

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 DATE: 03-30-2012 TIME: 15:23  
 2.  MANUALLY SUBMITTED COST REPORT  
 3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5.  COST REPORT STATUS 6. DATE RECEIVED: \_\_\_\_\_ 10. NPR DATE: \_\_\_\_\_  
 1 - AS SUBMITTED 7. CONTRACTOR NO: \_\_\_\_\_ 11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_  
 2 - SETTLED WITHOUT AUDIT 8.  INITIAL REPORT FOR THIS PROVIDER CCN 12.  IF LINE 5, COLUMN 1 IS 4: ENTER  
 3 - SETTLED WITH AUDIT 9.  FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.  
 4 - REOPENED  
 5 - AMENDED

PART II - CERTIFICATION

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 OSF HOLY FAMILY MED CTR (14-1318) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2010 AND ENDING 09/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		188,811	-171,592			1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		17,075				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			197,012			10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		205,886	25,420			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 OMB 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: 1000 WEST HARLEM AVENUE  
 2 CITY: MONMOUTH STATE: IL

P.O. BOX: ZIP CODE: 61462 COUNTY: WARREN

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)			
							2	3	4	5
3	HOSPITAL	OSF HOLY FAMILY MED CTR	14-1318	CABLE	1	05/01/2002	N	O	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	OSF HOLY FAMILY SWING BEDS	14-2318	CABLE		05/01/2002	N	O	N	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 HOSPIECE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	OSF HOLY FAMILY CLINICS	14-3461	CABLE		02/05/2003	N	O	N	15
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: 10/01/2010				TO: 09/30/2011				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.									N	N

		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.							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 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.							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

		V	XVIII	XIX
45	PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N
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
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N

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 IIME 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	IIME 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))
	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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
	PROGRAM NAME 1	PROGRAM CODE 2	3	4	5
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))

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	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	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.			V 1 XIX 2 N Y 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)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 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.			N N 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	RESPI- RATORY Y N Y N 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		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.	1		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.		25,000,000	25,000,000 119
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.	Y		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	149006	140
-----	--	---	--------	-----

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: OSF HEALTHCARE SYSTEM	CONTRACTOR'S NAME: 14-9006	CONTRACTOR'S NUMBER: 52280	141
142	STREET: 800 N.E. GLEN OAK AVENUE	P.O. BOX:		142
143	CITY: PEORIA	STATE: IL	ZIP CODE: 61603	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
		N 161

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

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)	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.	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.	Y	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.	N		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?	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

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
<b>PS&amp;R REPORT DATA</b>					
		1	2	3	4
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)	N		N	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	12/29/2011	Y	12/29/2011 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. N 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 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. N 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. N 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. N 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. N 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. Y 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. Y 35

HOME OFFICE COSTS

- |   | Y/N | DATE |
|---|-----|------|
| 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?   | 1   | 2    |
| 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  | Y   | 36   |
|   | Y   | 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. | N   | 38   |
| 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.   | N   | 39   |
| 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  | N   | 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	10,773,647	3,824,504		1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A					4
4.01	PHYSICIANS-PART A - DIRECT TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					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)		767,212	2,125		10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A					15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)					16
WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A					22
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS		205,969	3,672,192		26
27	ADMINISTRATIVE & GENERAL		2,144,625	78,359		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		355,316	4,250		30
31	LAUNDRY & LINEN SERVICE			22,901		31
32	HOUSEKEEPING		319,960	-22,051		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		271,199	5,313		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION					38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		149,671	81,172		41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	10,773,647	3,824,504	14,598,151	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	767,212	2,125	769,337	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	10,006,435	3,822,379	13,828,814	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)				4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)				5
6	TOTAL (SUM OF LINES 3 THRU 5)	10,006,435	3,822,379	13,828,814	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,446,740	3,842,136	7,288,876	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	3
4 PRIOR YEAR PENSION SERVICE COST	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL	3,029,493	2
3	SUBPROVIDER - IPF	3,029,493	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
 03/30/2012 15:23

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	05/01/2002	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
	1	2	3	4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA			17
18	RHC			18
19	RHB			19
20	RHA			20
21	RMC			21
22	RMB			22
23	RMA			23
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1			48
49	CC2			49
50	CC1			50
51	CB2			51
52	CB1			52
53	CA2			53
54	CA1			54
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1			66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
	1	2	3	4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

	CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OF THE COST REPORTING PERIOD (IF APPLICABLE)
	1	2
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

	EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?
	1	2	3
202	STAFFING		202
203	RECRUITMENT		203
204	RETENTION OF EMPLOYEES		204
205	TRAINING		205
206	OTHER (SPECIFY)		206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)		207

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

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

RHC I  
COMPONENT NO: 14-3461

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 W. HARLEM 1  
2 CITY: MONMOUTH STATE: ILLINOIS ZIP CODE: 61462 COUNTY: WARREN 2  
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

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	0700	2200	0700	2200	0700	2200	0700	2200	0700	2200	0700	2200	0700	0200

(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 Y/N V XVIII XIX 15  
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)

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)				0.429743	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,393,381	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				7,780,723	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,343,711	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				1,950,330	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)				1,950,330	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	2,362,078	937,412	3,299,490		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,015,086	402,846	1,417,932		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	13,333	761,279	774,612		22
23	COST OF CHARITY CARE	1,001,753	-358,433	643,320		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					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)			1,376,332		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			340,915		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,035,417		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			444,963		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,088,283		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			3,038,613		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 + COL. 2)	CATIONS	
				3	4	
GENERAL SERVICE COST CENTERS						
1	00100					1
2	00200		329,085	329,085	104,922	2
3	00300				501,715	3
4	00400	205,969	45,234	251,203	3,626,958	4
5	00500	2,144,625	2,995,889	5,140,514	-894,270	5
6	00600					6
7	00700	355,316	1,104,850	1,460,166	-263,896	7
8	00800		87,441	87,441	22,901	8
9	00900	319,960	224,545	544,505	-194,736	9
10	01000	271,199	416,567	687,766	-180,484	10
11	01100					11
12	01200					12
13	01300					13
14	01400					14
15	01500					15
16	01600	149,671	90,929	240,600	50,661	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	937,441	477,866	1,415,307	-431,533	30
ANCILLARY SERVICE COST CENTERS						
50	05000	395,072	705,433	1,100,505	-625,898	50
53	05300	168,535	282,417	450,952	-57,608	53
54	05400	449,530	385,101	834,631	-191,132	54
56	05600	51,097	122,566	173,663	-92,847	56
57	05700		478,064	478,064	-16,028	57
58	05800		188,792	188,792	-6,633	58
60	06000	381,429	785,663	1,167,092	-171,509	60
62.30	06250					62.30
65	06500	177	31,821	31,998	-8,475	65
66	06600	280,057	155,101	435,158	-127,961	66
67	06700	75,313	23,838	99,151	-22,401	67
68	06800		11,031	11,031		68
69	06900	102,454	64,041	166,495	-59,072	69
71	07100	20,111	17,620	37,731	468,615	71
72	07200				21,116	72
73	07300	265,163	508,452	773,615	104,765	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	2,501,891	1,547,826	4,049,717	-1,087,539	88
91	09100	931,425	1,086,529	2,017,954	-238,866	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300		67,500	67,500	-67,500	113
118		10,006,435	12,234,201	22,240,636	163,265	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	767,212	362,051	1,129,263	-163,265	192
200		10,773,647	12,596,252	23,369,899		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	434,007		434,007	1
2	00200	501,715	-19,595	482,120	2
3	00300				3
4	00400	3,878,161	-105,835	3,772,326	4
5	00500	4,246,244	1,103,232	5,349,476	5
6	00600				6
7	00700	1,196,270		1,196,270	7
8	00800	110,342		110,342	8
9	00900	349,769		349,769	9
10	01000	507,282	-35,118	472,164	10
11	01100				11
12	01200				12
13	01300				13
14	01400				14
15	01500				15
16	01600	291,261	-5,510	285,751	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	983,774		983,774	30
ANCILLARY SERVICE COST CENTERS					
50	05000	474,607		474,607	50
53	05300	393,344	-382,000	11,344	53
54	05400	643,499		643,499	54
56	05600	80,816		80,816	56
57	05700	462,036		462,036	57
58	05800	182,159	9,746	191,905	58
60	06000	995,583	-14,400	981,183	60
62.30	06250				62.30
65	06500	23,523		23,523	65
66	06600	307,197		307,197	66
67	06700	76,750		76,750	67
68	06800	11,031		11,031	68
69	06900	107,423		107,423	69
71	07100	506,346		506,346	71
72	07200	21,116		21,116	72
73	07300	878,380		878,380	73
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800	2,962,178	-10,971	2,951,207	88
91	09100	1,779,088	-755,801	1,023,287	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		22,403,901	-216,252	22,187,649	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
192	19200	965,998		965,998	192
200		23,369,899	-216,252	23,153,647	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER
			LINE #	SALARY	
1	1	2	3	4	5
1 INTEREST EXPENSE	A	CAP REL COSTS-MVBLE EQUIP	2		67,500 1
500 TOTAL RECLASSIFICATIONS					67,500 500
CODE LETTER - A					
1 MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHRGED TO PA	71		470,520 1
2		DRUGS CHARGED TO PATIENTS	73		174,544 2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
500 TOTAL RECLASSIFICATIONS					645,064 500
CODE LETTER - B					
1 RT SALARIES	C	RESPIRATORY THERAPY	65	15,618	1
2					2
3					3
4					4
500 TOTAL RECLASSIFICATIONS				15,618	500
CODE LETTER - C					
1 A&G EXPENSES	D	MEDICAL RECORDS & LIBRARY	16	78,622	1
500 TOTAL RECLASSIFICATIONS				78,622	500
CODE LETTER - D					
1 RHC PHYSICIAN RECRUITMENT	E	RURAL HEALTH CLINIC (RHC)	88		54,902 1
500 TOTAL RECLASSIFICATIONS					54,902 500
CODE LETTER - E					
1 PROPERTY INSURANCE	F	CAP REL COSTS-BLDG & FIXT	1		11,555 1
2		CAP REL COSTS-MVBLE EQUIP	2		18,430 2
500 TOTAL RECLASSIFICATIONS					29,985 500
CODE LETTER - F					
1 EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS	4	3,672,192	1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
500 TOTAL RECLASSIFICATIONS				3,672,192	500
CODE LETTER - G					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
1	1	2	3	4	5
1 TEAM AWARD ADJ RECLASS	H	ADMINISTRATIVE & GENERAL	5	78,359	1
2		OPERATION OF PLANT	7	4,250	2
3		LAUNDRY & LINEN SERVICE	8	850	3
4		DIETARY	10	5,313	4
5		MEDICAL RECORDS & LIBRARY	16	2,550	5
6		ADULTS & PEDIATRICS	30	11,178	6
7		OPERATING ROOM	50	4,123	7
8		ANESTHESIOLOGY	53	425	8
9		RADIOLOGY-DIAGNOSTIC	54	5,101	9
10		RADIOISOTOPE	56	425	10
11		LABORATORY	60	4,675	11
12		PHYSICAL THERAPY	66	2,975	12
13		OCCUPATIONAL THERAPY	67	425	13
14		DRUGS CHARGED TO PATIENTS	73	3,188	14
15		ELECTROCARDIOLOGY	69	1,275	15
16		RURAL HEALTH CLINIC (RHC)	88	20,060	16
17		EMERGENCY	91	5,015	17
18		PHYSICIANS' PRIVATE OFFICES	192	2,125	18
500 TOTAL RECLASSIFICATIONS				152,312	500
CODE LETTER - H					
1 DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		260,678
2		CAP REL COSTS-MVBLE EQUIP	2		415,785
3		ADMINISTRATIVE & GENERAL	5		19,550
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
500 TOTAL RECLASSIFICATIONS					696,013
CODE LETTER - I					500
1 LAUNDRY RECLASS	J	LAUNDRY & LINEN SERVICE	8	22,051	1
500 TOTAL RECLASSIFICATIONS				22,051	500
CODE LETTER - J					
1 IMPLANTABLE DEVICES	K	IMPL. DEV. CHARGED TO PATIENT	72		21,116
500 TOTAL RECLASSIFICATIONS					21,116
CODE LETTER - K					500
1 CLINIC A&G	L	ADMINISTRATIVE & GENERAL	5		86,148
2					2
500 TOTAL RECLASSIFICATIONS					86,148
CODE LETTER - L					500
GRAND TOTAL (INCREASES)				3,940,795	1,600,728

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 INTEREST EXPENSE	A	INTEREST EXPENSE	113		67,500	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					67,500	500
1 MEDICAL SUPPLIES	B	ADULTS & PEDIATRICS	30		2,719	1
2		OPERATING ROOM	50		400,503	2
3		ANESTHESIOLOGY	53		9,525	3
4		RADIOLOGY-DIAGNOSTIC	54		1,055	4
5		RADIOISOTOPE	56		64,478	5
6		COMPUTED TOMOGRAPHY (CT) SCAN	57		7,169	6
7		MAGNETIC RESONANCE IMAGING (M	58		3,561	7
8		RESPIRATORY THERAPY	65		20,993	8
9		PHYSICAL THERAPY	66		4,810	9
10		OCCUPATIONAL THERAPY	67		1,082	10
11		ELECTROCARDIOLOGY	69		381	11
12		EMERGENCY	91		5,418	12
13		RURAL HEALTH CLINIC (RHC)	88		96,986	13
14		PHYSICIANS' PRIVATE OFFICES	192		26,384	14
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					645,064	500
1 RT SALARIES	C	ADULTS & PEDIATRICS	30	15,232		1
2		OPERATING ROOM	50	60		2
3		ELECTROCARDIOLOGY	69	269		3
4		EMERGENCY	91	57		4
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				15,618		500
1 A&G EXPENSES	D	RURAL HEALTH CLINIC (RHC)	88	78,622		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D				78,622		500
1 RHC PHYSICIAN RECRUITMENT	E	ADMINISTRATIVE & GENERAL	5		54,902	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					54,902	500
1 PROPERTY INSURANCE	F	ADMINISTRATIVE & GENERAL	5		29,985	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					29,985	500
1 EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS	4		45,234	1
2		ADMINISTRATIVE & GENERAL	5		757,713	2
3		OPERATION OF PLANT	7		159,078	3
4		HOUSEKEEPING	9		170,969	4
5		DIETARY	10		168,766	5
6		MEDICAL RECORDS & LIBRARY	16		26,800	6
7		ADULTS & PEDIATRICS	30		372,610	7
8		OPERATING ROOM	50		152,964	8
9		ANESTHESIOLOGY	53		37,490	9
10		RADIOLOGY-DIAGNOSTIC	54		176,918	10
11		RADIOISOTOPE	56		28,596	11
12		LABORATORY	60		151,828	12
13		PHYSICAL THERAPY	66		106,376	13
14		OCCUPATIONAL THERAPY	67		21,744	14
15		DRUGS CHARGED TO PATIENTS	73		70,115	15
16		ELECTROCARDIOLOGY	69		40,717	16
17		RURAL HEALTH CLINIC (RHC)	88		853,325	17
18		EMERGENCY	91		215,071	18
19		PHYSICIANS' PRIVATE OFFICES	192		115,878	19
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					3,672,192	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TEAM AWARD ADJ RECLASS	H	ADMINISTRATIVE & GENERAL	5		152,312	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
500 TOTAL RECLASSIFICATIONS					152,312	500
CODE LETTER - H						
1 DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		167,311	9 1
2		ADMINISTRATIVE & GENERAL	5		83,415	9 2
3		OPERATION OF PLANT	7		109,068	3
4		HOUSEKEEPING	9		1,716	4
5		DIETARY	10		17,031	5
6		MEDICAL RECORDS & LIBRARY	16		3,711	6
7		ADULTS & PEDIATRICS	30		52,150	7
8		OPERATING ROOM	50		55,378	8
9		ANESTHESIOLOGY	53		11,018	9
10		RADIOLOGY-DIAGNOSTIC	54		18,260	10
11		RADIOISOTOPE	56		198	11
12		COMPUTED TOMOGRAPHY (CT) SCAN	57		8,859	12
13		MAGNETIC RESONANCE IMAGING (M	58		3,072	13
14		LABORATORY	60		24,356	14
15		RESPIRATORY THERAPY	65		3,100	15
16		PHYSICAL THERAPY	66		19,750	16
17		MEDICAL SUPPLIES CHRGED TO PA	71		1,905	17
18		DRUGS CHARGED TO PATIENTS	73		2,852	18
19		ELECTROCARDIOLOGY	69		18,980	19
20		RURAL HEALTH CLINIC (RHC)	88		58,988	20
21		EMERGENCY	91		23,335	21
22		PHYSICIANS' PRIVATE OFFICES	192		11,560	22
500 TOTAL RECLASSIFICATIONS					696,013	500
CODE LETTER - I						
1 LAUNDRY RECLASS	J	HOUSEKEEPING	9	22,051		1
500 TOTAL RECLASSIFICATIONS				22,051		500
CODE LETTER - J						
1 IMPLANTABLE DEVICES	K	OPERATING ROOM	50		21,116	1
500 TOTAL RECLASSIFICATIONS					21,116	500
CODE LETTER - K						
1 CLINIC A&G	L	RURAL HEALTH CLINIC (RHC)	88		74,580	1
2		PHYSICIANS' PRIVATE OFFICES	192		11,568	2
500 TOTAL RECLASSIFICATIONS					86,148	500
CODE LETTER - L						
GRAND TOTAL (DECREASES)				116,291	5,425,232	

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	325,000					325,000	1
2 LAND IMPROVEMENTS	146,120		46,032	46,032		192,152	2
3 BUILDINGS AND FIXTURES	2,676,780		72,600	72,600	2,413	2,746,967	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	4,061,531		264,273	264,273	27,915	4,297,889	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	7,209,431		382,905	382,905	30,328	7,562,008	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	7,209,431		382,905	382,905	30,328	7,562,008	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	329,085						329,085 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	329,085						329,085 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	RATIOS		INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4				
1 CAP REL COSTS-BLDG & FIXT	3,264,119		3,264,119	0.431647				1
2 CAP REL COSTS-MVBLE EQUIP	4,297,889		4,297,889	0.568353				2
3 TOTAL (SUM OF LINES 1-2)	7,562,008		7,562,008	1.000000				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	422,452			11,555			434,007 1
2 CAP REL COSTS-MVBLE EQUIP	415,785		47,905	18,430			482,120 2
3 TOTAL	838,237		47,905	29,985			916,127 3

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 5
			COST CENTER 3	LINE NO. 4	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-19,595	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-3,768	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-7,169	ADMINISTRATIVE & GENERAL	5	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-770,201			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	1,510,932			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-32,712	DIETARY	10	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-5,510	MEDICAL RECORDS & LIBRARY	16	16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					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		PHYSICAL THERAPY	66	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			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		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 RHC OTHER INCOME	B	-10,971	RURAL HEALTH CLINIC (RHC)	88	33
33.01 MISCELLANEOUS INCOME	B	-10,391	ADMINISTRATIVE & GENERAL	5	33.01
33.02 MISCELLANEOUS INCOME	B	-2,406	DIETARY	10	33.02
34 MARKETING AND DEVELOPMENT SALARIES	A	-18,139	ADMINISTRATIVE & GENERAL	5	34
34.01 MARKETING & DEVELOPMENT BENEFITS	A	-6,041	EMPLOYEE BENEFITS	4	34.01
34.02 MARKETING & DEVELOPMENT OTHER	A	-10,059	ADMINISTRATIVE & GENERAL	5	34.02
34.03 ADVERTISING EXPENSE	A	-159,503	ADMINISTRATIVE & GENERAL	5	34.03
35 LOBBYING	A	-10,648	ADMINISTRATIVE & GENERAL	5	35
36 CRNA PRO FEES	A	-210,948	ANESTHESIOLOGY	53	36
36.01 CRNA SALARIES	A	-168,535	ANESTHESIOLOGY	53	36.01
36.02 CRNA BENEFITS	A	-37,490	EMPLOYEE BENEFITS	4	36.02
36.03 CRNA CME	A	-2,517	ANESTHESIOLOGY	53	36.03
37 ER BENEFITS	A	-62,304	EMPLOYEE BENEFITS	4	37
38 DONATIONS	A	-500	ADMINISTRATIVE & GENERAL	5	38
38.01 ALCOHOLIC BEVERAGES	A	-1,428	ADMINISTRATIVE & GENERAL	5	38.01
38.02 PROVIDER TAX IDPA	A	-169,149	ADMINISTRATIVE & GENERAL	5	38.02
38.03 CAR ALLOWANCE	A	-7,200	ADMINISTRATIVE & GENERAL	5	38.03
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-216,252			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	ADMINISTRATIVE & GENERAL	A&G	1,586,312	577,675	1,008,637	1
2	5	ADMINISTRATIVE & GENERAL	INTEREST EXP CORP OFFICE	492,549		492,549	2
3	5	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	19,354	19,354		3
4	58	MAGNETIC RESONANCE IMAGING (MRI)	MOBILE MRI	202,837	181,875	20,962	4
4.01	58	MAGNETIC RESONANCE IMAGING (MRI)	ET MAINTENANCE AGREEMENT	155,736	166,952	-11,216	4.01
5		TOTALS (SUM OF LINES 1-4)		2,456,788	945,856	1,510,932	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.

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----							
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS		
1	2	3	4	5	6		
6	B	OSF HEALTHCARE SYSTEM		100.00			6
7							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:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	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	
LINE NO.	1	2	3	4	5	6	7	8	9
1	91	EMERGENCY	EMERGENCY AGGRE	1,066,859	755,801	311,057			1
2	60	LABORATORY	LABRATORY AGGRE	14,400	14,400				2
3	5	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE	77,695		77,695			3
200		TOTAL		1,158,954	770,201	388,752			200



PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS I & II

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA		69.66				10
11	STANDARD TRAVEL ALLOWANCE	34.83	34.83				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS						15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT						17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT						20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY						23

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS III & IV

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS	29
30	ASSISTANTS	30
31	SUBTOTAL	31
32	OPTIONAL TRAVEL EXPENSE	32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE		
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS V,VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5
47					47
48					48
49					49
50					50
51					51
52					52
53					53
54					54
55					55
56					56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					57
58					58
59					59
60					60
61					61
62					62
63					63
64					64
65					65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
 PARTS I & II

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					41	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					615	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					47	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					0.35	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		322.00				9
10	AHSEA		73.49				10
11	STANDARD TRAVEL ALLOWANCE	36.75	36.75				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					23,664	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					23,664	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					23,664	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					73.49	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					45,196	22
23	TOTAL SALARY EQUIVALENCY					45,196	23

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS III & IV

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	1,727 24
25	ASSISTANTS	25
26	SUBTOTAL	1,727 26
27	STANDARD TRAVEL EXPENSE	16 27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	1,743 28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS	29
30	ASSISTANTS	30
31	SUBTOTAL	31
32	OPTIONAL TRAVEL EXPENSE	32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	1,743 33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE		
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
 03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
 PARTS V,VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					45,196	57
58					1,743	58
59						59
60						60
61						61
62						62
63					46,939	63
64					12,863	64
65						65

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS I & II

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					49	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					735	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					110	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		230.75				9
10	AHSEA	66.94	66.94				10
11	STANDARD TRAVEL ALLOWANCE	33.47	33.47				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					15,446	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					15,446	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					15,446	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					66.94	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					49,201	22
23	TOTAL SALARY EQUIVALENCY					49,201	23

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS III & IV

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24 THERAPISTS	3,682	24
25 ASSISTANTS		25
26 SUBTOTAL	3,682	26
27 STANDARD TRAVEL EXPENSE	380	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	4,062	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29 THERAPISTS		29
30 ASSISTANTS		30
31 SUBTOTAL		31
32 OPTIONAL TRAVEL EXPENSE		32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	4,062	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE		
36 THERAPISTS		36
37 ASSISTANTS		37
38 SUBTOTAL		38
39 STANDARD TRAVEL EXPENSE		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40 THERAPISTS		40
41 ASSISTANTS		41
42 SUBTOTAL		42
43 OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS V,VI & VII

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					49,201	57
58					4,062	58
59						59
60						60
61						61
62						62
63					53,263	63
64					11,031	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	434,007	434,007				1
2 CAP REL COSTS-MVBLE EQUIP	482,120		482,120			2
4 EMPLOYEE BENEFITS	3,772,326			3,772,326		4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	5,349,476	38,774	43,072	815,613	6,246,935	5
6 OPERATION OF PLANT	1,196,270	108,393	120,409	131,925	1,556,997	7
8 LAUNDRY & LINEN SERVICE	110,342			8,402	118,744	8
9 HOUSEKEEPING	349,769	3,774	4,193	109,303	467,039	9
10 DIETARY	472,164	30,112	33,450	101,452	637,178	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	285,751	11,971	13,298	84,696	395,716	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
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	983,774	48,385	53,749	342,460	1,428,368	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	474,607	22,193	24,654	146,443	667,897	50
53 ANESTHESIOLOGY	11,344	1,054	1,171	156	13,725	53
54 RADIOLOGY-DIAGNOSTIC	643,499	22,221	24,684	166,804	857,208	54
56 RADIOISOTOPE	80,816			18,903	99,719	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	462,036				462,036	57
58 MAGNETIC RESONANCE IMAGING (MRI)	191,905				191,905	58
60 LABORATORY	981,183	8,849	9,830	141,662	1,141,524	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	23,523			5,795	29,318	65
66 PHYSICAL THERAPY	307,197	14,823	16,466	103,844	442,330	66
67 OCCUPATIONAL THERAPY	76,750	1,282	1,425	27,788	107,245	67
68 SPEECH PATHOLOGY	11,031	160	177		11,368	68
69 ELECTROCARDIOLOGY	107,423	5,860	6,509	37,959	157,751	69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	506,346	16,101	17,886	7,379	547,712	71
72 IMPL. DEV. CHARGED TO PATIENT	21,116				21,116	72
73 DRUGS CHARGED TO PATIENTS	878,380	5,070	5,632	98,458	987,540	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)	2,951,207	42,803	47,548	896,454	3,938,012	88
91 EMERGENCY	1,023,287	23,248	25,825	244,560	1,316,920	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	22,187,649	405,073	449,978	3,490,056	21,844,303	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,001	6,667		12,668	190
192 PHYSICIANS' PRIVATE OFFICES	965,998	22,933	25,475	282,270	1,296,676	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	23,153,647	434,007	482,120	3,772,326	23,153,647	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	6,246,935					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	575,301	2,132,298				7
8 LAUNDRY & LINEN SERVICE	43,875		162,619			8
9 HOUSEKEEPING	172,568	28,057	8,449	676,113		9
10 DIETARY	235,433	223,842		71,923	1,168,376	10
11 CAFETERIA					992,972	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	146,215	88,987		28,592		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
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	527,773	359,679	64,046	115,569	175,404	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	246,784	164,981	19,133	53,010		50
53 ANESTHESIOLOGY	5,071	7,837		2,518		53
54 RADIOLOGY-DIAGNOSTIC	316,733	165,184	18,703	53,075		54
56 RADIOISOTOPE	36,846					56
57 COMPUTED TOMOGRAPHY (CT) SCAN	170,720					57
58 MAGNETIC RESONANCE IMAGING (MRI)	70,908					58
60 LABORATORY	421,786	65,782	148	21,136		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	10,833					65
66 PHYSICAL THERAPY	163,438	110,191	23,334	35,405		66
67 OCCUPATIONAL THERAPY	39,626	9,533		3,063		67
68 SPEECH PATHOLOGY	4,200	1,187		382		68
69 ELECTROCARDIOLOGY	58,288	43,561	593	13,996		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	202,376	119,690		38,458		71
72 IMPL. DEV. CHARGED TO PATIENT	7,802					72
73 DRUGS CHARGED TO PATIENTS	364,890	37,691		12,111		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)	1,455,080	318,189	3,184	102,237		88
91 EMERGENCY	486,594	172,818	24,301	55,528		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	5,763,140	1,917,209	161,891	607,003	1,168,376	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,681	44,612		14,334		190
192 PHYSICIANS' PRIVATE OFFICES	479,114	170,477	728	54,776		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	6,246,935	2,132,298	162,619	676,113	1,168,376	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	992,972					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	42,542	702,052				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
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	167,627	38,935	2,877,401		2,877,401	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	52,792	60,169	1,264,766		1,264,766	50
53 ANESTHESIOLOGY	10,794	770	40,715		40,715	53
54 RADIOLOGY-DIAGNOSTIC	79,097	68,691	1,558,691		1,558,691	54
56 RADIOISOTOPE		13,758	150,323		150,323	56
57 COMPUTED TOMOGRAPHY (CT) SCAN		66,388	699,144		699,144	57
58 MAGNETIC RESONANCE IMAGING (MRI)		22,389	285,202		285,202	58
60 LABORATORY	76,103	136,458	1,862,937		1,862,937	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,810	7,550	51,511		51,511	65
66 PHYSICAL THERAPY	47,258	35,084	857,040		857,040	66
67 OCCUPATIONAL THERAPY	7,982	6,248	173,697		173,697	67
68 SPEECH PATHOLOGY		547	17,684		17,684	68
69 ELECTROCARDIOLOGY	16,690	5,834	296,713		296,713	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,538	46,228	958,002		958,002	71
72 IMPL. DEV. CHARGED TO PATIENT		551	29,469		29,469	72
73 DRUGS CHARGED TO PATIENTS	26,033	53,135	1,481,400		1,481,400	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)	317,747	59,252	6,193,701		6,193,701	88
91 EMERGENCY	92,975	80,065	2,229,201		2,229,201	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	944,988	702,052	21,027,597		21,027,597	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			76,295		76,295	190
192 PHYSICIANS' PRIVATE OFFICES	47,984		2,049,755		2,049,755	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	992,972	702,052	23,153,647		23,153,647	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5	306,972	38,774	43,072	388,818	388,818	5
6						6
7		108,393	120,409	228,802	35,808	7
8					2,731	8
9		3,774	4,193	7,967	10,741	9
10		30,112	33,450	63,562	14,654	10
11						11
12						12
13						13
14						14
15						15
16		11,971	13,298	25,269	9,101	16
17						17
19						19
20						20
21						21
22						22
23						23
30		48,385	53,749	102,134	32,850	30
ANCILLARY SERVICE COST CENTERS						
50		22,193	24,654	46,847	15,360	50
53		1,054	1,171	2,225	316	53
54	95,437	22,221	24,684	142,342	19,714	54
56					2,293	56
57	281,916			281,916	10,626	57
58					4,413	58
60		8,849	9,830	18,679	26,253	60
62.30						62.30
65					674	65
66		14,823	16,466	31,289	10,173	66
67		1,282	1,425	2,707	2,466	67
68		160	177	337	261	68
69		5,860	6,509	12,369	3,628	69
71		16,101	17,886	33,987	12,596	71
72					486	72
73		5,070	5,632	10,702	22,711	73
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88		42,803	47,548	90,351	90,564	88
91		23,248	25,825	49,073	30,287	91
92						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113						113
118	684,325	405,073	449,978	1,539,376	358,706	118
NONREIMBURSABLE COST CENTERS						
190		6,001	6,667	12,668	291	190
192		22,933	25,475	48,408	29,821	192
200						200
201						201
202	684,325	434,007	482,120	1,600,452	388,818	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	264,610					7
8 LAUNDRY & LINEN SERVICE		2,731				8
9 HOUSEKEEPING	3,482	142	22,332			9
10 DIETARY	27,778		2,376	108,370		10
11 CAFETERIA				92,101	92,101	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	11,043		944		3,946	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	44,636	1,077	3,819	16,269	15,548	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	20,473	321	1,751		4,897	50
53 ANESTHESIOLOGY	973		83		1,001	53
54 RADIOLOGY-DIAGNOSTIC	20,499	314	1,753		7,336	54
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY	8,163	2	698		7,059	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					353	65
66 PHYSICAL THERAPY	13,674	392	1,169		4,383	66
67 OCCUPATIONAL THERAPY	1,183		101		740	67
68 SPEECH PATHOLOGY	147		13			68
69 ELECTROCARDIOLOGY	5,406	10	462		1,548	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	14,853		1,270		328	71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	4,677		400		2,415	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)	39,486	53	3,377		29,472	88
91 EMERGENCY	21,446	408	1,834		8,624	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	237,919	2,719	20,050	108,370	87,650	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,536		473			190
192 PHYSICIANS' PRIVATE OFFICES	21,155	12	1,809		4,451	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	264,610	2,731	22,332	108,370	92,101	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
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	50,303				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	2,789	219,122		219,122	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	4,310	93,959		93,959	50
53 ANESTHESIOLOGY	55	4,653		4,653	53
54 RADIOLOGY-DIAGNOSTIC	4,921	196,879		196,879	54
56 RADIOISOTOPE	986	3,279		3,279	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	4,756	297,298		297,298	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,604	6,017		6,017	58
60 LABORATORY	9,785	70,639		70,639	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	541	1,568		1,568	65
66 PHYSICAL THERAPY	2,513	63,593		63,593	66
67 OCCUPATIONAL THERAPY	448	7,645		7,645	67
68 SPEECH PATHOLOGY	39	797		797	68
69 ELECTROCARDIOLOGY	418	23,841		23,841	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,312	66,346		66,346	71
72 IMPL. DEV. CHARGED TO PATIENT	39	525		525	72
73 DRUGS CHARGED TO PATIENTS	3,806	44,711		44,711	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)	4,245	257,548		257,548	88
91 EMERGENCY	5,736	117,408		117,408	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	50,303	1,475,828		1,475,828	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		18,968		18,968	190
192 PHYSICIANS' PRIVATE OFFICES		105,656		105,656	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	50,303	1,600,452		1,600,452	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	95,099					1
2 CAP REL COSTS-MVBLE EQUIP		95,099				2
4 EMPLOYEE BENEFITS			10,281,631			4
5 ADMINISTRATIVE & GENERAL	8,496	8,496	2,222,984	-6,246,935	16,906,712	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	23,751	23,751	359,566		1,556,997	7
8 LAUNDRY & LINEN SERVICE			22,901		118,744	8
9 HOUSEKEEPING	827	827	297,909		467,039	9
10 DIETARY	6,598	6,598	276,512		637,178	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	2,623	2,623	230,843		395,716	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	10,602	10,602	933,387		1,428,368	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,863	4,863	399,135		667,897	50
53 ANESTHESIOLOGY	231	231	425		13,725	53
54 RADIOLOGY-DIAGNOSTIC	4,869	4,869	454,631		857,208	54
56 RADIOISOTOPE			51,522		99,719	56
57 COMPUTED TOMOGRAPHY (CT) SCAN					462,036	57
58 MAGNETIC RESONANCE IMAGING (MRI)					191,905	58
60 LABORATORY	1,939	1,939	386,104		1,141,524	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			15,795		29,318	65
66 PHYSICAL THERAPY	3,248	3,248	283,032		442,330	66
67 OCCUPATIONAL THERAPY	281	281	75,738		107,245	67
68 SPEECH PATHOLOGY	35	35			11,368	68
69 ELECTROCARDIOLOGY	1,284	1,284	103,460		157,751	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,528	3,528	20,111		547,712	71
72 IMPL. DEV. CHARGED TO PATIENT					21,116	72
73 DRUGS CHARGED TO PATIENTS	1,111	1,111	268,351		987,540	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)	9,379	9,379	2,443,329		3,938,012	88
91 EMERGENCY	5,094	5,094	666,559		1,316,920	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	88,759	88,759	9,512,294	-6,246,935	15,597,368	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,315	1,315			12,668	190
192 PHYSICIANS' PRIVATE OFFICES	5,025	5,025	769,337		1,296,676	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	434,007	482,120	3,772,326		6,246,935	202
203 UNIT COST MULT-WS B PT I	4.563739	5.069664	0.366900		0.369494	203
204 COST TO BE ALLOC PER B PT II					388,818	204
205 UNIT COST MULT-WS B PT II					0.022998	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING		FTE'S	
	SQUARE	SERVICE	SQUARE	MEALS		
	FEET	POUNDS OF	FEET	SERVED		
	7	LAUNDRY	9	10	11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	62,852					7
8		122,823				8
9	827	6,381	62,025			9
10	6,598		6,598	50,038		10
11				42,526	10,947	11
12						12
13						13
14						14
15						15
16	2,623		2,623		469	16
17						17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	10,602	48,372	10,602	7,512	1,848	30
ANCILLARY SERVICE COST CENTERS						
50	4,863	14,451	4,863		582	50
53	231		231		119	53
54	4,869	14,126	4,869		872	54
56						56
57						57
58						58
60	1,939	112	1,939		839	60
62.30						62.30
65					42	65
66	3,248	17,624	3,248		521	66
67	281		281		88	67
68	35		35			68
69	1,284	448	1,284		184	69
71	3,528		3,528		39	71
72						72
73	1,111		1,111		287	73
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88	9,379	2,405	9,379		3,503	88
91	5,094	18,354	5,094		1,025	91
92						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	56,512	122,273	55,685	50,038	10,418	118
NONREIMBURSABLE COST CENTERS						
190	1,315		1,315			190
192	5,025	550	5,025		529	192
200						200
201						201
202	2,132,298	162,619	676,113	1,168,376	992,972	202
203	33,925,698	1,324,011	10,900,653	23,349,774	90,707,226	203
204	264,610	2,731	22,332	108,370	92,101	204
205	4,210,049	0,022,235	0,360,048	2,165,754	8,413,355	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY GROSS REVENUE	
	16	
GENERAL SERVICE COST CENTERS		
1 CAP REL COSTS-BLDG & FIXT		1
2 CAP REL COSTS-MVBLE EQUIP		2
4 EMPLOYEE BENEFITS		4
5 ADMINISTRATIVE & GENERAL		5
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	49,549,030	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	2,747,904	30
ANCILLARY SERVICE COST CENTERS		
50 OPERATING ROOM	4,246,489	50
53 ANESTHESIOLOGY	54,324	53
54 RADIOLOGY-DIAGNOSTIC	4,847,977	54
56 RADIOISOTOPE	971,011	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	4,685,405	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,580,151	58
60 LABORATORY	9,631,371	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65 RESPIRATORY THERAPY	532,824	65
66 PHYSICAL THERAPY	2,476,140	66
67 OCCUPATIONAL THERAPY	440,950	67
68 SPEECH PATHOLOGY	38,593	68
69 ELECTROCARDIOLOGY	411,738	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,262,637	71
72 IMPL. DEV. CHARGED TO PATIENT	38,880	72
73 DRUGS CHARGED TO PATIENTS	3,750,064	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)	4,181,822	88
91 EMERGENCY	5,650,750	91
92 OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS		
SPECIAL PURPOSE COST CENTERS		
118 SUBTOTALS (SUM OF LINES 1-117)	49,549,030	118
NONREIMBURSABLE COST CENTERS		
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192 PHYSICIANS' PRIVATE OFFICES		192
200 CROSS FOOT ADJUSTMENTS		200
201 NEGATIVE COST CENTER		201
202 COST TO BE ALLOC PER B PT I	702,052	202
203 UNIT COST MULT-WS B PT I	0.014169	203
204 COST TO BE ALLOC PER B PT II	50,303	204
205 UNIT COST MULT-WS B PT II	0.001015	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,877,401		2,877,401		2,877,401	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,264,766		1,264,766		1,264,766	50
53 ANESTHESIOLOGY	40,715		40,715		40,715	53
54 RADIOLOGY-DIAGNOSTIC	1,558,691		1,558,691		1,558,691	54
56 RADIOISOTOPE	150,323		150,323		150,323	56
57 COMPUTED TOMOGRAPHY (CT) SC	699,144		699,144		699,144	57
58 MAGNETIC RESONANCE IMAGING	285,202		285,202		285,202	58
60 LABORATORY	1,862,937		1,862,937		1,862,937	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	51,511		51,511		51,511	65
66 PHYSICAL THERAPY	857,040		857,040		857,040	66
67 OCCUPATIONAL THERAPY	173,697		173,697		173,697	67
68 SPEECH PATHOLOGY	17,684		17,684		17,684	68
69 ELECTROCARDIOLOGY	296,713		296,713		296,713	69
71 MEDICAL SUPPLIES CHRGED TO	958,002		958,002		958,002	71
72 IMPL. DEV. CHARGED TO PATIE	29,469		29,469		29,469	72
73 DRUGS CHARGED TO PATIENTS	1,481,400		1,481,400		1,481,400	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)	6,193,701		6,193,701		6,193,701	88
91 EMERGENCY	2,229,201		2,229,201		2,229,201	91
92 OBSERVATION BEDS	444,147		444,147		444,147	92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	21,471,744		21,471,744		21,471,744	200
201 LESS OBSERVATION BEDS	444,147		444,147		444,147	201
202 TOTAL (SEE INSTRUCTIONS)	21,027,597		21,027,597		21,027,597	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			
30 INPATIENT ROUTINE SERV COST CENTERS						30
ADULTS & PEDIATRICS	2,747,903		2,747,903			
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	892,672	3,353,816	4,246,488	0.297838	0.297838	50
53 ANESTHESIOLOGY	1,009	53,314	54,323	0.749498	0.749498	53
54 RADIOLOGY-DIAGNOSTIC	365,724	4,482,253	4,847,977	0.321514	0.321514	54
56 RADIOISOTOPE	31,892	939,118	971,010	0.154811	0.154811	56
57 COMPUTED TOMOGRAPHY (CT) SC	425,682	4,259,723	4,685,405	0.149217	0.149217	57
58 MAGNETIC RESONANCE IMAGING	23,860	1,556,291	1,580,151	0.180490	0.180490	58
60 LABORATORY	1,053,517	8,577,854	9,631,371	0.193424	0.193424	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	431,712	101,112	532,824	0.096675	0.096675	65
66 PHYSICAL THERAPY	284,418	2,191,722	2,476,140	0.346119	0.346119	66
67 OCCUPATIONAL THERAPY	122,992	317,957	440,949	0.393916	0.393916	67
68 SPEECH PATHOLOGY	11,989	26,604	38,593	0.458218	0.458218	68
69 ELECTROCARDIOLOGY	1,938	409,800	411,738	0.720635	0.720635	69
71 MEDICAL SUPPLIES CHRGD TO	862,279	2,400,357	3,262,636	0.293628	0.293628	71
72 IMPL. DEV. CHARGED TO PATIE		38,880	38,880	0.757948	0.757948	72
73 DRUGS CHARGED TO PATIENTS	1,931,422	1,818,643	3,750,065	0.395033	0.395033	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)		4,181,822	4,181,822			88
91 EMERGENCY	471,450	5,179,300	5,650,750	0.394496	0.394496	91
92 OBSERVATION BEDS		415,157	415,157	1.069829	1.069829	92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	9,660,459	40,303,723	49,964,182			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	9,660,459	40,303,723	49,964,182			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1318) [ ] 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	PPS	COST REIMB.	COST REIMB.	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SERVICES DED & COINS	SVCES NOT SUBJECT TO DED & COINS	SERVICES DED & COINS	SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.297838		952,462			283,679	50
53 ANESTHESIOLOGY	0.749498		24,517			18,375	53
54 RADIOLOGY-DIAGNOSTIC	0.321514		1,366,858			439,464	54
56 RADIOISOTOPE	0.154811		269,230			41,680	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.149217		1,474,112	22		219,963	3 57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.180490		317,902	3		57,378	1 58
60 LABORATORY	0.193424		3,661,945			708,308	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.096675		38,744			3,746	65
66 PHYSICAL THERAPY	0.346119		698,314			241,700	66
67 OCCUPATIONAL THERAPY	0.393916		120,447			47,446	67
68 SPEECH PATHOLOGY	0.458218		11,128			5,099	68
69 ELECTROCARDIOLOGY	0.720635		129,814			93,549	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.293628		700,716			205,750	71
72 IMPL. DEV. CHARGED TO PATIENT	0.757948		29,906			22,667	72
73 DRUGS CHARGED TO PATIENTS	0.395033		717,436	191		283,411	75 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
91 EMERGENCY	0.394496		1,628,199			642,318	91
92 OBSERVATION BEDS	1.069829		203,209			217,399	92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)			12,344,939	216		3,531,932	79 200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			12,344,939	216		3,531,932	79 202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  S/B-SNF (14-Z318)  
 APPLICABLE  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	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS				
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.297838						50
53 ANESTHESIOLOGY	0.749498						53
54 RADIOLOGY-DIAGNOSTIC	0.321514						54
56 RADIOISOTOPE	0.154811						56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.149217						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.180490						58
60 LABORATORY	0.193424						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.096675						65
66 PHYSICAL THERAPY	0.346119						66
67 OCCUPATIONAL THERAPY	0.393916						67
68 SPEECH PATHOLOGY	0.458218						68
69 ELECTROCARDIOLOGY	0.720635						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.293628						71
72 IMPL. DEV. CHARGED TO PATIENT	0.757948						72
73 DRUGS CHARGED TO PATIENTS	0.395033						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
91 EMERGENCY	0.394496						91
92 OBSERVATION BEDS	1.069829						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

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
 03/30/2012 15:23

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 CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
30 ADULTS & PEDIATRICS	219,122	60,928	158,194	1,637	96.64	11,693
31 INTENSIVE CARE UNIT						30
32 CORONARY CARE UNIT						31
33 BURN INTENSIVE CARE UNIT						32
34 SURGICAL INTENSIVE CARE UNIT						33
35 OTHER SPECIAL CARE (SPECIFY)						34
40 SUBPROVIDER - IPF						35
41 SUBPROVIDER - IRF						40
42 SUBPROVIDER I						41
43 NURSERY						42
44 SKILLED NURSING FACILITY						43
45 NURSING FACILITY						44
200 TOTAL (LINES 30-199)	219,122		158,194	1,637		121
						11,693
						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] OTHER

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL
	(FROM WKST B, PT. II, COL. 26)	(FROM WKST C, PT. I, COL. 8)	(COL.1 ÷ COL.2)		(COL.3 x COL.4)
	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	93,959	4,246,488	0.022126		50
53 ANESTHESIOLOGY	4,653	54,323	0.085654		53
54 RADIOLOGY-DIAGNOSTIC	196,879	4,847,977	0.040611		54
56 RADIOISOTOPE	3,279	971,010	0.003377		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	297,298	4,685,405	0.063452		57
58 MAGNETIC RESONANCE IMAGING (M	6,017	1,580,151	0.003808		58
60 LABORATORY	70,639	9,631,371	0.007334		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	1,568	532,824	0.002943		65
66 PHYSICAL THERAPY	63,593	2,476,140	0.025682		66
67 OCCUPATIONAL THERAPY	7,645	440,949	0.017338		67
68 SPEECH PATHOLOGY	797	38,593	0.020651		68
69 ELECTROCARDIOLOGY	23,841	411,738	0.057903		69
71 MEDICAL SUPPLIES CHRGED TO PA	66,346	3,262,636	0.020335		71
72 IMPL. DEV. CHARGED TO PATIENT	525	38,880	0.013503		72
73 DRUGS CHARGED TO PATIENTS	44,711	3,750,065	0.011923		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)	257,548	4,181,822	0.061588		88
91 EMERGENCY	117,408	5,650,750	0.020777		91
92 OBSERVATION BEDS	46,850	415,157	0.112849		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	1,303,556	47,216,279	47,216,279		200

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
 03/30/2012 15:23

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
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
 PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
 03/30/2012 15:23

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	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	1,637		121	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)	1,637		121	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1318)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

  

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	ANESTHETIST			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
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
56	RADIOISOTOPE					56
57	COMPUTED TOMOGRAPHY (CT) SCAN					57
58	MAGNETIC RESONANCE IMAGING (M					58
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY					69
71	MEDICAL SUPPLIES CHRGED TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
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
91	EMERGENCY					91
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 (14-1318)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	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 (COL. 8 x COL. 10)		O/P PGM CHARGES (COL. 9 x COL. 12)
	7		8		9		10		11
									12
									13
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM		4,246,488						50
53	ANESTHESIOLOGY		54,323						53
54	RADIOLOGY-DIAGNOSTIC		4,847,977						54
56	RADIOISOTOPE		971,010						56
57	COMPUTED TOMOGRAPHY (CT) SCA		4,685,405						57
58	MAGNETIC RESONANCE IMAGING (		1,580,151						58
60	LABORATORY		9,631,371						60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY		532,824						65
66	PHYSICAL THERAPY		2,476,140						66
67	OCCUPATIONAL THERAPY		440,949						67
68	SPEECH PATHOLOGY		38,593						68
69	ELECTROCARDIOLOGY		411,738						69
71	MEDICAL SUPPLIES CHRGED TO P		3,262,636						71
72	IMPL. DEV. CHARGED TO PATIEN		38,880						72
73	DRUGS CHARGED TO PATIENTS		3,750,065						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)		4,181,822						88
91	EMERGENCY		5,650,750						91
92	OBSERVATION BEDS		415,157						92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (SUM OF LINES 50-199)		47,216,279						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1318) [ ] 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	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS				
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.297838						50
53 ANESTHESIOLOGY	0.749498						53
54 RADIOLOGY-DIAGNOSTIC	0.321514						54
56 RADIOISOTOPE	0.154811						56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.149217						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.180490						58
60 LABORATORY	0.193424						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.096675						65
66 PHYSICAL THERAPY	0.346119						66
67 OCCUPATIONAL THERAPY	0.393916						67
68 SPEECH PATHOLOGY	0.458218						68
69 ELECTROCARDIOLOGY	0.720635						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.293628						71
72 IMPL. DEV. CHARGED TO PATIENT	0.757948						72
73 DRUGS CHARGED TO PATIENTS	0.395033						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
91 EMERGENCY	0.394496						91
92 OBSERVATION BEDS	1.069829						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

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] 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)	2,349	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,637	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,637	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	155	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)	467	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	23	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)	67	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	871	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)	155	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)	467	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	119.55	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.55	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,877,401	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)	2,750	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	8,010	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	800,072	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,077,329	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,680,187	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,680,187	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.236368	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,026.38	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,077,329	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] 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) 1,268.99 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,105,290 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) 1,105,290 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						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)					853,723	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,959,013	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) 196,693 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 592,618 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 789,311 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) 350 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,268.99 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 444,147 89

	COST 1	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	219,122	2,077,329	0.105483	444,147	46,850	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 (14-1318) [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] 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)	2,349	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,637	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,637	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	155	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)	467	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	23	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)	67	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	121	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	119.55	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.55	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,877,401	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)	2,750	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	8,010	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	800,072	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,077,329	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,680,187	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,680,187	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.236368	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,026.38	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,077,329	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1318) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] 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) 1,268.99 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 153,548 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) 153,548 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 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) 153,548 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 11,693 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 11,693 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 141,855 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) 350 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

	COST 1	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						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 (14-1318) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		1,124,280		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.297838	429,219	127,838	50
53 ANESTHESIOLOGY	0.749498	71	53	53
54 RADIOLOGY-DIAGNOSTIC	0.321514	189,924	61,063	54
56 RADIOISOTOPE	0.154811	15,014	2,324	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.149217	84,886	12,666	57
58 MAGNETIC RESONANCE IMAGING (MRI	0.180490	17,336	3,129	58
60 LABORATORY	0.193424	460,411	89,055	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.096675	263,689	25,492	65
66 PHYSICAL THERAPY	0.346119	53,457	18,502	66
67 OCCUPATIONAL THERAPY	0.393916	18,543	7,304	67
68 SPEECH PATHOLOGY	0.458218	5,597	2,565	68
69 ELECTROCARDIOLOGY	0.720635	854	615	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.293628	435,837	127,974	71
72 IMPL. DEV. CHARGED TO PATIENT	0.757948			72
73 DRUGS CHARGED TO PATIENTS	0.395033	944,962	373,291	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
91 EMERGENCY	0.394496	4,694	1,852	91
92 OBSERVATION BEDS	1.069829			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,924,494	853,723	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,924,494		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B SNF (14-Z318) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] 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	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.297838			50	50
53 ANESTHESIOLOGY	0.749498			53	53
54 RADIOLOGY-DIAGNOSTIC	0.321514	19,928	6,407	54	54
56 RADIOISOTOPE	0.154811	6,633	1,027	56	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.149217	10,823	1,615	57	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.180490			58	58
60 LABORATORY	0.193424	91,988	17,793	60	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30	62.30
65 RESPIRATORY THERAPY	0.096675	80,001	7,734	65	65
66 PHYSICAL THERAPY	0.346119	188,420	65,216	66	66
67 OCCUPATIONAL THERAPY	0.393916	80,373	31,660	67	67
68 SPEECH PATHOLOGY	0.458218	4,533	2,077	68	68
69 ELECTROCARDIOLOGY	0.720635	758	546	69	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.293628	44,610	13,099	71	71
72 IMPL. DEV. CHARGED TO PATIENT	0.757948			72	72
73 DRUGS CHARGED TO PATIENTS	0.395033	297,439	117,498	73	73
76.97 CARDIAC REHABILITATION				76.97	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98	76.98
76.99 LITHOTRIPSY				76.99	76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)				88	88
91 EMERGENCY	0.394496			91	91
92 OBSERVATION BEDS	1.069829			92	92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		825,506	264,672	200	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201	201
202 NET CHARGES (LINE 200 MINUS LINE 201)		825,506		202	202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1318)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	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		
30 INPATIENT ROUTINE SERVICE COST CENTERS					30
ADULTS & PEDIATRICS					
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.297838				50
53 ANESTHESIOLOGY	0.749498				53
54 RADIOLOGY-DIAGNOSTIC	0.321514				54
56 RADIOISOTOPE	0.154811				56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.149217				57
58 MAGNETIC RESONANCE IMAGING (MRI	0.180490				58
60 LABORATORY	0.193424				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.096675				65
66 PHYSICAL THERAPY	0.346119				66
67 OCCUPATIONAL THERAPY	0.393916				67
68 SPEECH PATHOLOGY	0.458218				68
69 ELECTROCARDIOLOGY	0.720635				69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.293628				71
72 IMPL. DEV. CHARGED TO PATIENT	0.757948				72
73 DRUGS CHARGED TO PATIENTS	0.395033				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
91 EMERGENCY	0.394496				91
92 OBSERVATION BEDS	1.069829				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



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (14-1318) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A

PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,513,803		1,758,444
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
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 04/07/2011	65,734	04/07/2011	352,108
	.02 09/21/2011	38,006	09/21/2011	123,889
	.03			3.03
	.04			3.04
	.05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50	NONE		NONE
	.51			3.51
	.52			3.52
	.53			3.53
	.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)		103,740		475,997
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,617,543		2,234,441

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.				
	.01			5.01
	.02			5.02
	.03			5.03
	.04			5.04
	.05			5.05
	.06			5.06
	.07			5.07
	.08			5.08
	.09			5.09
	.50			5.50
	.51			5.51
	.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				
	.01			6.01
	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				7

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



PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK  
APPLICABLE BOX

HOSPITAL (14-1318)     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	410	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	871	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	56	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,287	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	49,964,182	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	3,299,490	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

PROVIDER CCN: 14-1318 OSF HOLY FAMILY MED CTR  
PERIOD FROM 10/01/2010 TO 09/30/2011

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

VERSION: 2011.10  
03/30/2012 15:23

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-Z318)  
APPLICABLE [XX] TITLE XVIII [ ] SWING BED - NF  
BOXES [ ] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	797,204	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	267,319	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	622	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	1,064,523	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	1,064,523	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	1,064,523	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	10,015	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,054,508	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	1,054,508	19
20 INTERIM PAYMENTS	1,037,433	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	17,075	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	7,794	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART V

CHECK [XX] HOSPITAL (14-1318)  
 APPLICABLE BOX: [ ] SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	INPATIENT SERVICES	1,959,013	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,959,013	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,978,603	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	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)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	1,978,603	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	212,188	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,766,415	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,766,415	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	39,939	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	39,939	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	39,939	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,806,354	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,806,354	30
31	INTERIM PAYMENTS	1,617,543	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	188,811	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	14,481	34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-1318) [ ] SNF [XX] PPS  
APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
BOXES: [ ] IRF [ ] ICF/MR [ ] 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	1
2 MEDICAL AND OTHER SERVICES	2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	4
5 INPATIENT PRIMARY PAYER PAYMENTS	5
6 OUTPATIENT PRIMARY PAYER PAYMENTS	6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	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)	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))	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
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	5,903,727			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3,808,324			4
5	OTHER RECEIVABLES	74,883			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	601,000			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS	177,621			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	10,565,555			11
FIXED ASSETS					
12	LAND	325,000			12
13	LAND IMPROVEMENTS	192,152			13
14	ACCUMULATED DEPRECIATION	-122,996			14
15	BUILDINGS	2,746,966			15
16	ACCUMULATED DEPRECIATION	-1,562,659			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	4,297,889			23
24	ACCUMULATED DEPRECIATION	-2,709,814			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)	3,166,538			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	10,268,068			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	10,268,068			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	24,000,161			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	831,387			37
38	SALARIES, WAGES & FEES PAYABLE	1,522,493			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	610,626			43
44	OTHER CURRENT LIABILITIES	1,854,076			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,818,582			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	171,400			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	171,400			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	4,989,982			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	19,010,179			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)	19,010,179			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	24,000,161			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		15,037,880							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		1,575,975							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		16,613,855							3
4 ADDITIONS (CREDIT ADJUSTMENTS)		2,405,269							4
5 CONTRIBUTIONS									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		2,405,269							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		19,019,124							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 CONTRIBUTIONS RELEASED		8,945							13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		8,945							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		19,010,179							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	1,680,187		1,680,187	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	546,285		546,285	6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,226,472		2,226,472	11
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,226,472		2,226,472	17
18 ANCILLARY SERVICES	6,498,449		6,498,449	18
19 OUTPATIENT SERVICES		42,606,997	42,606,997	19
20 RHC		4,181,822	4,181,822	20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	8,724,921	46,788,819	55,513,740	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		23,369,899	29
30 ADD (SPECIFY)			30
31 BAD DEBTS	1,479,694		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		1,479,694	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		24,849,593	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	55,513,740	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	29,246,223	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	26,267,517	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	24,849,593	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,417,924	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	26,192	6
7	INCOME FROM INVESTMENTS	19,644	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	33,113	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		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	5,826	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT INCOME)	79,413	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	164,188	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,582,112	26
27	OTHER EXPENSES (SALE OF ASSETS)	6,137	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	6,137	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,575,975	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((14-131) [XX] PPS  
APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT	
1 CAPITAL DRG OTHER THAN OUTLIER	1
2 CAPITAL DRG OUTLIER PAYMENTS	2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	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)	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- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	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 ADMINISTRATIVE & GENERAL					5
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
30 INPATIENT ROUTINE SERV COST CENTERS					30
ADULTS & PEDIATRICS					
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
56 RADIOISOTOPE					56
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
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
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
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					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
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

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

RHC I  
 COMPONENT NO: 14-3461

WORKSHEET M-1

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	1,357,594	3,991	1,361,585			1,361,585	1
2	PHYSICIAN ASSISTANT	451,694		451,694			451,694	2
3	NURSE PRACTITIONER							3
4	VISITING NURSE							4
5	OTHER NURSE	613,981		613,981			613,981	5
6	CLINICAL PSYCHOLOGIST							6
7	CLINICAL SOCIAL WORKER							7
8	LABORATORY TECHNICIAN							8
9	OTHER FACILITY HEALTH CARE STAFF COSTS							9
10	SUBTOTAL (SUM OF LINES 1-9)	2,423,269	3,991	2,427,260		2,427,260	2,427,260	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		129,557	129,557	-96,986	32,571	32,571	15
16	TRANSPORTATION (HEALTH CARE STAFF)		4,584	4,584		4,584	4,584	16
17	DEPRECIATION-MEDICAL EQUIPMENT							17
18	PROFESSIONAL LIABILITY INSURANCE		55,904	55,904		55,904	55,904	18
19	OTHER HEALTH CARE COSTS		335,380	335,380		335,380	335,380	19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (SUM OF LINES 15-20)		525,425	525,425	-96,986	428,439	428,439	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,423,269	529,416	2,952,685	-96,986	2,855,699	2,855,699	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY							23
24	DENTAL							24
25	OPTOMETRY							25
26	ALL OTHER NONREIMBURSABLE COSTS		9,568	9,568		9,568	9,568	26
27	NONALLOWABLE GME COSTS							27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		9,568	9,568		9,568	9,568	28
FACILITY OVERHEAD								
29	FACILITY COSTS							29
30	ADMINISTRATIVE COSTS	78,622	1,008,841	1,087,463	-990,552	96,911	-10,971	85,940
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	78,622	1,008,841	1,087,463	-990,552	96,911	-10,971	85,940
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	2,501,891	1,547,825	4,049,716	-1,087,538	2,962,178	-10,971	2,951,207

RHC I  
 COMPONENT NO: 14-3461

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	4.61	20,810	4,200	19,362	1
2	PHYSICIAN ASSISTANTS	3.76	16,217	2,100	7,896	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	8.37	37,027		27,258	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER	0.89	806			7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	9.26	37,833			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)				2,855,699	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				9,568	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				2,865,267	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				0.996661	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				85,940	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				3,242,494	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				3,328,434	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				3,328,434	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				3,317,320	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				6,173,019	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3461

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)		6,173,019	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		47,393	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)		6,125,626	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)		37,833	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)			5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)		37,833	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)		161.91	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)	161.91	161.91	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,783	5,351	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	288,686	866,380	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)	288,686	866,380	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		918,391	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		3,690	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		3,481	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		597,367	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	230,949	600,848	16.05
17	PRIMARY PAYOR PAYMENTS		906	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		116,190	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		160,205	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		830,891	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		25,308	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		856,199	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			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)		856,199	26
27	INTERIM PAYMENTS		659,187	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		197,012	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		6,923	30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I  
 COMPONENT NO: 14-3461

WORKSHEET M-4

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)	2,427,260	2,427,260	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000286	0.001230	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	694	2,986	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	10,088	8,116	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	10,782	11,102	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	2,855,699	2,855,699	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	3,328,434	3,328,434	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.003776	0.003888	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	12,568	12,941	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	23,350	24,043	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	169	724	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	138.17	33.21	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	100	346	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	13,817	11,491	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)		47,393	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)		25,308	16

