,177	25
26	TOTAL (LINE 5 PLUS LINE 25)	12,637,740	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	12,637,740	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((14-014) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
 BOXES [ ] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	365,067	1
2	CAPITAL DRG OUTLIER PAYMENTS	2,868	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	13.65	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	367,935	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)		3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST &	TOTAL
	NARY CAP- REL COSTS			POST STEP- DOWN ADJS	
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 COMMUNICATIONS					5.01
5.02 INFORMATION SYSTEMS					5.02
5.03 PURCHASING					5.03
5.04 ADMITTING					5.04
5.05 BUSINESS OFFICE					5.05
5.06 ADMIN & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
63 BLOOD STORING, PROCESSING & TR					63
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGED TO PAT					71
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
91.01 PRIORITY CARE CARLYLE					91.01
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	40,174	568,051	608,225	608,225	-34,981	573,244	1
2	PHYSICIAN ASSISTANT	4,522	49,480	54,002	54,002		54,002	2
3	NURSE PRACTITIONER	714	109,618	110,332	110,332		110,332	3
4	VISITING NURSE							4
5	OTHER NURSE	202	35,076	35,278	35,278		35,278	5
6	CLINICAL PSYCHOLOGIST							6
7	CLINICAL SOCIAL WORKER							7
8	LABORATORY TECHNICIAN							8
9	OTHER FACILITY HEALTH CARE STAFF COSTS		202	202	202		202	9
10	SUBTOTAL (SUM OF LINES 1-9)	45,612	762,427	808,039	808,039	-34,981	773,058	10
COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT							11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13	OTHER COSTS UNDER AGREEMENT							13
14	SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		22,776	22,776	22,776		22,776	15
16	TRANSPORTATION (HEALTH CARE STAFF)							16
17	DEPRECIATION-MEDICAL EQUIPMENT							17
18	PROFESSIONAL LIABILITY INSURANCE		33,291	33,291	33,291		33,291	18
19	OTHER HEALTH CARE COSTS							19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (SUM OF LINES 15-20)		56,067	56,067	56,067		56,067	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	45,612	818,494	864,106	864,106	-34,981	829,125	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY		89,533	89,533	89,533		89,533	23
24	DENTAL							24
25	OPTOMETRY							25
26	ALL OTHER NONREIMBURSABLE COSTS		6,991	6,991	6,991	-6,991		26
27	NONALLOWABLE GME COSTS							27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		96,524	96,524	96,524	-6,991	89,533	28
FACILITY OVERHEAD								
29	FACILITY COSTS		128,250	128,250	128,250	-91,328	36,922	29
30	ADMINISTRATIVE COSTS		1,079,519	1,079,519	1,079,519	-1,173	1,078,346	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		1,207,769	1,207,769	1,207,769	-92,501	1,115,268	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	45,612	2,122,787	2,168,399	2,168,399	-134,473	2,033,926	32

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.83	15,322	4,200	11,886	1
2	PHYSICIAN ASSISTANTS	0.63	2,559	2,100	1,323	2
3	NURSE PRACTITIONERS	1.28	4,319	2,100	2,688	3
4	SUBTOTAL (SUM OF LINES 1-3)	4.74	22,200		15,897	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4.74	22,200			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				829,125	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				89,533	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				918,658	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				0.902539	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				1,115,268	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				583,696	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,698,964	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,698,964	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,533,381	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				2,362,506	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-3

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	2,362,506	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	163,019	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,199,487	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	22,200	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	22,200	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	99.08	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	77.76	78.07	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	77.76	78.07	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	2,824	2,823	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	219,594	220,392	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)			15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	219,594	220,392	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		296,195	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		106,036	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	175,675	106,036	16.05
17	PRIMARY PAYOR PAYMENTS		166	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		87,847	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		100,879	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		281,545	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		38,100	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		319,645	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		711	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		320,356	26
27	INTERIM PAYMENTS		277,170	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		43,186	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	773,058	773,058	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.026810	0.006581	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	20,726	5,087	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	19,102	8,550	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	39,828	13,637	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	829,125	829,125	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,698,964	1,698,964	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.048036	0.016447	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	81,611	27,943	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	121,439	41,580	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	317	778	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	383.09	53.44	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	59	290	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	22,602	15,498	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		163,019	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		38,100	16



RHC II  
 COMPONENT NO: 14-8502

WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	28,322	105,243	133,565	133,565		133,565	1
2	PHYSICIAN ASSISTANT		6,166	6,166	6,166		6,166	2
3	NURSE PRACTITIONER		20,708	20,708	20,708		20,708	3
4	VISITING NURSE							4
5	OTHER NURSE		7,438	7,438	7,438		7,438	5
6	CLINICAL PSYCHOLOGIST							6
7	CLINICAL SOCIAL WORKER							7
8	LABORATORY TECHNICIAN							8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	2,046	49	2,095	2,095		2,095	9
10	SUBTOTAL (SUM OF LINES 1-9)	30,368	139,604	169,972	169,972		169,972	10
COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT							11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13	OTHER COSTS UNDER AGREEMENT							13
14	SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		4,802	4,802	4,802		4,802	15
16	TRANSPORTATION (HEALTH CARE STAFF)							16
17	DEPRECIATION-MEDICAL EQUIPMENT							17
18	PROFESSIONAL LIABILITY INSURANCE		7,019	7,019	7,019		7,019	18
19	OTHER HEALTH CARE COSTS							19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (SUM OF LINES 15-20)		11,821	11,821	11,821		11,821	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	30,368	151,425	181,793	181,793		181,793	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY		18,878	18,878	18,878		18,878	23
24	DENTAL							24
25	OPTOMETRY							25
26	ALL OTHER NONREIMBURSABLE COSTS							26
27	NONALLOWABLE GME COSTS							27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		18,878	18,878	18,878		18,878	28
FACILITY OVERHEAD								
29	FACILITY COSTS		23,022	23,022	23,022		23,022	29
30	ADMINISTRATIVE COSTS		227,618	227,618	227,618	-256	227,362	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		250,640	250,640	250,640	-256	250,384	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	30,368	420,943	451,311	451,311	-256	451,055	32

RHC II  
 COMPONENT NO: 14-8502

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	0.67	3,570	4,200	2,814	1
2	PHYSICIAN ASSISTANTS	0.07	228	2,100	147	2
3	NURSE PRACTITIONERS	0.24	1,080	2,100	504	3
4	SUBTOTAL (SUM OF LINES 1-3)	0.98	4,878		3,465	4,878
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.98	4,878			4,878
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)					181,793
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					18,878
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)					200,671
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)					0.905926
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)					250,384
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)					109,347
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)					359,731
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					
18	SUBTRACT LINE 17 FROM LINE 16					359,731
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)					325,890
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)					507,683

RHC II  
 COMPONENT NO: 14-8502

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	507,683	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	25,436	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	482,247	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,878	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,878	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	98.86	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	77.76	78.07	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	77.76	78.07	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	741	451	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	57,620	35,210	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)			15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	57,620	35,210	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		46,384	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		5,598	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	46,096	5,598	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		28,212	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		18,874	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		51,694	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		14,383	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		66,077	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		93	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		66,170	26
27	INTERIM PAYMENTS		49,973	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		16,197	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC II  
 COMPONENT NO: 14-8502

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	169,972	169,972	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.003164	0.007683	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	538	1,306	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	4,640	2,055	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	5,178	3,361	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	181,793	181,793	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	359,731	359,731	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.028483	0.018488	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	10,246	6,651	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	15,424	10,012	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	77	187	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	200.31	53.54	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	40	119	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	8,012	6,371	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		25,436	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		14,383	16

