

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: 02-26-2013 TIME: 13:12
 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 SAINT JAMES HOSPITAL (14-0161) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2011 AND ENDING 09/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		238,809	-107,448	-9,547		1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		238,809	-107,448	-9,547		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: 2500 WEST REYNOLDS STREET P.O. BOX: 1
 2 CITY: PONTIAC STATE: IL ZIP CODE: 61764 COUNTY: LIVINGSTON 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL SAINT JAMES HOSPITAL	14-0161	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF ST JAMES HOSPITAL SWING	14-U161	16974		10/10/2002	N	P	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 HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								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: 10/01/2011			TO: 09/30/2012				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.							Y	N	22	
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.								3	N	23

		IN-STATE		OUT-OF		MEDICAID	OTHER			
		IN-STATE	IN-STATE	STATE	STATE					
		PAID	ELIGIBLE	PAID	ELIGIBLE	HMO	MEDICAID			
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS			
		1	2	3	4	5	6			
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1,032	140			14		24		
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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 IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				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.				1			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: 10/01/2011	ENDING: 09/30/2012	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		
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							Y	Y	39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER \$413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	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))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			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
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			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
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
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
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N 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
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2
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.			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- RESPI- SICAL ATIONAL SPEECH RATORY	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. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	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
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: SELF INSURANCE: 353,180			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	Y	Y	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.	1 Y	2 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: WPS	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, LINE 74 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)

	TITLE XVIII	TITLE	TITLE	
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	N 155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

PROVIDER CCN: 14-0161 SAINT JAMES HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

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.	Y	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.	0.75	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		
PROVIDER ORGANIZATION AND OPERATION					
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	
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	
FINANCIAL DATA AND REPORTS					
		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	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		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	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N	2	N	4
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	12/19/2012	Y	12/19/2012
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	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

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

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 35

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- 41 FIRST NAME: JENNIFER LAST NAME: DAVIS TITLE: MGR THIRD PARTY REIM 41
- 42 EMPLOYER: OSF HEALTHCARE SYSTEM 42
- 43 PHONE NUMBER: (309) 655-4096 E-MAIL ADDRESS: JENNIFER.Y.DAVIS@OSFHEALTHCARE 43

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	24,147,388	-1,409	24,145,979	717,135.00	33.67
2	NON-PHYSICIAN ANESTHETIST PART A						1
3	NON-PHYSICIAN ANESTHETIST PART B						2
4	PHYSICIAN-PART A ADMINISTRATIVE						3
4.01	PHYSICIAN-PART A - TEACHING						4
5	PHYSICIAN-PART B						4.01
6	NON-PHYSICIAN-PART B						5
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					6
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7
8	HOME OFFICE PERSONNEL						7.01
9	SNF	44					8
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		9,033,404	54,665	9,088,069	105,129.00	86.45
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		382,129		382,129	7,267.00	52.58
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						11
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		723,416		723,416	2,883.00	250.92
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,811,003		3,811,003	76,346.00	49.92
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						14
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						15
	WAGE-RELATED COSTS						16
17	WAGE-RELATED COSTS (CORE)		4,961,354		4,961,354		17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		1,774,186		1,774,186		19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
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		335,394	-335,394			26
27	ADMINISTRATIVE & GENERAL		1,977,873	137,342	2,115,215	54,197.00	39.03
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		171,939		171,939	804.00	213.85
29	MAINTENANCE & REPAIRS		53,441	462	53,903	2,345.00	22.99
30	OPERATION OF PLANT		370,294	3,983	374,277	18,216.00	20.55
31	LAUNDRY & LINEN SERVICE		28,564	-20	28,544	2,231.00	12.79
32	HOUSEKEEPING		475,581	5,892	481,473	41,541.00	11.59
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		414,796	-334,510	80,286	5,061.00	15.86
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						34
36	CAFETERIA			341,463	341,463	25,163.00	13.57
37	MAINTENANCE OF PERSONNEL						35
38	NURSING ADMINISTRATION		1,013,250	-187,270	825,980	29,940.00	27.59
39	CENTRAL SERVICES AND SUPPLY						37
40	PHARMACY						38
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		348,325	4,250	352,575	19,353.00	18.22
42	SOCIAL SERVICE		120,373	56	120,429	5,491.00	21.93
43	OTHER GENERAL SERVICE						39
							40
							41
							42
							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	24,319,327	-1,409	24,317,918	717,939.00	33.87	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	9,033,404	54,665	9,088,069	105,129.00	86.45	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	15,285,923	-56,074	15,229,849	612,810.00	24.85	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4,916,548		4,916,548	86,496.00	56.84	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	4,961,354		4,961,354		32.58	5
6	TOTAL (SUM OF LINES 3 THRU 5)	25,163,825	-56,074	25,107,751	699,306.00	35.90	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,309,830	-363,746	4,946,084	204,342.00	24.20	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	1,675,415	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	186,000	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		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)	3,005,070	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	19,081	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	21,557	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	282,869	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	1,481,028	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	12,694	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	51,826	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	6,735,540	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

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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	9,833,441	2
3	SUBPROVIDER - IPF		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 OLTC		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: 14-0161 SAINT JAMES HOSPITAL
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PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 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		4	4 76
77	PA2			77
78	PA1		3	3 78
199	AAA			199
200	TOTAL		120	120 200

CBSA AT BEGINNING OF COST REPORTING PERIOD 1
 CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF APPLICABLE) 2

SNF SERVICES

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)

ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 1
 PERCENTAGE 2
 EXPENSES? 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

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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.220651	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				3,489,713	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				24,060,120	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				5,308,890	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				1,819,177	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) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					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) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					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)				1,819,177	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 FACILITY	9,079,352	1,110,917	10,190,269		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	2,003,368	245,125	2,248,493		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	90,630	11,089	101,719		22
23	COST OF CHARITY CARE	1,912,738	234,036	2,146,774		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 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					N 24
25	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				2,953,845	25
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				231,464	26
27	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				2,722,381	27
28	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				600,696	28
29	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				2,747,470	29
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				4,566,647	30
31						31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,450,722	1,450,722	22,632	1
2	00200		1,226,123	1,226,123	19,129	2
3	00300					3
4	00400	335,394	6,408,187	6,743,581	-305,341	4
5	00500	1,977,873	7,212,929	9,190,802	86,720	5
6	00600	53,441	51,769	105,210	462	6
7	00700	370,294	1,036,744	1,407,038	3,983	7
8	00800	28,564	131,168	159,732	-20	8
9	00900	475,581	263	475,844	7,408	9
10	01000	414,796	139,339	554,135	-447,244	10
11	01100				454,197	11
12	01200					12
13	01300					13
14	01400	1,013,250	76,310	1,089,560	-210,125	14
15	01500					15
16	01600	348,325	48,712	397,037	4,250	16
17	01700	120,373	4,105	124,478	1,163	17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,213,078	207,765	2,420,843	21,511	30
31	03100	726,963	80,999	807,962	5,878	31
43	04300					43
ANCILLARY SERVICE COST CENTERS						
50	05000	1,533,521	3,325,460	4,858,981	-2,596,218	50
53	05300		772,713	772,713		53
54	05400	486,593	99,495	586,088	15,984	54
54.10	03630	208,354	49,106	257,460	1,701	54.10
54.20	03440	109,490	282,017	391,507	921	54.20
56	05600	80,578	252,161	332,739	442	56
57	05700	128,476	575,741	704,217	908	57
58	05800	63,368	578,597	641,965	954	58
60	06000	857,081	708,424	1,565,505	-111,018	60
62.30	06250					62.30
63	06300				121,902	63
65	06500	297,242	63,994	361,236	-42,902	65
66	06600	592,574	50,517	643,091	144,259	66
67	06700	214,971	4,103	219,074	47,934	67
68	06800	186,211	70,740	256,951	56,584	68
69	06900	209,667	45,369	255,036	3,100	69
71	07100	140,685	181,246	321,931	708,578	71
72	07200				1,950,266	72
73	07300	523,211	840,987	1,364,198	3,574	73
76	03950	68,431	5,468	73,899	450	76
76.97	07697	45,193	1,799	46,992	-472	76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	1,290,406	1,791,326	3,081,732	11,773	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118		15,113,984	27,774,398	42,888,382	-16,677	118
SUBTOTALS (SUM OF LINES 1-117)						
NONREIMBURSABLE COST CENTERS						
190	19000	18,956	19,600	38,556	-14	190
192	19200	8,844,623	10,782,247	19,626,870	13,675	192
192.01	19201				790	192.01
192.02	19202	158,725	487,000	645,725	2,235	192.02
192.03	19203	11,100	1,096	12,196	-9	192.03
193	19300					193
194	07950					194
194.01	07951					194.01
200		24,147,388	39,064,341	63,211,729		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,473,354		1,473,354	1
2	00200	1,245,252		1,245,252	2
3	00300				3
4	00400	6,438,240	-58,836	6,379,404	4
5	00500	9,277,522	-3,164,684	6,112,838	5
6	00600	105,672		105,672	6
7	00700	1,411,021	-63,661	1,347,360	7
8	00800	159,712		159,712	8
9	00900	483,252	-745	482,507	9
10	01000	106,891	-7,774	99,117	10
11	01100	454,197		454,197	11
12	01200				12
13	01300	879,435	-4,372	875,063	13
14	01400				14
15	01500				15
16	01600	401,287	-23,835	377,452	16
17	01700	125,641		125,641	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,442,354	-11,563	2,430,791	30
31	03100	813,840		813,840	31
43	04300				43
ANCILLARY SERVICE COST CENTERS					
50	05000	2,262,763	-12,733	2,250,030	50
53	05300	772,713	-712,175	60,538	53
54	05400	602,072	-11,890	590,182	54
54.10	03630	259,161		259,161	54.10
54.20	03440	392,428	-13,338	379,090	54.20
56	05600	333,181	-3,621	329,560	56
57	05700	705,125	-34,493	670,632	57
58	05800	642,919	-110,426	532,493	58
60	06000	1,454,487	-11,863	1,442,624	60
62.30	06250				62.30
63	06300	121,902		121,902	63
65	06500	318,334		318,334	65
66	06600	787,350	-381	786,969	66
67	06700	267,008		267,008	67
68	06800	313,535	-345	313,190	68
69	06900	258,136		258,136	69
71	07100	1,030,509	-34,804	995,705	71
72	07200	1,950,266		1,950,266	72
73	07300	1,367,772	-2,361	1,365,411	73
76	03950	74,349	-540	73,809	76
76.97	07697	46,520	-6,000	40,520	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
91	09100	3,093,505	-1,611,299	1,482,206	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118		42,871,705	-5,901,739	36,969,966	118
NONREIMBURSABLE COST CENTERS					
190	19000	38,542		38,542	190
192	19200	19,640,545		19,640,545	192
192.01	19201	790		790	192.01
192.02	19202	647,960		647,960	192.02
192.03	19203	12,187		12,187	192.03
193	19300				193
194	07950				194
194.01	07951				194.01
200		63,211,729	-5,901,739	57,309,990	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
		COST CENTER	LINE #	SALARY	OTHER
	1	2	3	4	5
1 FIRE INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		22,632 1
2		CAP REL COSTS-MVBLE EQUIP	2		19,129 2
500 TOTAL RECLASSIFICATIONS					41,761 500
CODE LETTER - A					
1 CAFETERIA RECLASS	B	CAFETERIA	11	341,463	112,734 1
500 TOTAL RECLASSIFICATIONS				341,463	112,734 500
CODE LETTER - B					
1 BLOOD	C	BLOOD STORING, PROCESSING & T	63		121,902 1
500 TOTAL RECLASSIFICATIONS					121,902 500
CODE LETTER - C					
1 REHAB ADMIN RECLASS	E	PHYSICAL THERAPY	66	125,053	13,132 1
2		OCCUPATIONAL THERAPY	67	42,613	4,475 2
3		SPEECH PATHOLOGY	68	49,969	5,248 3
500 TOTAL RECLASSIFICATIONS				217,635	22,855 500
CODE LETTER - E					
1 VACATION ACCRUAL RECLASS	F	EMPLOYEE BENEFITS	4		17,100 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
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35		PHYSICIANS' PRIVATE OFFICES	192	38,022	35
500 TOTAL RECLASSIFICATIONS				38,022	17,100 500
CODE LETTER - F					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
1	2	3	4	5	
1 TEAM AWARDS	G	ADMINISTRATIVE & GENERAL	5	139,174	1
2		MAINTENANCE & REPAIRS	6	500	2
3		OPERATION OF PLANT	7	4,250	3
4		HOUSEKEEPING	9	7,750	4
5		DIETARY	10	7,250	5
6		NURSING ADMINISTRATION	13	31,093	6
7		MEDICAL RECORDS & LIBRARY	16	4,500	7
8		SOCIAL SERVICE	17	1,250	8
9		ADULTS & PEDIATRICS	30	23,100	9
10		INTENSIVE CARE UNIT	31	6,400	10
11		OPERATING ROOM	50	17,700	11
12		RADIOLOGY-DIAGNOSTIC	54	7,500	12
13		ULTRASONOGRAPHY	54.10	1,850	13
14		COMPUTED TOMOGRAPHY (CT) SCAN	57	1,000	14
15		MAGNETIC RESONANCE IMAGING (M	58	1,000	15
16		MAMMOGRAPHY	54.20	1,000	16
17		RADIOISOTOPE	56	500	17
18		LABORATORY	60	11,500	18
19		RESPIRATORY THERAPY	65	3,000	19
20		PHYSICAL THERAPY	66	6,500	20
21		OCCUPATIONAL THERAPY	67	1,000	21
22		SPEECH PATHOLOGY	68	1,500	22
23		ELECTROCARDIOLOGY	69	3,250	23
24		CARDIAC REHABILITATION	76.97	350	24
25		DRUGS CHARGED TO PATIENTS	73	3,950	25
26		DIABETES SERVICES	76	500	26
27		EMERGENCY	91	12,700	27
28		PHYSICIANS' PRIVATE OFFICES	192	20,024	28
29		FUND DEVELOPMENT	192.02	2,350	29
30		EMPLOYEE BENEFITS	4	7,241	30
31		EMPLOYEE BENEFITS	4		19,793 31
32		EMPLOYEE BENEFITS	4		401 32
500 TOTAL RECLASSIFICATIONS				329,682	20,194 500
CODE LETTER - G					
1 CARDIAC PHASE III NON-ALLOW	H	CARDIAC PHASE III	192.01	756	34 1
500 TOTAL RECLASSIFICATIONS				756	34 500
CODE LETTER - H					
1 IMPLANT DEVICE	J	IMPL. DEV. CHARGED TO PATIENT	72		1,950,266 1
500 TOTAL RECLASSIFICATIONS					1,950,266 500
CODE LETTER - J					
1 CENTRAL SUPPLY	K	MEDICAL SUPPLIES CHRGED TO PA	71		708,679 1
2					2
500 TOTAL RECLASSIFICATIONS					708,679 500
CODE LETTER - K					
1 DISABILITY	L	ADMINISTRATIVE & GENERAL	5		411 1
2		HOUSEKEEPING	9		1,516 2
3		SOCIAL SERVICE	17		1,107 3
4		ADULTS & PEDIATRICS	30		4,455 4
5		OPERATING ROOM	50		1,239 5
6		SPEECH PATHOLOGY	68		650 6
500 TOTAL RECLASSIFICATIONS					9,378 500
CODE LETTER - L					
1 SLEEP CTR RENT RECLASS	M	RADIOLOGY-DIAGNOSTIC	54		8,832 1
2		RESPIRATORY THERAPY	65		440 2
500 TOTAL RECLASSIFICATIONS					9,272 500
CODE LETTER - M					
GRAND TOTAL (INCREASES)				927,558	3,014,175

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 FIRE INSURANCE	A	ADMINISTRATIVE & GENERAL	5		41,761	9 1
2						9 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					41,761	500
1 CAFETERIA RECLASS	B	DIETARY	10	341,463	112,734	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B				341,463	112,734	500
1 BLOOD	C	LABORATORY	60		121,902	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					121,902	500
1 REHAB ADMIN RECLASS	E	NURSING ADMINISTRATION	13	217,635	22,855	1
2						2
3						3
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				217,635	22,855	500
1 VACATION ACCRUAL RECLASS	F	ADMINISTRATIVE & GENERAL	5	1,421		1
2		MAINTENANCE & REPAIRS	6	38		2
3		OPERATION OF PLANT	7	267		3
4		LAUNDRY & LINEN SERVICE	8	20		4
5		HOUSEKEEPING	9	342		5
6		DIETARY	10	297		6
7		NURSING ADMINISTRATION	13	728		7
8		MEDICAL RECORDS & LIBRARY	16	250		8
9		SOCIAL SERVICE	17	87		9
10		ADULTS & PEDIATRICS	30	1,589		10
11		INTENSIVE CARE UNIT	31	522		11
12		OPERATING ROOM	50	1,101		12
13		RADIOLOGY-DIAGNOSTIC	54	333		13
14		ULTRASONOGRAPHY	54.10	149		14
15		MAMMOGRAPHY	54.20	79		15
16		RADIOISOTOPE	56	58		16
17		COMPUTED TOMOGRAPHY (CT) SCAN	57	92		17
18		MAGNETIC RESONANCE IMAGING (M	58	46		18
19		LABORATORY	60	616		19
20		RESPIRATORY THERAPY	65	214		20
21		PHYSICAL THERAPY	66	426		21
22		OCCUPATIONAL THERAPY	67	154		22
23		SPEECH PATHOLOGY	68	133		23
24		ELECTROCARDIOLOGY	69	150		24
25		CARDIAC REHABILITATION	76.97	32		25
26		RADIOLOGY-DIAGNOSTIC	54	15		26
27		MEDICAL SUPPLIES CHRGED TO PA	71	101		27
28		DRUGS CHARGED TO PATIENTS	73	376		28
29		DIABETES SERVICES	76	50		29
30		EMERGENCY	91	927		30
31		GIFT, FLOWER, COFFEE SHOP & C	190	14		31
32		PHYSICIANS' PRIVATE OFFICES	192	6,349		32
33		FUND DEVELOPMENT	192.02	115		33
34		PULMONARY FUNCTION	192.03	9		34
35		PHYSICIANS' PRIVATE OFFICES	192		38,022	35
500 TOTAL RECLASSIFICATIONS CODE LETTER - F				17,100	38,022	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	-----		DECREASE	-----		WKST A-7
		COST CENTER		LINE #	SALARY	OTHER	REF.
	1	6		7	8	9	10
1 TEAM AWARDS	G	EMPLOYEE BENEFITS		4	322,441		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
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30		EMPLOYEE BENEFITS		4		7,241	30
31		EMPLOYEE BENEFITS		4	19,793		31
32		EMPLOYEE BENEFITS		4	401		32
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					342,635	7,241	500
1 CARDIAC PHASE III NON-ALLOW	H	CARDIAC REHABILITATION		76.97	756	34	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					756	34	500
1 IMPLANT DEVICE	J	OPERATING ROOM		50		1,950,266	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - J						1,950,266	500
1 CENTRAL SUPPLY	K	OPERATING ROOM		50		662,551	1
2		RESPIRATORY THERAPY		65		46,128	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - K						708,679	500
1 DISABILITY	L	ADMINISTRATIVE & GENERAL		5	411		1
2		HOUSEKEEPING		9	1,516		2
3		SOCIAL SERVICE		17	1,107		3
4		ADULTS & PEDIATRICS		30	4,455		4
5		OPERATING ROOM		50	1,239		5
6		SPEECH PATHOLOGY		68	650		6
500 TOTAL RECLASSIFICATIONS CODE LETTER - L					9,378		500
1 SLEEP CTR RENT RECLASS	M	ADMINISTRATIVE & GENERAL		5		8,832	1
2		ADMINISTRATIVE & GENERAL		5		440	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - M						9,272	500
GRAND TOTAL (DECREASES)					928,967	3,012,766	

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	749,404					749,404	1
2 LAND IMPROVEMENTS	2,287,904					2,287,904	2
3 BUILDINGS AND FIXTURES	35,881,333	156,468		156,468		36,037,801	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	97,230					97,230	5
6 MOVABLE EQUIPMENT	28,301,551	1,455,088		1,455,088		29,756,639	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	67,317,422	1,611,556		1,611,556		68,928,978	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	67,317,422	1,611,556		1,611,556		68,928,978	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)
1 CAP REL COSTS-BLDG & FIXT	1,450,722						1,450,722 1
2 CAP REL COSTS-MVBLE EQUIP	1,226,123						1,226,123 2
3 TOTAL (SUM OF LINES 1-2)	2,676,845						2,676,845 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14)
1 CAP REL COSTS-BLDG & FIXT	1,473,354						1,473,354 1
2 CAP REL COSTS-MVBLE EQUIP	1,245,252						1,245,252 2
3 TOTAL	2,718,606						2,718,606 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)			CAP REL COSTS-MVBLE EQUIP	2	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	-3,066	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,351,664			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-2,428,902			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-23,835	MEDICAL RECORDS & LIBRARY	16	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		RESPIRATORY THERAPY	65	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		OCCUPATIONAL THERAPY	67	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 PHYSICIAN RECRUITMENT	A	-44,800	ADMINISTRATIVE & GENERAL	5	33
34 AHA AND IHA DUES	A	-16,476	ADMINISTRATIVE & GENERAL	5	34
35 UNEMPLOYMENT COMPENSATION	A	12,694	EMPLOYEE BENEFITS	4	35
36 PRE EMPLOYMENT PHYSICALS	A	-58,978	EMPLOYEE BENEFITS	4	36
37 PRENATAL BABY PICTURES	B	-437	ADULTS & PEDIATRICS	30	37
38 EMERGENCY MEDICAL TRANSPORTATION	B	-17,807	EMERGENCY	91	38
39 LAB NON PATIENT INCOME	B	-621	LABORATORY	60	39
40 RADIOLOGY - SILVER RECOVERY & FILM	B	-65	RADIOLOGY-DIAGNOSTIC	54	40
41 PEDIATRIC DEVELOPMENT	B	-341	PHYSICAL THERAPY	66	41
42 AUDIOLOGY	B	-345	SPEECH PATHOLOGY	68	42
43 PHARMACY - ITEMS SOLD TO PATIENTS	B	-2,361	DRUGS CHARGED TO PATIENTS	73	43
44 HOUSEKEEPING CAN RECYCLING	B	-745	HOUSEKEEPING	9	44
45 HOSPITAL ADMIN - FARM INCOME & OTH	B	-49,015	ADMINISTRATIVE & GENERAL	5	45
46 REYNOLDS STREET PROPERTY - RENTAL	B	-10,808	ADMINISTRATIVE & GENERAL	5	46
47 CHAPLAINCY - CANDLES & RENTAL INCO	B	-9,656	ADMINISTRATIVE & GENERAL	5	47
48 INSERVICE EDUC - NURSING - CLASS F	B	-355	NURSING ADMINISTRATION	13	48
49 UTILIZATION REVIEW - GRANTS	B	-4,017	ADMINISTRATIVE & GENERAL	5	49
49.01 DIABETES SERVICES	B	-540	DIABETES SERVICES	76	49.01
49.02 TEAM AWARD - PRIOR YEAR	A	7,241	EMPLOYEE BENEFITS	4	49.02
49.03 TEAM AWARD - CURRENT YEAR	A	-19,793	EMPLOYEE BENEFITS	4	49.03
49.04 SPORTSCARE MEDICINE - WEIGHT TRAIN	B	-40	PHYSICAL THERAPY	66	49.04
49.06 DISASTER PREPAREDNESS - GRANTS	B	-23,920	ADMINISTRATIVE & GENERAL	5	49.06
49.07 NURSING ADMIN	B	-4,017	NURSING ADMINISTRATION	13	49.07
49.09 PUBLIC HEALTH PREPAREDNESS	B	-5,911	ADMINISTRATIVE & GENERAL	5	49.09
49.10 PATIENT ACCOUNTING	B	-60	ADMINISTRATIVE & GENERAL	5	49.10
49.11 DIETARY OP REVENUE	B	-7,774	DIETARY	10	49.11
49.12 MEDICAID ASSESSMENT	A	-776,190	ADMINISTRATIVE & GENERAL	5	49.12
49.13 REVENUE CYCLE ADMINISTRATION	B	-59,135	ADMINISTRATIVE & GENERAL	5	49.13
50 TOTAL (SUM OF LINES 1 THRU 49)		-5,901,739			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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	CORPORATE OFFICE CHARGES	3,546,517	5,708,147	-2,161,630	1
2	7	OPERATION OF PLANT	CORPORATE OFFICECHARGES	104,447	168,108	-63,661	2
3	71	MEDICAL SUPPLIES CHRGED TO PATI	CORPORATE OFFICE CHARGES	57,100	91,904	-34,804	3
4	54	RADIOLOGY-DIAGNOSTIC	SFI PURCHASED MAINT	56,591	62,829	-6,238	4
4.01	54.20	MAMMOGRAPHY	SFI PURCHASED MAINT	89,408	99,264	-9,856	4.01
4.02	56	RADIOISOTOPE	SFI PURCHASED MAINT	32,850	36,471	-3,621	4.02
4.03	57	COMPUTED TOMOGRAPHY (CT) SCAN	SFI PURCHASED MAINT	135,784	150,752	-14,968	4.03
4.04	54	RADIOLOGY-DIAGNOSTIC	SFI PURCHASED SERVICES	5,720	7,076	-1,356	4.04
4.05	54.20	MAMMOGRAPHY	SFI PURCHASED SERVICES	14,682	18,164	-3,482	4.05
4.06	58	MAGNETIC RESONANCE IMAGING (MRI)	SFI PURCHASED SERVICES	465,672	576,098	-110,426	4.06
4.07	57	COMPUTED TOMOGRAPHY (CT) SCAN	SFI PURCHASED SERVICES	79,533	98,393	-18,860	4.07
4.08	60	LABORATORY	SYSTEMS LAB	661,492	661,492		4.08
4.09	31	INTENSIVE CARE UNIT	EICU	32,378	32,378		4.09
5		TOTALS (SUM OF LINES 1-4)		5,282,174	7,711,076	-2,428,902	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		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
1	2		3	4	5	6	7	8	9
1	53	ANESTHESIOLOGY	ASSOC ANESTESIO	712,175	712,175	167,500	1	81	4 1
2	60	LABORATORY	CENTRAL IL PATH	11,242	11,242	208,000	1	100	5 2
3	76.97	CARDIAC REHABILITATION	MEDICAL DIRECTO	6,000	6,000	150,200	1	72	4 3
4	91	EMERGENCY	SAINTE FRANCIS M	1,593,492	1,593,492	159,800	1	77	4 4
5	57	COMPUTED TOMOGRAPHY (CT)	MEDICAL DIRECTO	665	665	217,600	1	105	5 5
6	50	OPERATING ROOM	MEDICAL DIRECTO	12,733	12,733	182,900	1	88	4 6
7	30	ADULTS & PEDIATRICS	PEDS	5,093	5,093	130,900	1	63	3 7
8	30	ADULTS & PEDIATRICS	OB/GYN	6,033	6,033	200,300	1	96	5 8
9	54	RADIOLOGY-DIAGNOSTIC	SLEEP LAB	4,231	4,231	159,800	1	77	4 9
200		TOTAL		2,351,664	2,351,664		9	759	38 200

PROVIDER CCN: 14-0161 SAINT JAMES HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/26/2013 13:12

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
10	11	12	13	14	15	16	17	18	
1	53 ANESTHESIOLOGY	ASSOC ANESTESIO				81		712,175	1
2	60 LABORATORY	CENTRAL IL PATH				100		11,242	2
3	76.97 CARDIAC REHABILITATION	MEDICAL DIRECTO				72		6,000	3
4	91 EMERGENCY	SAINTE FRANCIS M				77		1,593,492	4
5	57 COMPUTED TOMOGRAPHY (CT)	MEDICAL DIRECTO				105		665	5
6	50 OPERATING ROOM	MEDICAL DIRECTO				88		12,733	6
7	30 ADULTS & PEDIATRICS	PEDS				63		5,093	7
8	30 ADULTS & PEDIATRICS	OB/GYN				96		6,033	8
9	54 RADIOLOGY-DIAGNOSTIC	SLEEP LAB				77		4,231	9
200	TOTAL					759		2,351,664	200

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	1,473,354	1,473,354				1
2 CAP REL COSTS-MVBLE EQUIP	1,245,252		1,245,252			2
4 EMPLOYEE BENEFITS	6,379,404		861	6,380,265		4
5 ADMINISTRATIVE & GENERAL	6,112,838	507,006	498,147	558,918	7,676,909	5
6 MAINTENANCE & REPAIRS	105,672	12,394		14,243	132,309	6
7 OPERATION OF PLANT	1,347,360	97,990	48,277	98,898	1,592,525	7
8 LAUNDRY & LINEN SERVICE	159,712	30,162		7,542	197,416	8
9 HOUSEKEEPING	482,507	30,001	9,609	127,223	649,340	9
10 DIETARY	99,117	29,725	2,081	21,215	152,138	10
11 CAFETERIA	454,197	16,721	8,820	90,227	569,965	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	875,063	3,349	51,705	218,254	1,148,371	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	377,452	25,156	278	93,163	496,049	16
17 SOCIAL SERVICE	125,641	6,065		31,822	163,528	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	2,430,791	182,229	58,425	589,284	3,260,729	30
31 INTENSIVE CARE UNIT	813,840	32,349	38,920	193,644	1,078,753	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,250,030	167,004	235,732	409,272	3,062,038	50
53 ANESTHESIOLOGY	60,538		8,855		69,393	53
54 RADIOLOGY-DIAGNOSTIC	590,182	63,282	121,512	130,466	905,442	54
54.10 ULTRASONOGRAPHY	259,161	3,314	26,549	55,504	344,528	54.10
54.20 MAMMOGRAPHY	379,090		3,393	29,175	411,658	54.20
56 RADIOISOTOPE	329,560	1,243	3,843	21,408	356,054	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	670,632	7,400	9,880	34,188	722,100	57
58 MAGNETIC RESONANCE IMAGING (MRI)	532,493			16,996	549,489	58
60 LABORATORY	1,442,624	14,535	56,900	229,348	1,743,407	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	121,902				121,902	63
65 RESPIRATORY THERAPY	318,334	4,810	4,631	79,278	407,053	65
66 PHYSICAL THERAPY	786,969	52,994	11,560	191,229	1,042,752	66
67 OCCUPATIONAL THERAPY	267,008	17,412	1,283	68,287	353,990	67
68 SPEECH PATHOLOGY	313,190	22,015	14,423	62,597	412,225	68
69 ELECTROCARDIOLOGY	258,136	2,670	5,864	56,221	322,891	69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	995,705	22,015	771	37,147	1,055,638	71
72 IMPL. DEV. CHARGED TO PATIENT	1,950,266				1,950,266	72
73 DRUGS CHARGED TO PATIENTS	1,365,411	11,715	2,900	139,196	1,519,222	73
76 DIABETES SERVICES	73,809	1,185		18,201	93,195	76
76.97 CARDIAC REHABILITATION	40,520	13,384	1,576	11,826	67,306	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,482,206	61,660	18,457	344,084	1,906,407	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	36,969,966	1,439,785	1,245,252	3,978,856	34,534,988	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,542			5,005	43,547	190
192 PHYSICIANS' PRIVATE OFFICES	19,640,545			2,350,741	21,991,286	192
192.01 CARDIAC PHASE III	790	265		200	1,255	192.01
192.02 FUND DEVELOPMENT	647,960	4,396		42,532	694,888	192.02
192.03 PULMONARY FUNCTION	12,187			2,931	15,118	192.03
193 NONPAID WORKERS		28,908			28,908	193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	57,309,990	1,473,354	1,245,252	6,380,265	57,309,990	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
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	7,676,909					5
6 MAINTENANCE & REPAIRS	20,465	152,774				6
7 OPERATION OF PLANT	246,321	11,736	1,850,582			7
8 LAUNDRY & LINEN SERVICE	30,535	3,612	47,400	278,963		8
9 HOUSEKEEPING	100,435	3,593	47,147		800,515	9
10 DIETARY	23,532	3,560	46,713	2,194	21,295	10
11 CAFETERIA	88,158	2,003	26,277		11,979	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	177,622	401	5,263		2,399	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	76,725	3,013	39,533		18,022	16
17 SOCIAL SERVICE	25,293	726	9,531		4,345	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	504,347	21,825	286,370	94,480	130,546	30
31 INTENSIVE CARE UNIT	166,854	3,874	50,836	18,769	23,174	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	473,615	20,002	262,444	56,587	119,639	50
53 ANESTHESIOLOGY	10,733					53
54 RADIOLOGY-DIAGNOSTIC	140,047	7,579	99,447	28,779	45,335	54
54.10 ULTRASONOGRAPHY	53,289	397	5,208		2,374	54.10
54.20 MAMMOGRAPHY	63,672					54.20
56 RADIOISOTOPE	55,072	149	1,953		890	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	111,689	886	11,628		5,301	57
58 MAGNETIC RESONANCE IMAGING (MRI)	84,991					58
60 LABORATORY	269,658	1,741	22,841		10,412	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	18,855					63
65 RESPIRATORY THERAPY	62,960	576	7,559		3,446	65
66 PHYSICAL THERAPY	161,286	6,347	83,280	13,904	37,964	66
67 OCCUPATIONAL THERAPY	54,753	2,085	27,362		12,473	67
68 SPEECH PATHOLOGY	63,760	2,637	34,596		15,771	68
69 ELECTROCARDIOLOGY	49,943	320	4,196		1,913	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	163,279	2,637	34,596		15,771	71
72 IMPL. DEV. CHARGED TO PATIENT	301,653					72
73 DRUGS CHARGED TO PATIENTS	234,983	1,403	18,410		8,393	73
76 DIABETES SERVICES	14,415	142	1,863		849	76
76.97 CARDIAC REHABILITATION	10,410	1,603	21,032		9,588	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	294,870	7,385	96,897	62,691	44,172	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	4,154,220	110,232	1,292,382	277,404	546,051	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,736	522	6,854		3,125	190
192 PHYSICIANS' PRIVATE OFFICES	3,401,470	35,574	466,764	1,559	212,781	192
192.01 CARDIAC PHASE III	194	32	416		190	192.01
192.02 FUND DEVELOPMENT	107,480	2,952	38,737		17,659	192.02
192.03 PULMONARY FUNCTION	2,338					192.03
193 NONPAID WORKERS	4,471	3,462	45,429		20,709	193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	7,676,909	152,774	1,850,582	278,963	800,515	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
	10	11	13	16	17	
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	249,432					10
11 CAFETERIA		698,382				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		32,121	1,366,177			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		25,008		658,350		16
17 SOCIAL SERVICE		7,252			210,675	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	200,410	127,875	558,212	36,159	167,552	30
31 INTENSIVE CARE UNIT	39,047	31,649	138,158	10,218	43,123	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	9,975	84,971	370,929	66,684		50
53 ANESTHESIOLOGY				7,299		53
54 RADIOLOGY-DIAGNOSTIC		29,759		25,385		54
54.10 ULTRASONOGRAPHY		8,919		14,849		54.10
54.20 MAMMOGRAPHY		5,696		7,892		54.20
56 RADIOISOTOPE		3,751		19,001		56
57 COMPUTED TOMOGRAPHY (CT) SCAN		6,697		82,738		57
58 MAGNETIC RESONANCE IMAGING (MRI)		4,112		39,422		58
60 LABORATORY		55,739		118,815		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.				1,570		63
65 RESPIRATORY THERAPY		16,755		4,718		65
66 PHYSICAL THERAPY		36,233		14,910		66
67 OCCUPATIONAL THERAPY		11,781		6,617		67
68 SPEECH PATHOLOGY		11,059		3,152		68
69 ELECTROCARDIOLOGY		11,893		23,264		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		11,281		49,744		71
72 IMPL. DEV. CHARGED TO PATIENT				43,785		72
73 DRUGS CHARGED TO PATIENTS		15,588		41,540		73
76 DIABETES SERVICES		3,473	15,162	685		76
76.97 CARDIAC REHABILITATION		1,834		832		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		64,992	283,716	39,071		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	249,432	608,438	1,366,177	658,350	210,675	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES		89,333				192
192.01 CARDIAC PHASE III						192.01
192.02 FUND DEVELOPMENT		83				192.02
192.03 PULMONARY FUNCTION		528				192.03
193 NONPAID WORKERS						193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	249,432	698,382	1,366,177	658,350	210,675	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	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				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	5,388,505		5,388,505	30
31 INTENSIVE CARE UNIT	1,604,455		1,604,455	31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	4,526,884		4,526,884	50
53 ANESTHESIOLOGY	87,425		87,425	53
54 RADIOLOGY-DIAGNOSTIC	1,281,773		1,281,773	54
54.10 ULTRASONOGRAPHY	429,564		429,564	54.10
54.20 MAMMOGRAPHY	488,918		488,918	54.20
56 RADIOISOTOPE	436,870		436,870	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	941,039		941,039	57
58 MAGNETIC RESONANCE IMAGING (MRI)	678,014		678,014	58
60 LABORATORY	2,222,613		2,222,613	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRANS.	142,327		142,327	63
65 RESPIRATORY THERAPY	503,067		503,067	65
66 PHYSICAL THERAPY	1,396,676		1,396,676	66
67 OCCUPATIONAL THERAPY	469,061		469,061	67
68 SPEECH PATHOLOGY	543,200		543,200	68
69 ELECTROCARDIOLOGY	414,420		414,420	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,332,946		1,332,946	71
72 IMPL. DEV. CHARGED TO PATIENT	2,295,704		2,295,704	72
73 DRUGS CHARGED TO PATIENTS	1,839,539		1,839,539	73
76 DIABETES SERVICES	129,784		129,784	76
76.97 CARDIAC REHABILITATION	112,605		112,605	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	2,800,201		2,800,201	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	30,065,590		30,065,590	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	60,784		60,784	190
192 PHYSICIANS' PRIVATE OFFICES	26,198,767		26,198,767	192
192.01 CARDIAC PHASE III	2,087		2,087	192.01
192.02 FUND DEVELOPMENT	861,799		861,799	192.02
192.03 PULMONARY FUNCTION	17,984		17,984	192.03
193 NONPAID WORKERS	102,979		102,979	193
194 CONTRACT NURSING				194
194.01 NON-PATIENT DIETARY				194.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	57,309,990		57,309,990	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	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS			861	861	861	4
5 ADMINISTRATIVE & GENERAL	1,134,803	507,006	498,147	2,139,956	76	5
6 MAINTENANCE & REPAIRS		12,394		12,394	2	6
7 OPERATION OF PLANT	10,262	97,990	48,277	156,529	13	7
8 LAUNDRY & LINEN SERVICE		30,162		30,162	1	8
9 HOUSEKEEPING		30,001	9,609	39,610	17	9
10 DIETARY		29,725	2,081	31,806	3	10
11 CAFETERIA		16,721	8,820	25,541	12	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,349	51,705	55,054	30	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,807	25,156	278	27,241	13	16
17 SOCIAL SERVICE		6,065		6,065	4	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	2,376	182,229	58,425	243,030	80	30
31 INTENSIVE CARE UNIT	825	32,349	38,920	72,094	26	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	989	167,004	235,732	403,725	56	50
53 ANESTHESIOLOGY			8,855	8,855		53
54 RADIOLOGY-DIAGNOSTIC	8,832	63,282	121,512	193,626	18	54
54.10 ULTRASONOGRAPHY		3,314	26,549	29,863	8	54.10
54.20 MAMMOGRAPHY	151,584		3,393	154,977	4	54.20
56 RADIOISOTOPE		1,243	3,843	5,086	3	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	260,376	7,400	9,880	277,656	5	57
58 MAGNETIC RESONANCE IMAGING (MRI)					2	58
60 LABORATORY		14,535	56,900	71,435	31	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	1,358	4,810	4,631	10,799	11	65
66 PHYSICAL THERAPY	1,997	52,994	11,560	66,551	26	66
67 OCCUPATIONAL THERAPY	248	17,412	1,283	18,943	9	67
68 SPEECH PATHOLOGY	291	22,015	14,423	36,729	9	68
69 ELECTROCARDIOLOGY		2,670	5,864	8,534	8	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	652	22,015	771	23,438	5	71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS		11,715	2,900	14,615	19	73
76 DIABETES SERVICES		1,185		1,185	2	76
76.97 CARDIAC REHABILITATION		13,384	1,576	14,960	2	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	4,116	61,660	18,457	84,233	47	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,580,516	1,439,785	1,245,252	4,265,553	542	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	196,347			196,347	312	192
192.01 CARDIAC PHASE III		265		265		192.01
192.02 FUND DEVELOPMENT		4,396		4,396	6	192.02
192.03 PULMONARY FUNCTION						192.03
193 NONPAID WORKERS		28,908		28,908		193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,776,863	1,473,354	1,245,252	4,495,469	861	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
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	2,140,032					5
6 MAINTENANCE & REPAIRS	5,705	18,101				6
7 OPERATION OF PLANT	68,665	1,391	226,598			7
8 LAUNDRY & LINEN SERVICE	8,512	428	5,804	44,907		8
9 HOUSEKEEPING	27,998	426	5,773		73,824	9
10 DIETARY	6,560	422	5,720	353	1,964	10
11 CAFETERIA	24,575	237	3,218		1,105	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	49,514	48	644		221	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	21,388	357	4,841		1,662	16
17 SOCIAL SERVICE	7,051	86	1,167		401	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	140,593	2,586	35,065	15,210	12,039	30
31 INTENSIVE CARE UNIT	46,513	459	6,225	3,021	2,137	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	132,026	2,370	32,135	9,109	11,033	50
53 ANESTHESIOLOGY	2,992					53
54 RADIOLOGY-DIAGNOSTIC	39,040	898	12,177	4,633	4,181	54
54.10 ULTRASONOGRAPHY	14,855	47	638		219	54.10
54.20 MAMMOGRAPHY	17,749					54.20
56 RADIOISOTOPE	15,352	18	239		82	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	31,135	105	1,424		489	57
58 MAGNETIC RESONANCE IMAGING (MRI)	23,692					58
60 LABORATORY	75,170	206	2,797		960	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	5,256					63
65 RESPIRATORY THERAPY	17,551	68	926		318	65
66 PHYSICAL THERAPY	44,960	752	10,197	2,238	3,501	66
67 OCCUPATIONAL THERAPY	15,263	247	3,350		1,150	67
68 SPEECH PATHOLOGY	17,774	312	4,236		1,454	68
69 ELECTROCARDIOLOGY	13,922	38	514		176	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	45,516	312	4,236		1,454	71
72 IMPL. DEV. CHARGED TO PATIENT	84,090					72
73 DRUGS CHARGED TO PATIENTS	65,504	166	2,254		774	73
76 DIABETES SERVICES	4,018	17	228		78	76
76.97 CARDIAC REHABILITATION	2,902	190	2,575		884	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	82,199	875	11,865	10,092	4,074	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,158,040	13,061	158,248	44,656	50,356	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,878	62	839		288	190
192 PHYSICIANS' PRIVATE OFFICES	948,201	4,214	57,154	251	19,624	192
192.01 CARDIAC PHASE III	54	4	51		17	192.01
192.02 FUND DEVELOPMENT	29,961	350	4,743		1,629	192.02
192.03 PULMONARY FUNCTION	652					192.03
193 NONPAID WORKERS	1,246	410	5,563		1,910	193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,140,032	18,101	226,598	44,907	73,824	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
	10	11	13	16	17	
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	46,828					10
11 CAFETERIA		54,688				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		2,515	108,026			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		1,958		57,460		16
17 SOCIAL SERVICE		568			15,342	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	37,624	10,015	44,139	3,159	12,202	30
31 INTENSIVE CARE UNIT	7,331	2,478	10,924	893	3,140	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,873	6,654	29,330	5,826		50
53 ANESTHESIOLOGY				638		53
54 RADIOLOGY-DIAGNOSTIC		2,330		2,218		54
54.10 ULTRASONOGRAPHY		698		1,297		54.10
54.20 MAMMOGRAPHY		446		689		54.20
56 RADIOISOTOPE		294		1,660		56
57 COMPUTED TOMOGRAPHY (CT) SCAN		524		7,228		57
58 MAGNETIC RESONANCE IMAGING (MRI)		322		3,444		58
60 LABORATORY		4,365		10,325		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.				137		63
65 RESPIRATORY THERAPY		1,312		412		65
66 PHYSICAL THERAPY		2,837		1,303		66
67 OCCUPATIONAL THERAPY		923		578		67
68 SPEECH PATHOLOGY		866		275		68
69 ELECTROCARDIOLOGY		931		2,032		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		883		4,346		71
72 IMPL. DEV. CHARGED TO PATIENT				3,825		72
73 DRUGS CHARGED TO PATIENTS		1,221		3,629		73
76 DIABETES SERVICES		272	1,199	60		76
76.97 CARDIAC REHABILITATION		144		73		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		5,089	22,434	3,413		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	46,828	47,645	108,026	57,460	15,342	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES		6,995				192
192.01 CARDIAC PHASE III						192.01
192.02 FUND DEVELOPMENT		7				192.02
192.03 PULMONARY FUNCTION		41				192.03
193 NONPAID WORKERS						193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	46,828	54,688	108,026	57,460	15,342	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS		TOTAL	
	24	25		
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 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	555,742		555,742	30
31 INTENSIVE CARE UNIT	155,241		155,241	31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	634,137		634,137	50
53 ANESTHESIOLOGY	12,485		12,485	53
54 RADIOLOGY-DIAGNOSTIC	259,121		259,121	54
54.10 ULTRASONOGRAPHY	47,625		47,625	54.10
54.20 MAMMOGRAPHY	173,865		173,865	54.20
56 RADIOISOTOPE	22,734		22,734	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	318,566		318,566	57
58 MAGNETIC RESONANCE IMAGING (MRI)	27,460		27,460	58
60 LABORATORY	165,289		165,289	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRANS.	5,393		5,393	63
65 RESPIRATORY THERAPY	31,397		31,397	65
66 PHYSICAL THERAPY	132,365		132,365	66
67 OCCUPATIONAL THERAPY	40,463		40,463	67
68 SPEECH PATHOLOGY	61,655		61,655	68
69 ELECTROCARDIOLOGY	26,155		26,155	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	80,190		80,190	71
72 IMPL. DEV. CHARGED TO PATIENT	87,915		87,915	72
73 DRUGS CHARGED TO PATIENTS	88,182		88,182	73
76 DIABETES SERVICES	7,059		7,059	76
76.97 CARDIAC REHABILITATION	21,730		21,730	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	224,321		224,321	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	3,179,090		3,179,090	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,068		3,068	190
192 PHYSICIANS' PRIVATE OFFICES	1,233,098		1,233,098	192
192.01 CARDIAC PHASE III	391		391	192.01
192.02 FUND DEVELOPMENT	41,092		41,092	192.02
192.03 PULMONARY FUNCTION	693		693	192.03
193 NONPAID WORKERS	38,037		38,037	193
194 CONTRACT NURSING				194
194.01 NON-PATIENT DIETARY				194.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	4,495,469		4,495,469	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 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	128,029					1
2 CAP REL COSTS-MVBLE EQUIP		1,211,477				2
4 EMPLOYEE BENEFITS		838	24,145,979			4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	44,057	484,637	2,115,215	-7,676,909	49,633,081	5
6 OPERATION OF PLANT	1,077		53,903		132,309	6
7 LAUNDRY & LINEN SERVICE	8,515	46,968	374,277		1,592,525	7
8 HOUSEKEEPING	2,621		28,544		197,416	8
9 DIETARY	2,607	9,348	481,473		649,340	9
10 CAFETERIA	2,583	2,025	80,286		152,138	10
11 MAINTENANCE OF PERSONNEL	1,453	8,581	341,463		569,965	11
12 NURSING ADMINISTRATION	291	50,303	825,980		1,148,371	12
13 CENTRAL SERVICES & SUPPLY						13
14 PHARMACY						14
15 MEDICAL RECORDS & LIBRARY	2,186	270	352,575		496,049	15
16 SOCIAL SERVICE	527		120,429		163,528	16
17 NONPHYSICIAN ANESTHETISTS						17
19 NURSING SCHOOL						19
20 I&R SRVCES-SALARY & FRINGES APPRVD						20
21 I&R SRVCES-OTHER PRGM COSTS APPRVD						21
22 PARAMED ED PRGM-(SPECIFY)						22
23 INPATIENT ROUTINE SERV COST CENTERS						23
30 ADULTS & PEDIATRICS	15,835	56,840	2,230,134		3,260,729	30
31 INTENSIVE CARE UNIT	2,811	37,864	732,841		1,078,753	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,512	229,338	1,548,881		3,062,038	50
53 ANESTHESIOLOGY		8,615			69,393	53
54 RADIOLOGY-DIAGNOSTIC	5,499	118,216	493,745		905,442	54
54.10 ULTRASONOGRAPHY	288	25,829	210,055		344,528	54.10
54.20 MAMMOGRAPHY		3,301	110,411		411,658	54.20
56 RADIOISOTOPE	108	3,739	81,020		356,054	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	643	9,612	129,384		722,100	57
58 MAGNETIC RESONANCE IMAGING (MRI)			64,322		549,489	58
60 LABORATORY	1,263	55,357	867,965		1,743,407	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					121,902	62.30
63 BLOOD STORING, PROCESSING & TRANS.					407,053	63
65 RESPIRATORY THERAPY	418	4,505	300,028		1,042,752	65
66 PHYSICAL THERAPY	4,605	11,246	723,701		353,990	66
67 OCCUPATIONAL THERAPY	1,513	1,248	258,430		412,225	67
68 SPEECH PATHOLOGY	1,913	14,032	236,897		322,891	68
69 ELECTROCARDIOLOGY	232	5,705	212,767		1,055,638	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,913	750	140,584		1,950,266	71
72 IMPL. DEV. CHARGED TO PATIENT					1,519,222	72
73 DRUGS CHARGED TO PATIENTS	1,018	2,821	526,785		93,195	73
76 DIABETES SERVICES	103		68,881		67,306	76
76.97 CARDIAC REHABILITATION	1,163	1,533	44,755			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	5,358	17,956	1,302,179		1,906,407	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	125,112	1,211,477	15,057,910	-7,676,909	26,858,079	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			18,942		43,547	190
192 PHYSICIANS' PRIVATE OFFICES			8,896,320		21,991,286	192
192.01 CARDIAC PHASE III	23		756		1,255	192.01
192.02 FUND DEVELOPMENT	382		160,960		694,888	192.02
192.03 PULMONARY FUNCTION			11,091		15,118	192.03
193 NONPAID WORKERS	2,512				28,908	193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,473,354	1,245,252	6,380,265		7,676,909	202
203	UNIT COST MULT-WS B PT I	11.507971	1.027879	0.264237		0.154673	203
204	COST TO BE ALLOC PER B PT II			861		2,140,032	204
205	UNIT COST MULT-WS B PT II			0.000036		0.043117	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN-	OPERATION	LAUNDRY	HOUSE-	DIETARY	
	TENANCE & REPAIRS	OF PLANT	& LINEN SERVICE	KEEPING	MEALS SERVED	
	SQUARE FEET	SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET		
	6	7	8	9	10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	110,844					6
7 OPERATION OF PLANT	8,515	102,329				7
8 LAUNDRY & LINEN SERVICE	2,621	2,621	261,469			8
9 HOUSEKEEPING	2,607	2,607		97,101		9
10 DIETARY	2,583	2,583	2,056	2,583	14,028	10
11 CAFETERIA	1,453	1,453		1,453		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	291	291		291		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,186	2,186		2,186		16
17 SOCIAL SERVICE	527	527		527		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	15,835	15,835	88,556	15,835	11,271	30
31 INTENSIVE CARE UNIT	2,811	2,811	17,592	2,811	2,196	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,512	14,512	53,038	14,512	561	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	5,499	5,499	26,974	5,499		54
54.10 ULTRASONOGRAPHY	288	288		288		54.10
54.20 MAMMOGRAPHY						54.20
56 RADIOISOTOPE	108	108		108		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	643	643		643		57
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY	1,263	1,263		1,263		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	418	418		418		65
66 PHYSICAL THERAPY	4,605	4,605	13,032	4,605		66
67 OCCUPATIONAL THERAPY	1,513	1,513		1,513		67
68 SPEECH PATHOLOGY	1,913	1,913		1,913		68
69 ELECTROCARDIOLOGY	232	232		232		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,913	1,913		1,913		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	1,018	1,018		1,018		73
76 DIABETES SERVICES	103	103		103		76
76.97 CARDIAC REHABILITATION	1,163	1,163		1,163		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	5,358	5,358	58,760	5,358		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	79,978	71,463	260,008	66,235	14,028	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	379	379		379		190
192 PHYSICIANS' PRIVATE OFFICES	25,810	25,810	1,461	25,810		192
192.01 CARDIAC PHASE III	23	23		23		192.01
192.02 FUND DEVELOPMENT	2,142	2,142		2,142		192.02
192.03 PULMONARY FUNCTION						192.03
193 NONPAID WORKERS	2,512	2,512		2,512		193
194 CONTRACT NURSING						194
194.01 NON-PATIENT DIETARY						194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAIN- TENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	152,774	1,850,582	278,963	800,515	249,432	202
203	UNIT COST MULT-WS B PT I	1.378279	18.084629	1.066907	8.244148	17.781009	203
204	COST TO BE ALLOC PER B PT II	18,101	226,598	44,907	73,824	46,828	204
205	UNIT COST MULT-WS B PT II	0.163302	2.214406	0.171749	0.760281	3.338181	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY TOTAL REVENUE	SOCIAL SERVICE PATIENT DAYS	
	FTE'S	FTE'S			
	11	13	16	17	
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	25,134				11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	1,156	11,263			13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	900		137,266,478		16
17 SOCIAL SERVICE	261			4,050	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	4,602	4,602	7,539,337	3,221	30
31 INTENSIVE CARE UNIT	1,139	1,139	2,130,496	829	31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	3,058	3,058	13,904,083		50
53 ANESTHESIOLOGY			1,521,857		53
54 RADIOLOGY-DIAGNOSTIC	1,071		5,293,055		54
54.10 ULTRASONOGRAPHY	321		3,096,180		54.10
54.20 MAMMOGRAPHY	205		1,645,545		54.20
56 RADIOISOTOPE	135		3,961,884		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	241		17,251,388		57
58 MAGNETIC RESONANCE IMAGING (MRI)	148		8,219,679		58
60 LABORATORY	2,006		24,769,397		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRANS.			327,409		63
65 RESPIRATORY THERAPY	603		983,696		65
66 PHYSICAL THERAPY	1,304		3,108,778		66
67 OCCUPATIONAL THERAPY	424		1,379,778		67
68 SPEECH PATHOLOGY	398		657,248		68
69 ELECTROCARDIOLOGY	428		4,850,669		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	406		10,371,999		71
72 IMPL. DEV. CHARGED TO PATIENT			9,129,581		72
73 DRUGS CHARGED TO PATIENTS	561		8,661,487		73
76 DIABETES SERVICES	125	125	142,820		76
76.97 CARDIAC REHABILITATION	66		173,434		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	2,339	2,339	8,146,678		91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	21,897	11,263	137,266,478	4,050	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
192 PHYSICIANS' PRIVATE OFFICES	3,215				192
192.01 CARDIAC PHASE III					192.01
192.02 FUND DEVELOPMENT	3				192.02
192.03 PULMONARY FUNCTION	19				192.03
193 NONPAID WORKERS					193
194 CONTRACT NURSING					194
194.01 NON-PATIENT DIETARY					194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY TOTAL REVENUE	SOCIAL SERVICE PATIENT DAYS	
		FTE'S	FTE'S			
		11	13	16	17	
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	698,382	1,366,177	658,350	210,675	202
203	UNIT COST MULT-WS B PT I	27.786345	121.297789	0.004796	52.018519	203
204	COST TO BE ALLOC PER B PT II	54,688	108,026	57,460	15,342	204
205	UNIT COST MULT-WS B PT II	2.175857	9.591228	0.000419	3.788148	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,388,505		5,388,505		5,388,505	30
31 INTENSIVE CARE UNIT	1,604,455		1,604,455		1,604,455	31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,526,884		4,526,884		4,526,884	50
53 ANESTHESIOLOGY	87,425		87,425		87,425	53
54 RADIOLOGY-DIAGNOSTIC	1,281,773		1,281,773		1,281,773	54
54.10 ULTRASONOGRAPHY	429,564		429,564		429,564	54.10
54.20 MAMMOGRAPHY	488,918		488,918		488,918	54.20
56 RADIOISOTOPE	436,870		436,870		436,870	56
57 COMPUTED TOMOGRAPHY (CT) SC	941,039		941,039		941,039	57
58 MAGNETIC RESONANCE IMAGING	678,014		678,014		678,014	58
60 LABORATORY	2,222,613		2,222,613		2,222,613	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	142,327		142,327		142,327	63
65 RESPIRATORY THERAPY	503,067		503,067		503,067	65
66 PHYSICAL THERAPY	1,396,676		1,396,676		1,396,676	66
67 OCCUPATIONAL THERAPY	469,061		469,061		469,061	67
68 SPEECH PATHOLOGY	543,200		543,200		543,200	68
69 ELECTROCARDIOLOGY	414,420		414,420		414,420	69
71 MEDICAL SUPPLIES CHRGED TO	1,332,946		1,332,946		1,332,946	71
72 IMPL. DEV. CHARGED TO PATIE	2,295,704		2,295,704		2,295,704	72
73 DRUGS CHARGED TO PATIENTS	1,839,539		1,839,539		1,839,539	73
76 DIABETES SERVICES	129,784		129,784		129,784	76
76.97 CARDIAC REHABILITATION	112,605		112,605		112,605	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,800,201		2,800,201		2,800,201	91
92 OBSERVATION BEDS	1,166,568		1,166,568		1,166,568	92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	31,232,158		31,232,158		31,232,158	200
201 LESS OBSERVATION BEDS	1,166,568		1,166,568		1,166,568	201
202 TOTAL (SEE INSTRUCTIONS)	30,065,590		30,065,590		30,065,590	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,894,716		4,894,716			30
31 INTENSIVE CARE UNIT	1,929,578		1,929,578			31
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,635,144	9,268,939	13,904,083	0.325579	0.325579	0.325579 50
53 ANESTHESIOLOGY	639,777	882,080	1,521,857	0.057446	0.057446	0.057446 53
54 RADIOLOGY-DIAGNOSTIC	710,057	4,582,998	5,293,055	0.242161	0.242161	0.242161 54
54.10 ULTRASONOGRAPHY	156,350	2,939,830	3,096,180	0.138740	0.138740	0.138740 54.10
54.20 MAMMOGRAPHY	1,248	1,644,297	1,645,545	0.297116	0.297116	0.297116 54.20
56 RADIOISOTOPE	283,897	3,677,987	3,961,884	0.110268	0.110268	0.110268 56
57 COMPUTED TOMOGRAPHY (CT) SC	1,749,719	15,501,669	17,251,388	0.054549	0.054549	0.054549 57
58 MAGNETIC RESONANCE IMAGING	420,967	7,798,712	8,219,679	0.082487	0.082487	0.082487 58
60 LABORATORY	3,754,956	21,014,441	24,769,397	0.089732	0.089732	0.089732 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	196,205	131,204	327,409	0.434707	0.434707	0.434707 63
65 RESPIRATORY THERAPY	438,854	544,842	983,696	0.511405	0.511405	0.511405 65
66 PHYSICAL THERAPY	362,286	2,746,492	3,108,778	0.449268	0.449268	0.449268 66
67 OCCUPATIONAL THERAPY	267,600	1,112,178	1,379,778	0.339954	0.339954	0.339954 67
68 SPEECH PATHOLOGY	14,756	642,492	657,248	0.826476	0.826476	0.826476 68
69 ELECTROCARDIOLOGY	699,469	4,151,200	4,850,669	0.085436	0.085436	0.085436 69
71 MEDICAL SUPPLIES CHRGD TO	5,041,931	5,330,068	10,371,999	0.128514	0.128514	0.128514 71
72 IMPL. DEV. CHARGED TO PATIE	7,534,643	1,594,938	9,129,581	0.251458	0.251458	0.251458 72
73 DRUGS CHARGED TO PATIENTS	4,428,966	4,232,521	8,661,487	0.212381	0.212381	0.212381 73
76 DIABETES SERVICES	200	142,620	142,820	0.908724	0.908724	0.908724 76
76.97 CARDIAC REHABILITATION		173,434	173,434	0.649267	0.649267	0.649267 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	863,912	7,282,766	8,146,678	0.343723	0.343723	0.343723 91
92 OBSERVATION BEDS	229,485	1,608,102	1,837,587	0.634837	0.634837	0.634837 92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	39,254,716	97,003,810	136,258,526			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	39,254,716	97,003,810	136,258,526			202

PROVIDER CCN: 14-0161 SAINT JAMES HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3		5		7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	555,742		555,742	4,111	135.18	1,609	217,505	30
31 INTENSIVE CARE UNIT	155,241		155,241	829	187.26	537	100,559	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				459				43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	710,983		710,983	5,399		2,146	318,064	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0161) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	634,137	13,904,083	0.045608	1,501,798	68,494	50
53 ANESTHESIOLOGY	12,485	1,521,857	0.008204	201,870	1,656	53
54 RADIOLOGY-DIAGNOSTIC	259,121	5,293,055	0.048955	380,932	18,649	54
54.10 ULTRASONOGRAPHY	47,625	3,096,180	0.015382	77,567	1,193	54.10
54.20 MAMMOGRAPHY	173,865	1,645,545	0.105658	1,223	129	54.20
56 RADIOISOTOPE	22,734	3,961,884	0.005738	170,904	981	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	318,566	17,251,388	0.018466	881,512	16,278	57
58 MAGNETIC RESONANCE IMAGING (M	27,460	8,219,679	0.003341	259,151	866	58
60 LABORATORY	165,289	24,769,397	0.006673	2,196,226	14,655	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T	5,393	327,409	0.016472			63
65 RESPIRATORY THERAPY	31,397	983,696	0.031917	282,173	9,006	65
66 PHYSICAL THERAPY	132,365	3,108,778	0.042578	215,588	9,179	66
67 OCCUPATIONAL THERAPY	40,463	1,379,778	0.029326	139,310	4,085	67
68 SPEECH PATHOLOGY	61,655	657,248	0.093808	12,866	1,207	68
69 ELECTROCARDIOLOGY	26,155	4,850,669	0.005392	448,692	2,419	69
71 MEDICAL SUPPLIES CHRGED TO PA	80,190	10,371,999	0.007731	2,415,088	18,671	71
72 IMPL. DEV. CHARGED TO PATIENT	87,915	9,129,581	0.009630	2,913,472	28,057	72
73 DRUGS CHARGED TO PATIENTS	88,182	8,661,487	0.010181	2,172,944	22,123	73
76 DIABETES SERVICES	7,059	142,820	0.049426			76
76.97 CARDIAC REHABILITATION	21,730	173,434	0.125293			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	224,321	8,146,678	0.027535	497,895	13,710	91
92 OBSERVATION BEDS	120,314	1,837,587	0.065474	142,522	9,331	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	2,588,421	129,434,232		14,911,733	240,689	200

PROVIDER CCN: 14-0161 SAINT JAMES HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
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: 14-0161 SAINT JAMES HOSPITAL
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL	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	4,111		1,609	30
31 INTENSIVE CARE UNIT	829		537	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	459			43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	5,399		2,146	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-0161)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF			<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF				

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST					
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.10 ULTRASONOGRAPHY						54.10
54.20 MAMMOGRAPHY						54.20
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
63 BLOOD STORING, PROCESSING & T						63
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 DIABETES SERVICES						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
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 (14-0161)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,904,083		1,501,798		2,479,110	50
53	ANESTHESIOLOGY	1,521,857		201,870		187,212	53
54	RADIOLOGY-DIAGNOSTIC	5,293,055		380,932		1,250,456	54
54.10	ULTRASONOGRAPHY	3,096,180		77,567		720,473	54.10
54.20	MAMMOGRAPHY	1,645,545		1,223		58,846	54.20
56	RADIOISOTOPE	3,961,884		170,904		1,537,577	56
57	COMPUTED TOMOGRAPHY (CT) SCA	17,251,388		881,512		5,400,076	57
58	MAGNETIC RESONANCE IMAGING (8,219,679		259,151		2,071,464	58
60	LABORATORY	24,769,397		2,196,226		772,850	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
63	BLOOD STORING, PROCESSING &	327,409					63
65	RESPIRATORY THERAPY	983,696		282,173		239,833	65
66	PHYSICAL THERAPY	3,108,778		215,588		1,246	66
67	OCCUPATIONAL THERAPY	1,379,778		139,310			67
68	SPEECH PATHOLOGY	657,248		12,866		67,630	68
69	ELECTROCARDIOLOGY	4,850,669		448,692		1,747,131	69
71	MEDICAL SUPPLIES CHRGD TO P	10,371,999		2,415,088		1,399,092	71
72	IMPL. DEV. CHARGED TO PATIEN	9,129,581		2,913,472		387,046	72
73	DRUGS CHARGED TO PATIENTS	8,661,487		2,172,944		1,483,719	73
76	DIABETES SERVICES	142,820					76
76.97	CARDIAC REHABILITATION	173,434				104,769	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	8,146,678		497,895		1,615,058	91
92	OBSERVATION BEDS	1,837,587		142,522		630,943	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	129,434,232		14,911,733		22,154,531	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0161) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.325579	2,479,110			807,146			50
53 ANESTHESIOLOGY	0.057446	187,212			10,755			53
54 RADIOLOGY-DIAGNOSTIC	0.242161	1,250,456			302,812			54
54.10 ULTRASONOGRAPHY	0.138740	720,473			99,958			54.10
54.20 MAMMOGRAPHY	0.297116	58,846			17,484			54.20
56 RADIOISOTOPE	0.110268	1,537,577			169,546			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.054549	5,400,076			294,569			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.082487	2,071,464			170,869			58
60 LABORATORY	0.089732	772,850			69,349			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63 BLOOD STORING, PROCESSING & TRA	0.434707							63
65 RESPIRATORY THERAPY	0.511405	239,833			122,652			65
66 PHYSICAL THERAPY	0.449268	1,246			560			66
67 OCCUPATIONAL THERAPY	0.339954							67
68 SPEECH PATHOLOGY	0.826476	67,630			55,895			68
69 ELECTROCARDIOLOGY	0.085436	1,747,131			149,268			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.128514	1,399,092			179,803			71
72 IMPL. DEV. CHARGED TO PATIENT	0.251458	387,046			97,326			72
73 DRUGS CHARGED TO PATIENTS	0.212381	1,483,719		16,205	315,114		3,442	73
76 DIABETES SERVICES	0.908724							76
76.97 CARDIAC REHABILITATION	0.649267	104,769			68,023			76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.343723	1,615,058			555,133			91
92 OBSERVATION BEDS	0.634837	630,943			400,546			92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)		22,154,531		16,205	3,886,808		3,442	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		22,154,531		16,205	3,886,808		3,442	202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-U161)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.325579						50
53 ANESTHESIOLOGY	0.057446						53
54 RADIOLOGY-DIAGNOSTIC	0.242161						54
54.10 ULTRASONOGRAPHY	0.138740						54.10
54.20 MAMMOGRAPHY	0.297116						54.20
56 RADIOISOTOPE	0.110268						56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.054549						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.082487						58
60 LABORATORY	0.089732						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63 BLOOD STORING, PROCESSING & TRA	0.434707						63
65 RESPIRATORY THERAPY	0.511405						65
66 PHYSICAL THERAPY	0.449268						66
67 OCCUPATIONAL THERAPY	0.339954						67
68 SPEECH PATHOLOGY	0.826476						68
69 ELECTROCARDIOLOGY	0.085436						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.128514						71
72 IMPL. DEV. CHARGED TO PATIENT	0.251458						72
73 DRUGS CHARGED TO PATIENTS	0.212381						73
76 DIABETES SERVICES	0.908724						76
76.97 CARDIAC REHABILITATION	0.649267						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.343723						91
92 OBSERVATION BEDS	0.634837						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: 14-0161 SAINT JAMES HOSPITAL
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED 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	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	555,742		555,742	4,111	135.18	693	93,680	30
31 INTENSIVE CARE UNIT	155,241		155,241	829	187.26	57	10,674	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				459		367		43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	710,983		710,983	5,399		1,117	104,354	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0161) [] IPF [] IRF	[] SUB (OTHER)	[] PPS [] TEFRA [XX] OTHER	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS									
50					634,137	13,904,083	0.045608		50
53					12,485	1,521,857	0.008204		53
54					259,121	5,293,055	0.048955		54
54.10					47,625	3,096,180	0.015382		54.10
54.20					173,865	1,645,545	0.105658		54.20
56					22,734	3,961,884	0.005738		56
57					318,566	17,251,388	0.018466		57
58					27,460	8,219,679	0.003341		58
60					165,289	24,769,397	0.006673		60
62.30									62.30
63					5,393	327,409	0.016472		63
65					31,397	983,696	0.031917		65
66					132,365	3,108,778	0.042578		66
67					40,463	1,379,778	0.029326		67
68					61,655	657,248	0.093808		68
69					26,155	4,850,669	0.005392		69
71					80,190	10,371,999	0.007731		71
72					87,915	9,129,581	0.009630		72
73					88,182	8,661,487	0.010181		73
76					7,059	142,820	0.049426		76
76.97					21,730	173,434	0.125293		76.97
76.98									76.98
76.99									76.99
OUTPATIENT SERVICE COST CENTERS									
91					224,321	8,146,678	0.027535		91
92					120,314	1,837,587	0.065474		92
OTHER REIMBURSABLE COST CENTERS									
200					2,588,421	129,434,232			200

PROVIDER CCN: 14-0161 SAINT JAMES HOSPITAL
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
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: 14-0161 SAINT JAMES HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/26/2013 13:12

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	4,111		693	30
31 INTENSIVE CARE UNIT	829		57	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	459		367	43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	5,399		1,117	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-0161)	[]	SUB (OTHER)	[]	ICF/MR	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[XX]	OTHER
COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P				
	PHYSICIAN						SCHOOL	HEALTH	MEDICAL	COST
	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				
54.10	ULTRASONOGRAPHY					54.10				
54.20	MAMMOGRAPHY					54.20				
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				
63	BLOOD STORING, PROCESSING & T					63				
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	DIABETES SERVICES					76				
76.97	CARDIAC REHABILITATION					76.97				
76.98	HYPERBARIC OXYGEN THERAPY					76.98				
76.99	LITHOTRIPSY					76.99				
OUTPATIENT SERVICE COST CENTERS										
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 (14-0161) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO				
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x	CHARGES	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	CHARGES	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	13,904,083						50
53 ANESTHESIOLOGY	1,521,857						53
54 RADIOLOGY-DIAGNOSTIC	5,293,055						54
54.10 ULTRASONOGRAPHY	3,096,180						54.10
54.20 MAMMOGRAPHY	1,645,545						54.20
56 RADIOISOTOPE	3,961,884						56
57 COMPUTED TOMOGRAPHY (CT) SCA	17,251,388						57
58 MAGNETIC RESONANCE IMAGING (8,219,679						58
60 LABORATORY	24,769,397						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
63 BLOOD STORING, PROCESSING &	327,409						63
65 RESPIRATORY THERAPY	983,696						65
66 PHYSICAL THERAPY	3,108,778						66
67 OCCUPATIONAL THERAPY	1,379,778						67
68 SPEECH PATHOLOGY	657,248						68
69 ELECTROCARDIOLOGY	4,850,669						69
71 MEDICAL SUPPLIES CHRGED TO P	10,371,999						71
72 IMPL. DEV. CHARGED TO PATIEN	9,129,581						72
73 DRUGS CHARGED TO PATIENTS	8,661,487						73
76 DIABETES SERVICES	142,820						76
76.97 CARDIAC REHABILITATION	173,434						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	8,146,678						91
92 OBSERVATION BEDS	1,837,587						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	129,434,232						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0161) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.325579						50
53 ANESTHESIOLOGY	0.057446						53
54 RADIOLOGY-DIAGNOSTIC	0.242161						54
54.10 ULTRASONOGRAPHY	0.138740						54.10
54.20 MAMMOGRAPHY	0.297116						54.20
56 RADIOISOTOPE	0.110268						56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.054549						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.082487						58
60 LABORATORY	0.089732						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63 BLOOD STORING, PROCESSING & TRA	0.434707						63
65 RESPIRATORY THERAPY	0.511405						65
66 PHYSICAL THERAPY	0.449268						66
67 OCCUPATIONAL THERAPY	0.339954						67
68 SPEECH PATHOLOGY	0.826476						68
69 ELECTROCARDIOLOGY	0.085436						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.128514						71
72 IMPL. DEV. CHARGED TO PATIENT	0.251458						72
73 DRUGS CHARGED TO PATIENTS	0.212381						73
76 DIABETES SERVICES	0.908724						76
76.97 CARDIAC REHABILITATION	0.649267						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.343723						91
92 OBSERVATION BEDS	0.634837						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 (14-0161) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,325	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,111	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,220	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	214	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,609	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)	120	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,388,505	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,388,505	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,122,960	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	9,405	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,113,555	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.880049	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	9,405.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	1,898.62	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	7,506.38	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	6,605.98	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	6,606	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,381,899	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0161) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,310.75 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,108,997 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 2,108,997 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	1,604,455	829	1,935.41	537	1,039,315	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,992,888	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					6,141,200	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 318,064 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 240,689 51
 52 TOTAL PROGRAM EXCLUDABLE COST 558,753 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 5,582,447 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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 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 INSTRUCTIONS) (TITLE XVII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVII 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) 890 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,310.75 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,166,568 89

COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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	
90 CAPITAL-RELATED COST	555,742	5,388,505	0.103135	1,166,568	120,314	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 (14-0161) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,325	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,111	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,220	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	214	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	693	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)	459	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	367	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,388,505	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,388,505	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,122,960	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	9,405	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,113,555	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.880049	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	9,405.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	1,898.62	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	7,506.38	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	6,605.98	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	6,606	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,381,899	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0161) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,309.15 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 907,241 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) 907,241 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)		459		367		42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	1,604,455	829	1,935.41	57	110,318	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)					1,017,559	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 104,354 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 104,354 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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 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 INSTRUCTIONS) (TITLE XVII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVII 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) 890 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 (14-0161) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		1,907,263			30
31 INTENSIVE CARE UNIT		1,211,315			31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.325579	1,501,798	488,954		50
53 ANESTHESIOLOGY	0.057446	201,870	11,597		53
54 RADIOLOGY-DIAGNOSTIC	0.242161	380,932	92,247		54
54.10 ULTRASONOGRAPHY	0.138740	77,567	10,762		54.10
54.20 MAMMOGRAPHY	0.297116	1,223	363		54.20
56 RADIOISOTOPE	0.110268	170,904	18,845		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.054549	881,512	48,086		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.082487	259,151	21,377		58
60 LABORATORY	0.089732	2,196,226	197,072		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRA	0.434707				63
65 RESPIRATORY THERAPY	0.511405	282,173	144,305		65
66 PHYSICAL THERAPY	0.449268	215,588	96,857		66
67 OCCUPATIONAL THERAPY	0.339954	139,310	47,359		67
68 SPEECH PATHOLOGY	0.826476	12,866	10,633		68
69 ELECTROCARDIOLOGY	0.085436	448,692	38,334		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.128514	2,415,088	310,373		71
72 IMPL. DEV. CHARGED TO PATIENT	0.251458	2,913,472	732,616		72
73 DRUGS CHARGED TO PATIENTS	0.212381	2,172,944	461,492		73
76 DIABETES SERVICES	0.908724				76
76.97 CARDIAC REHABILITATION	0.649267				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.343723	497,895	171,138		91
92 OBSERVATION BEDS	0.634837	142,522	90,478		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		14,911,733	2,992,888		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		14,911,733			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-U161) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.325579	86	28		50
53 ANESTHESIOLOGY	0.057446				53
54 RADIOLOGY-DIAGNOSTIC	0.242161	1,163	282		54
54.10 ULTRASONOGRAPHY	0.138740	687	95		54.10
54.20 MAMMOGRAPHY	0.297116	3	1		54.20
56 RADIOISOTOPE	0.110268				56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.054549				57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.082487				58
60 LABORATORY	0.089732	21,798	1,956		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRA	0.434707				63
65 RESPIRATORY THERAPY	0.511405	3,015	1,542		65
66 PHYSICAL THERAPY	0.449268	28,373	12,747		66
67 OCCUPATIONAL THERAPY	0.339954	29,755	10,115		67
68 SPEECH PATHOLOGY	0.826476				68
69 ELECTROCARDIOLOGY	0.085436				69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.128514	34,444	4,427		71
72 IMPL. DEV. CHARGED TO PATIENT	0.251458				72
73 DRUGS CHARGED TO PATIENTS	0.212381	62,693	13,315		73
76 DIABETES SERVICES	0.908724				76
76.97 CARDIAC REHABILITATION	0.649267				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.343723	20	7		91
92 OBSERVATION BEDS	0.634837				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		182,037	44,515		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		182,037			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0161) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.325579			50
53 ANESTHESIOLOGY	0.057446			53
54 RADIOLOGY-DIAGNOSTIC	0.242161			54
54.10 ULTRASONOGRAPHY	0.138740			54.10
54.20 MAMMOGRAPHY	0.297116			54.20
56 RADIOISOTOPE	0.110268			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.054549			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.082487			58
60 LABORATORY	0.089732			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.434707			63
65 RESPIRATORY THERAPY	0.511405			65
66 PHYSICAL THERAPY	0.449268			66
67 OCCUPATIONAL THERAPY	0.339954			67
68 SPEECH PATHOLOGY	0.826476			68
69 ELECTROCARDIOLOGY	0.085436			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.128514			71
72 IMPL. DEV. CHARGED TO PATIENT	0.251458			72
73 DRUGS CHARGED TO PATIENTS	0.212381			73
76 DIABETES SERVICES	0.908724			76
76.97 CARDIAC REHABILITATION	0.649267			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.343723			91
92 OBSERVATION BEDS	0.634837			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (14-0161)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	4,409,790	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	67,532	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	38.98	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0318	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.2588	31
32	SUM OF LINES 30 AND 31	0.2906	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1200	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	529,175	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	5,006,497	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	5,678,362	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	5,678,362	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	362,256	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (14-0161)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	6,040,618	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	6,040,618	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	570,064	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	1,156	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	110,161	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	77,113	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	106,055	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	5,546,511	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.97	LOW VOLUME PAYMENT ADJUSTMENT - 2	977,287	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	6,523,798	71
72	INTERIM PAYMENTS	6,284,989	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	238,809	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	261,827	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL (14-0161) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,442	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	3,886,808	2
3	PPS PAYMENTS	4,119,811	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	3,442	11
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	16,205	12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)	16,205	14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	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)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16,205	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	12,763	19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,442	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	4,119,811	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	1,024,186	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,099,067	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	3,099,067	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,099,067	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	220,502	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	154,351	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	208,303	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	3,253,418	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	3,253,418	40
41	INTERIM PAYMENTS	3,360,866	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-107,448	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK HOSPITAL (14-0161) SUB (OTHER)
 APPLICABLE IPF SNF
 BOX: IRF SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		6,284,989		3,341,766	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	.01	NONE			3.01
	.02		05/01/2012	19,100	3.02
	.03				3.03
	.04				3.04
	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.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			19,100	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		6,284,989		3,360,866	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	.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:		NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER) INPATIENT
 APPLICABLE [] IPF [] SNF PART A PART B
 BOX: [] IRF [XX] SWING BED SNF (14-U161)

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		31,089		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		3.01
	.02			3.02
	.03			3.03
	.04			3.04
	.05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50	NONE		3.50
	.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)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		31,089		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02			5.02
	PROVIDER .03			5.03
	.04			5.04
	.05			5.05
	.06			5.06
	.07			5.07
	.08			5.08
	.09			5.09
	PROVIDER .50			5.50
	TO .51			5.51
	PROGRAM .52			5.52
	.53			5.53
	.54			5.54
	.55			5.55
	.56			5.56
	.57			5.57
	.58			5.58
	.59			5.59
	.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			6.01
	TO .02			6.02
	PROVIDER .03			6.03
	PROVIDER .04			6.04
	TO .05			6.05
	PROGRAM .06			6.06
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ NPR DATE: _____ 8

PROVIDER CCN: 14-0161 SAINT JAMES HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/26/2013 13:12

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0161) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,521	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,146	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	213	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,050	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	136,258,526	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	10,190,269	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)	979,485	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	989,032	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 + LINE 31)	-9,547	32

PROVIDER CCN: 14-0161 SAINT JAMES HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/26/2013 13:12

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-U161)
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)	31,089	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)		3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	120	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)	31,089	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	31,089	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	31,089	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		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)	31,089	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)	31,089	19
20 INTERIM PAYMENTS	31,089	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)		22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0161) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES	1,017,559	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	1,017,559	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	1,017,559	7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	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))	1,017,559	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	702,362	285,841	882,223	1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	34,038,333			4
5	OTHER RECEIVABLES	3,178,681			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-24,312,848			6
7	INVENTORY	570,332			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS	19,690			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	14,196,550	285,841	882,223	11
FIXED ASSETS					
12	LAND	749,404			12
13	LAND IMPROVEMENTS	2,287,903			13
14	ACCUMULATED DEPRECIATION	-1,854,976			14
15	BUILDINGS	36,170,456			15
16	ACCUMULATED DEPRECIATION	-16,810,434			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	29,756,639			23
24	ACCUMULATED DEPRECIATION	-24,680,940			24
25	MINOR EQUIPMENT DEPRECIABLE	97,230			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)	25,715,282			30
OTHER ASSETS					
31	INVESTMENTS	14,789,832			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	500,000			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	15,289,832			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	55,201,664	285,841	882,223	36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	825,051			37
38	SALARIES, WAGES & FEES PAYABLE	4,494,220			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	1,705,077			43
44	OTHER CURRENT LIABILITIES	503,601			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	7,527,949			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	61,000			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	61,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	7,588,949			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	47,612,715			52
53	SPECIFIC PURPOSE FUND BALANCE		285,841		53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			882,223	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)	47,612,715	285,841	882,223	59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	55,201,664	285,841	882,223	60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD	49,217,171			148,719		881,093			1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	-1,604,456								2
3 TOTAL (SUM OF LINE 1 AND LINE 2)	47,612,715			148,719		881,093			3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 RESTRICTED ASSETS			137,122		1,130				5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)				137,122		1,130			10
11 SUBTOTAL (LINE 3 PLUS LINE 10)	47,612,715			285,841		882,223			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	47,612,715			285,841		882,223			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	4,232,035		4,232,035	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	4,232,035		4,232,035	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	1,890,925		1,890,925	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	1,890,925		1,890,925	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	6,122,960		6,122,960	17
18 ANCILLARY SERVICES	33,579,110	103,261,702	136,840,812	18
19 OUTPATIENT SERVICES		29,263,751	29,263,751	19
20 RHC				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)	39,702,070	132,525,453	172,227,523	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		63,211,729	29
30 ADD (SPECIFY)			30
31 BAD DEBTS	3,075,000		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		3,075,000	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)		66,286,729	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	172,227,523	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	111,095,088	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	61,132,435	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	66,286,729	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-5,154,294	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	253,245	6
7	INCOME FROM INVESTMENTS	981,376	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		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		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER REVENUES)	2,315,217	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,549,838	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,604,456	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-1,604,456	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-016) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT		
2	CAPITAL DRG OTHER THAN OUTLIER	356,624	1
3	CAPITAL DRG OUTLIER PAYMENTS	5,632	2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	11.07	3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
10	SUM OF LINES 7 AND 8		9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	362,256	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
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.10 ULTRASONOGRAPHY					54.10
54.20 MAMMOGRAPHY					54.20
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
63 BLOOD STORING, PROCESSING & TR					63
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 DIABETES SERVICES					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 CARDIAC PHASE III					192.01
192.02 FUND DEVELOPMENT					192.02
192.03 PULMONARY FUNCTION					192.03
193 NONPAID WORKERS					193
194 CONTRACT NURSING					194
194.01 NON-PATIENT DIETARY					194.01
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