

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: 11-28-2012 TIME: 17:00  
 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 ST. FRANCIS HOSPITAL (14-1350) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, 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		-136,992	-20,850		483,376	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		61,865				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		-75,127	-20,850		483,376	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: 1215 FRANCISCAN DRIVE  
 2 CITY: LITCHFIELD

STATE: IL

P.O. BOX:  
 ZIP CODE: 62056

COUNTY: MONTGOMERY

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			
							2	3	4	5
3	HOSPITAL	ST. FRANCIS HOSPITAL	14-1350	00014	1	12/01/2005	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	ST. FRANCIS HOSPITAL	14-2350	00014		05/31/2007	N	O	O	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: 07/01/2011 TO: 06/30/2012									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.									1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.									1	N 23

		IN-STATE MEDICAID						OUT-OF-STATE MEDICAID		OTHER MEDICAID
		IN-STATE MEDICAID PAID		OUT-OF-STATE MEDICAID PAID		OUT-OF-STATE MEDICAID UNPAID		HMO		
		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.									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 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.									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.									35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						BEGINNING:		ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						BEGINNING:		ENDING:	38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR 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 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
<b>LONG TERM CARE HOSPITAL PPS</b>				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
<b>TEFRA PROVIDERS</b>				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- SICAL ATIONAL N N	RESPI- RATORY N 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.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 92,013 PAID LOSSES: SELF INSURANCE: 440,101			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.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 Y	2 148005	140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: HOSPITAL SISTERS HEALTH SYSTEM CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES CONTRACTOR'S NUMBER: 00131			141
142	STREET: 4736 LAVERNA ROAD P.O. BOX:			142
143	CITY: SPRINGFIELD STATE: IL ZIP CODE: 62794			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	N	161

MULTICAMPUS

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

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

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

(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N	2	1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
<b>FINANCIAL DATA AND REPORTS</b>					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5	
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
			Y/N		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y	12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N	13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14	
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15	
<b>PS&amp;R REPORT DATA</b>					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	10/29/2012	Y	10/29/2012
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)	N		N	
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. N 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 27

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- |                                  |  |                             |    |
|----------------------------------|--|-----------------------------|----|
| 41 FIRST NAME: SUSAN             | LAST NAME: HORST                         | TITLE: DIRECTOR, THIRD PART | 41 |
| 42 EMPLOYER: ST. JOHN'S HOSPITAL |  |                             | 42 |
| 43 PHONE NUMBER: 217-814-4395    | E-MAIL ADDRESS: SUSAN.HORST@ST-JOHNS.ORG |                             | 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	10,276,223			1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE					4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		235,233			10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING WAGE-RELATED COSTS					16
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - 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) OVERHEAD COSTS - DIRECT SALARIES					25
26	EMPLOYEE BENEFITS		102,615			26
27	ADMINISTRATIVE & GENERAL		2,082,884			27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS		252,827			29
30	OPERATION OF PLANT		67,232			30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING		288,880			32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		344,172	-239,474		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA			239,474		36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		179,076			38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY		298,257			40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		275,023			41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	10,276,223		10,276,223		1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		235,233		235,233	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	10,040,990		10,040,990		3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)					4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)					5
6	TOTAL (SUM OF LINES 3 THRU 5)	10,040,990		10,040,990		6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)		3,890,966		3,890,966	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	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)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
11/28/2012 17:00

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			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 OLTG			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
 11/28/2012 17:00

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE				
		1	2				
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1			
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N		2			
							TOTAL
	GROUP	SNF	SWING BED	(COLS.			
	1	DAYS	SNF DAYS	2 + 3)			
		2	3	4			
3	RUX						3
4	RUL						4
5	RVX						5
6	RVL						6
7	RHX						7
8	RHL						8
9	RMX						9
10	RML						10
11	RLX						11
12	RUC						12
13	RUB						13
14	RUA						14
15	RVC						15
16	RVB						16
17	RVA						17
18	RHC						18
19	RHB						19
20	RHA						20
21	RMC						21
22	RMB						22
23	RMA						23
24	RLB						24
25	RLA						25
26	ES3						26
27	ES2						27
28	ES1						28
29	HE2						29
30	HE1						30
31	HD2						31
32	HD1						32
33	HC2						33
34	HC1						34
35	HB2						35
36	HB1						36
37	LE2						37
38	LE1						38
39	LD2						39
40	LD1						40
41	LC2						41
42	LC1						42
43	LB2						43
44	LB1						44
45	CE2						45
46	CE1						46
47	CD2						47
48	CD1						48
49	CC2						49
50	CC1						50
51	CB2						51
52	CB1						52
53	CA2						53
54	CA1						54
55	SE3						55
56	SE2						56
57	SE1						57
58	SSC						58
59	SSB						59
60	SSA						60
61	IB2						61
62	IB1						62
63	IA1						63
64	IA2						64
65	BB2						65
66	BB1						66
67	BA2						67
68	BA1						68

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
 11/28/2012 17:00

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

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

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

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

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

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)				0.303511	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				4,325,534	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				18,760,670	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				5,694,070	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.				1,368,536	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				964	17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				19,432	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,368,536	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	1,458,711	147,997	1,606,708		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	442,735	44,919	487,654		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	84,684	20,510	105,194		22
23	COST OF CHARITY CARE	358,051	24,409	382,460		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)					25
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				2,595,807	26
27	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				812,143	27
28	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				1,783,664	28
29	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				541,362	29
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				923,822	30
31					2,292,358	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS		
		1	2	3	4		
GENERAL SERVICE COST CENTERS							
1	00100		444,483	444,483	33,152	1	
2	00200		874,463	874,463		2	
3	00300					3	
4	00400	102,615	3,911,348	4,013,963	21,732	4	
5.01	00570	362,507	104,213	466,720		5.01	
5.02	00580	282,965	185,111	468,076	8,134	5.02	
5.03	00590	1,437,412	4,424,241	5,861,653	-228,719	5.03	
6	00600	252,827	26,475	279,302		6	
7	00700	67,232	914,365	981,597	-31,942	7	
8	00800		-346	-346	95,919	8	
9	00900	288,880	164,573	453,453		9	
10	01000	344,172	297,820	641,992	-422,247	10	
11	01100				421,491	11	
12	01200					12	
13	01300	179,076	7,115	186,191		13	
14	01400					14	
15	01500	298,257	919,207	1,217,464	-616,088	15	
16	01600	275,023	239,989	515,012		16	
17	01700					17	
19	01900					19	
20	02000					20	
21	02100					21	
22	02200					22	
23	02300					23	
INPATIENT ROUTINE SERV COST CENTERS							
30	03000	2,322,720	183,835	2,506,555	-1,167,201	30	
43	04300				71,977	43	
ANCILLARY SERVICE COST CENTERS							
50	05000	807,137	915,986	1,723,123	-550,588	50	
52	05200				348,357	52	
53	05300		773,798	773,798	-13,714	53	
54	05400	877,915	419,952	1,297,867	-17,012	54	
57	05700	41,885	165,183	207,068	2,262	57	
58	05800	74,716	188,239	262,955	5,361	58	
60	06000	613,872	1,041,224	1,655,096	99,350	60	
62.30	06250					62.30	
65	06500	245,668	115,738	361,406	5,147	65	
66	06600	237,948	55,095	293,043	-2,336	66	
71	07100		65,517	65,517	240,146	71	
72	07200				359,103	72	
73	07300				1,373,357	73	
76.97	07697	115,819	14,711	130,530		76.97	
76.98	07698					76.98	
76.99	07699					76.99	
OUTPATIENT SERVICE COST CENTERS							
91	09100	812,344	1,822,291	2,634,635	-33,175	91	
92	09200					92	
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)		10,040,990	18,274,626	28,315,616	2,466	118
NONREIMBURSABLE COST CENTERS							
190	19000		36,448	36,448		190	
192	19200	173,242	569,304	742,546	-21,730	192	
192.01	19201				19,264	192.01	
194	07950	61,991	85,485	147,476		194	
200	TOTAL (SUM OF LINES 118-199)		10,276,223	18,965,863	29,242,086	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	477,635		477,635	1
2	00200	874,463		874,463	2
3	00300				3
4	00400	4,035,695	-630,181	3,405,514	4
5.01	00570	466,720		466,720	5.01
5.02	00580	476,210	-1,321	474,889	5.02
5.03	00590	5,632,934	-1,404,322	4,228,612	5.03
6	00600	279,302		279,302	6
7	00700	949,655		949,655	7
8	00800	95,573		95,573	8
9	00900	453,453		453,453	9
10	01000	219,745		219,745	10
11	01100	421,491	-1,599	419,892	11
12	01200				12
13	01300	186,191	-70	186,121	13
14	01400				14
15	01500	601,376		601,376	15
16	01600	515,012	-502	514,510	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,339,354		1,339,354	30
43	04300	71,977		71,977	43
ANCILLARY SERVICE COST CENTERS					
50	05000	1,172,535		1,172,535	50
52	05200	348,357		348,357	52
53	05300	760,084	-644,516	115,568	53
54	05400	1,280,855		1,280,855	54
57	05700	209,330		209,330	57
58	05800	268,316		268,316	58
60	06000	1,754,446	-110	1,754,336	60
62.30	06250				62.30
65	06500	366,553	-54,150	312,403	65
66	06600	290,707	-450	290,257	66
71	07100	305,663		305,663	71
72	07200	359,103		359,103	72
73	07300	1,373,357		1,373,357	73
76.97	07697	130,530	-11,044	119,486	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
91	09100	2,601,460	-1,590,277	1,011,183	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118		28,318,082	-4,338,542	23,979,540	118
NONREIMBURSABLE COST CENTERS					
190	19000	36,448		36,448	190
192	19200	720,816	-234,023	486,793	192
192.01	19201	19,264		19,264	192.01
194	07950	147,476		147,476	194
200		29,242,086	-4,572,565	24,669,521	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 RECLASSIFY L&D AND NURSERY COSTS	A	NURSERY	43	65,208	7,000	1
2 RECLASSIFY L&D AND NURSERY COSTS	A	DELIVERY ROOM & LABOR ROOM	52	408,007	43,797	2
500 TOTAL RECLASSIFICATIONS				473,215	50,797	500
CODE LETTER -						
1 RECLASSIFY DRUG COSTS	B	DRUGS CHARGED TO PATIENTS	73		758,411	1
500 TOTAL RECLASSIFICATIONS					758,411	500
CODE LETTER - B						
1 RECLASSIFY CAFETERIA COSTS	C	CAFETERIA	11	239,474	182,017	1
500 TOTAL RECLASSIFICATIONS				239,474	182,017	500
CODE LETTER - C						
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11 RECLASSIFY LAUNDRY COSTS	D	LAUNDRY & LINEN SERVICE	8		95,919	11
500 TOTAL RECLASSIFICATIONS					95,919	500
CODE LETTER -						
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10 RECLASSIFY MEDICAL SUPPLY COSTS	E	MEDICAL SUPPLIES CHRGED TO PA	71		240,146	9
500 TOTAL RECLASSIFICATIONS	E	IMPL. DEV. CHARGED TO PATIENT	72		359,103	10
CODE LETTER -					599,249	500
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10 RECLASSIFY MEDICAL SUPPLY COSTS	E	MEDICAL SUPPLIES CHRGED TO PA	71		240,146	9
500 TOTAL RECLASSIFICATIONS	E	IMPL. DEV. CHARGED TO PATIENT	72		359,103	10
CODE LETTER -					599,249	500
1						1
2						2
3						3
4						4
5 DRUG ADMINISTRATION COSTS	F	LABORATORY	60	73,579	3,871	4
500 TOTAL RECLASSIFICATIONS	F	DRUGS CHARGED TO PATIENTS	73	583,820	31,324	5
CODE LETTER -				657,399	35,195	500
1 RECLASSIFY DEPREC COSTS FOR MOB	G	MEDICAL OFFICE BUILDING	192.01		19,264	1
500 TOTAL RECLASSIFICATIONS					19,264	500
CODE LETTER - G						
1		EMPLOYEE BENEFITS	4		21,732	1
2		PATIENT ACCOUNTING	5.02		8,337	2
3		PHARMACY	15		142,323	3
4		ADULTS & PEDIATRICS	30		1,601	4
5		OPERATING ROOM	50		472	5
6		RADIOLOGY-DIAGNOSTIC	54		2,409	6
7		LABORATORY	60		22,873	7
8 RECLASSIFY SHARED SERVICE COSTS	H	RESPIRATORY THERAPY	65		28,972	8
500 TOTAL RECLASSIFICATIONS					228,719	500
CODE LETTER -						
1						1
2						2
3 RECLASSIFY BUILDING INSURANCE COSTS	I	CAP REL COSTS-BLDG & FIXT	1		33,152	3
500 TOTAL RECLASSIFICATIONS					33,152	500
CODE LETTER -						

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
11/28/2012 17:00

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- COST CENTER	INCREASE LINE #	SALARY	OTHER
	1	2	3	4	5
1		COMPUTED TOMOGRAPHY (CT) SCAN	57	3,735	1
2 RECLASSIFY RADIOLOGY MGR COSTS	J	MAGNETIC RESONANCE IMAGING (M	58	6,037	2
500 TOTAL RECLASSIFICATIONS				9,772	500
CODE LETTER -					
GRAND TOTAL (INCREASES)				1,379,860	2,002,723

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 RECLASSIFY L&D AND NURSERY COSTS	A	ADULTS & PEDIATRICS	30	473,215	50,797	1
500 TOTAL RECLASSIFICATIONS				473,215	50,797	500
CODE LETTER -						
1 RECLASSIFY DRUG COSTS	B	PHARMACY	15		758,411	1
500 TOTAL RECLASSIFICATIONS					758,411	500
CODE LETTER - B						
1 RECLASSIFY CAFETERIA COSTS	C	DIETARY	10	239,474	182,017	1
500 TOTAL RECLASSIFICATIONS				239,474	182,017	500
CODE LETTER - C						
1 RECLASSIFY LAUNDRY COSTS	D	PHYSICIANS' PRIVATE OFFICES	192		1,459	11
500 TOTAL RECLASSIFICATIONS					95,919	500
CODE LETTER -						
1 RECLASSIFY MEDICAL SUPPLY COSTS	E	EMERGENCY	91		16,531	10
500 TOTAL RECLASSIFICATIONS					599,249	500
CODE LETTER -						
1 RECLASSIFY DEPREC COSTS FOR MOB	G	PHYSICIANS' PRIVATE OFFICES	192		19,264	1
500 TOTAL RECLASSIFICATIONS					19,264	500
CODE LETTER - G						
1 RECLASSIFY SHARED SERVICE COSTS	H	ADMIN & GENERAL	5.03		228,719	8
500 TOTAL RECLASSIFICATIONS					228,719	500
CODE LETTER -						
1 RECLASSIFY BUILDING INSURANCE COSTS	I	PHYSICIANS' PRIVATE OFFICES	192		1,007	12
500 TOTAL RECLASSIFICATIONS					33,152	500
CODE LETTER -						

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
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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						1
2 RECLASSIFY RADIOLOGY MGR COSTS	J	RADIOLOGY-DIAGNOSTIC	54	9,772		2
500 TOTAL RECLASSIFICATIONS				9,772		500
CODE LETTER -						
GRAND TOTAL (DECREASES)				1,379,860	2,002,723	

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	76,883					76,883		1
2 LAND IMPROVEMENTS	1,007,759	64,365		64,365		1,072,124	739,384	2
3 BUILDINGS AND FIXTURES	15,996,670	6,561,087		6,561,087		22,557,757	6,271,149	3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	16,351,673	792,717		792,717	548,312	16,596,078	10,487,745	6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	33,432,985	7,418,169		7,418,169	548,312	40,302,842	17,498,278	8
9 RECONCILING ITEMS	1,100,720	1,075,976		1,075,976		2,176,696		9
10 TOTAL (LINE 7 MINUS LINE 9)	32,332,265	6,342,193		6,342,193	548,312	38,126,146	17,498,278	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)	
							(SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	444,483						444,483	1
2 CAP REL COSTS-MVBLE EQUIP	874,463						874,463	2
3 TOTAL (SUM OF LINES 1-2)	1,318,946						1,318,946	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)	
							(SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	444,483			33,152			477,635	1
2 CAP REL COSTS-MVBLE EQUIP	874,463						874,463	2
3 TOTAL	1,318,946			33,152			1,352,098	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)	B	-1,311	CAFETERIA	11	5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,299,987			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-299,835			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-288	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-502	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 MISCELLANEOUS INCOME	B	-224,927	ADMIN & GENERAL	5.03	33
33.01 MISCELLANEOUS INCOME	B	-70	NURSING ADMINISTRATION	13	33.01
33.02 MISCELLANEOUS INCOME	B	-110	LABORATORY	60	33.02
33.03 MISCELLANEOUS INCOME	B	-450	PHYSICAL THERAPY	66	33.03
34					34
35 MEDICAID TAX ASSESSMENT	A	-651,465	ADMIN & GENERAL	5.03	35
36 PHYSICIAN RECRUITMENT	A	-272,484	ADMIN & GENERAL	5.03	36
37 NONALLOWABLE LEGAL FEES	A	-1,850	ADMIN & GENERAL	5.03	37
38 SELF-INS TO HOSP/EMPLOYEE CLAIMS	A	-518,566	EMPLOYEE BENEFITS	4	38
39 INTEREST EXPENSE	A	-15,418	ADMIN & GENERAL	5.03	39
40					40
41 CHARITY EXPENSE	A	-1,321	PATIENT ACCOUNTING	5.02	41
42 NONALLOW LOBBYING/ADVERTISING EXP	A	-49,826	ADMIN & GENERAL	5.03	42
42.01 NONALLOWABLE ALCOHOL EXPENSE	A	-132	ADMIN & GENERAL	5.03	42.01
43 PURCGASED SVCS-HSHS MEDICAL GRP	A	-234,023	PHYSICIANS' PRIVATE OFFICES	192	43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,572,565			50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	4	EMPLOYEE BENEFITS	1,895,664	2,007,279	-111,615	1
2	4	EMPLOYEE BENEFITS	7,544	7,544		2
3	5.03	ADMIN & GENERAL	1,689,180	1,877,400	-188,220	3
4	5.03	ADMIN & GENERAL	293,355	293,355		4
4.01	5.03	ADMIN & GENERAL	374,598	374,598		4.01
4.02	8	LAUNDRY & LINEN SERVICE	132,279	132,279		4.02
4.03	60	LABORATORY	111,262	111,262		4.03
4.04	60	LABORATORY	6,732	6,732		4.04
4.05	66	PHYSICAL THERAPY	40,037	40,037		4.05
4.06	71	MEDICAL SUPPLIES CHRGED TO PATI	248	248		4.06
4.07	71	MEDICAL SUPPLIES CHRGED TO PATI	92	92		4.07
4.08	71	MEDICAL SUPPLIES CHRGED TO PATI	801	801		4.08
4.09	73	DRUGS CHARGED TO PATIENTS	2,648	2,648		4.09
5		TOTALS (SUM OF LINES 1-4)	4,554,440	4,854,275	-299,835	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

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

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

		----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
SYMBOL	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
(1)	2	3	4	5	6
6	B		HOSPITAL SISTERS HEALTH SYSTEM	100.00	CORPORATE OFFICE
7	G		ST. MARY'S HOSPITAL		HOSPITAL
8	G		ST. JOHN'S HOSPITAL		HOSPITAL
9	G		ST. JOSEPH'S HOSPITAL-BREESE		HOSPITAL
10	G		ST. ELIZABETH'S HOSPITAL		HOSPITAL

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
  - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
  - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
  - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
  - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
  - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
  - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY: FINANCIAL

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	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	644,516	644,516					1
2	60 LABORATORY	30,000		30,000				2
3	65 RESPIRATORY THERAPY	54,150	54,150					3
4	76.97 CARDIAC REHABILITATION	11,044	11,044					4
5	91 EMERGENCY	1,749,250	1,590,277	158,973				5
200	TOTAL	2,488,960	2,299,987	188,973				200

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
 11/28/2012 17:00

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	53 ANESTHESIOLOGY							644,516	1
2	60 LABORATORY								2
3	65 RESPIRATORY THERAPY							54,150	3
4	76.97 CARDIAC REHABILITATION							11,044	4
5	91 EMERGENCY							1,590,277	5
200	TOTAL							2,299,987	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	ADMITTING 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	477,635	477,635				1
2 CAP REL COSTS-MVBLE EQUIP	874,463		874,463			2
4 EMPLOYEE BENEFITS	3,405,514	9,908	5,550	3,420,972		4
5.01 ADMITTING	466,720	3,910	5,667	121,896	598,193	5.01
5.02 PATIENT ACCOUNTING	474,889	22,094	1,233	95,150		5.02
5.03 ADMIN & GENERAL	4,228,612	89,165	175,690	483,347		5.03
6 MAINTENANCE & REPAIRS	279,302			85,015		6
7 OPERATION OF PLANT	949,655	95,455	8,574	22,607		7
8 LAUNDRY & LINEN SERVICE	95,573	3,893				8
9 HOUSEKEEPING	453,453	4,863	365	97,138		9
10 DIETARY	219,745	26,543	11,375	35,206		10
11 CAFETERIA	419,892	7,540		80,525		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	186,121	2,324	23,779	60,216		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	601,376	3,913	2,425	100,292		15
16 MEDICAL RECORDS & LIBRARY	514,510	7,001	12,591	92,479		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	1,339,354	60,915	40,130	432,035	32,206	30
43 NURSERY	71,977	2,248		21,917	1,569	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,172,535	21,982	172,306	271,407	42,919	50
52 DELIVERY ROOM & LABOR ROOM	348,357	6,621		106,325	7,786	52
53 ANESTHESIOLOGY	115,568	764	40,754		24,969	53
54 RADIOLOGY-DIAGNOSTIC	1,280,855	18,398	134,130	291,921	83,219	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	209,330	1,372	131,900	15,340	92,736	57
58 MAGNETIC RESONANCE IMAGING (MRI)	268,316			27,154	38,180	58
60 LABORATORY	1,754,336	13,336	51,511	231,162	85,021	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	312,403	7,014	21,563	82,608	23,084	65
66 PHYSICAL THERAPY	290,257	16,334	6,248	79,912	11,797	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	305,663	6,020			23,027	71
72 IMPL. DEV. CHARGED TO PATIENT	359,103	1,446			7,089	72
73 DRUGS CHARGED TO PATIENTS	1,373,357			196,315	42,657	73
76.97 CARDIAC REHABILITATION	119,486	4,751	14,533	38,945	2,188	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,011,183	14,906	9,136	272,961	79,746	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	23,979,540	452,716	869,460	3,341,873	598,193	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,448	996	368			190
192 PHYSICIANS' PRIVATE OFFICES	486,793	23,923	3,918	58,254		192
192.01 MEDICAL OFFICE BUILDING	19,264					192.01
194 OTHER NONALLOWABLE	147,476		717	20,845		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	24,669,521	477,635	874,463	3,420,972	598,193	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	PATIENT ACCOUNTING 5.02	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5.03	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING	593,366					5.02
5.03 ADMIN & GENERAL		4,976,814	4,976,814			5.03
6 MAINTENANCE & REPAIRS		364,317	92,072	456,389		6
7 OPERATION OF PLANT		1,076,291	272,005	123,569	1,471,865	7
8 LAUNDRY & LINEN SERVICE		99,466	25,137	5,039	22,285	8
9 HOUSEKEEPING		555,819	140,469	6,295	27,841	9
10 DIETARY		292,869	74,015	34,361	151,956	10
11 CAFETERIA		507,957	128,373	9,761	43,165	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		272,440	68,852	3,009	13,306	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		708,006	178,930	5,065	22,402	15
16 MEDICAL RECORDS & LIBRARY		626,581	158,352	9,063	40,080	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	31,944	1,936,584	489,421	78,855	348,731	30
43 NURSERY	1,556	99,267	25,087	2,910	12,868	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	42,570	1,723,719	435,625	28,455	125,841	50
52 DELIVERY ROOM & LABOR ROOM	7,723	476,812	120,502	8,570	37,901	52
53 ANESTHESIOLOGY	24,765	206,820	52,268	989	4,372	53
54 RADIOLOGY-DIAGNOSTIC	82,542	1,891,065	477,918	23,816	105,325	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	92,024	542,702	137,154	1,776	7,852	57
58 MAGNETIC RESONANCE IMAGING (MRI)	37,870	371,520	93,892			58
60 LABORATORY	84,329	2,219,695	560,965	17,263	76,344	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	22,896	469,568	118,671	9,080	40,153	65
66 PHYSICAL THERAPY	11,701	416,249	105,196	21,145	93,510	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	22,839	357,549	90,361	7,793	34,465	71
72 IMPL. DEV. CHARGED TO PATIENT	7,031	374,669	94,688	1,871	8,276	72
73 DRUGS CHARGED TO PATIENTS	42,309	1,654,638	418,167			73
76.97 CARDIAC REHABILITATION	2,170	182,073	46,014	6,150	27,198	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	79,097	1,467,029	370,753	19,296	85,337	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	593,366	23,870,519	4,774,887	424,131	1,329,208	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		37,812	9,556	1,290	5,703	190
192 PHYSICIANS' PRIVATE OFFICES		572,888	144,783	30,968	136,954	192
192.01 MEDICAL OFFICE BUILDING		19,264	4,868			192.01
194 OTHER NONALLOWABLE		169,038	42,720			194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	593,366	24,669,521	4,976,814	456,389	1,471,865	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINISTRATION 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 ADMIN & GENERAL						5.03
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	151,927					8
9 HOUSEKEEPING		730,424				9
10 DIETARY	1,172		554,373			10
11 CAFETERIA				689,256		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		8,545		5,148	371,300	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		4,928		37,867		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	77,054	250,674	554,373	197,185	193,685	30
43 NURSERY	3,394	8,474		5,198	5,106	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	20,253	85,590		76,397	75,041	50
52 DELIVERY ROOM & LABOR ROOM	6,254			32,618	32,039	52
53 ANESTHESIOLOGY		4,751				53
54 RADIOLOGY-DIAGNOSTIC	7,144	35,739		79,812		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	2,284	6,524		3,924		57
58 MAGNETIC RESONANCE IMAGING (MRI)	938			6,371		58
60 LABORATORY	1,500	16,026		60,445		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	952	21,557		27,929		65
66 PHYSICAL THERAPY	4,418	13,473		19,265		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		8,474				71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS		13,331		20,641		73
76.97 CARDIAC REHABILITATION		17,267		9,734		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	22,945	105,055		66,612	65,429	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	148,308	600,408	554,373	649,146	371,300	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,581				190
192 PHYSICIANS' PRIVATE OFFICES	3,619	126,435		34,402		192
192.01 MEDICAL OFFICE BUILDING						192.01
194 OTHER NONALLOWABLE				5,708		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	151,927	730,424	554,373	689,256	371,300	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 ADMIN & GENERAL						5.03
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	914,403					15
16 MEDICAL RECORDS & LIBRARY		876,871				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		47,206	4,173,768		4,173,768	30
43 NURSERY		2,300	164,604		164,604	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		62,909	2,633,830		2,633,830	50
52 DELIVERY ROOM & LABOR ROOM		11,413	726,109		726,109	52
53 ANESTHESIOLOGY		36,598	305,798		305,798	53
54 RADIOLOGY-DIAGNOSTIC		121,978	2,742,797		2,742,797	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		136,000	838,216		838,216	57
58 MAGNETIC RESONANCE IMAGING (MRI)		55,963	528,684		528,684	58
60 LABORATORY		124,619	3,076,857		3,076,857	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		33,835	721,745		721,745	65
66 PHYSICAL THERAPY		17,291	690,547		690,547	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		33,751	532,393		532,393	71
72 IMPL. DEV. CHARGED TO PATIENT		10,390	489,894		489,894	72
73 DRUGS CHARGED TO PATIENTS	914,403	62,524	3,083,704		3,083,704	73
76.97 CARDIAC REHABILITATION		3,207	291,643		291,643	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		116,887	2,319,343		2,319,343	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	914,403	876,871	23,319,932		23,319,932	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			57,942		57,942	190
192 PHYSICIANS' PRIVATE OFFICES			1,050,049		1,050,049	192
192.01 MEDICAL OFFICE BUILDING			24,132		24,132	192.01
194 OTHER NONALLOWABLE			217,466		217,466	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	914,403	876,871	24,669,521		24,669,521	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		9,908	5,550	15,458	15,458	4
5.01 ADMITTING		3,910	5,667	9,577	551	5.01
5.02 PATIENT ACCOUNTING		22,094	1,233	23,327	430	5.02
5.03 ADMIN & GENERAL	374,650	89,165	175,690	639,505	2,187	5.03
6 MAINTENANCE & REPAIRS					384	6
7 OPERATION OF PLANT	1,290	95,455	8,574	105,319	102	7
8 LAUNDRY & LINEN SERVICE		3,893		3,893		8
9 HOUSEKEEPING		4,863	365	5,228	439	9
10 DIETARY		26,543	11,375	37,918	159	10
11 CAFETERIA		7,540		7,540	364	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		2,324	23,779	26,103	272	13
14 CENTRAL SERVICES & SUPPLY	11,877			11,877		14
15 PHARMACY	113,583	3,913	2,425	119,921	453	15
16 MEDICAL RECORDS & LIBRARY		7,001	12,591	19,592	418	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		60,915	40,130	101,045	1,952	30
43 NURSERY		2,248		2,248	99	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	37	21,982	172,306	194,325	1,226	50
52 DELIVERY ROOM & LABOR ROOM		6,621		6,621	480	52
53 ANESTHESIOLOGY	710	764	40,754	42,228		53
54 RADIOLOGY-DIAGNOSTIC		18,398	134,130	152,528	1,319	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		1,372	131,900	133,272	69	57
58 MAGNETIC RESONANCE IMAGING (MRI)					123	58
60 LABORATORY	8,238	13,336	51,511	73,085	1,044	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	14,097	7,014	21,563	42,674	373	65
66 PHYSICAL THERAPY		16,334	6,248	22,582	361	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		6,020		6,020		71
72 IMPL. DEV. CHARGED TO PATIENT		1,446		1,446		72
73 DRUGS CHARGED TO PATIENTS					887	73
76.97 CARDIAC REHABILITATION		4,751	14,533	19,284	176	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		14,906	9,136	24,042	1,233	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	524,482	452,716	869,460	1,846,658	15,101	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	102	996	368	1,466		190
192 PHYSICIANS' PRIVATE OFFICES		23,923	3,918	27,841	263	192
192.01 MEDICAL OFFICE BUILDING						192.01
194 OTHER NONALLOWABLE	6,050		717	6,767	94	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	530,634	477,635	874,463	1,882,732	15,458	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMITTING 5.01	PATIENT ACCOUNTING 5.02	ADMIN & GENERAL 5.03	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING	10,128					5.01
5.02 PATIENT ACCOUNTING		23,757				5.02
5.03 ADMIN & GENERAL			641,692			5.03
6 MAINTENANCE & REPAIRS			11,871	12,255		6
7 OPERATION OF PLANT			35,071	3,317	143,809	7
8 LAUNDRY & LINEN SERVICE			3,241	135	2,177	8
9 HOUSEKEEPING			18,111	169	2,720	9
10 DIETARY			9,543	923	14,847	10
11 CAFETERIA			16,552	262	4,217	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			8,877	81	1,300	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY			23,070	136	2,189	15
16 MEDICAL RECORDS & LIBRARY			20,417	243	3,916	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	546	1,280	63,104	2,117	34,076	30
43 NURSERY	27	62	3,235	78	1,257	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	728	1,706	56,167	764	12,295	50
52 DELIVERY ROOM & LABOR ROOM	132	310	15,537	230	3,703	52
53 ANESTHESIOLOGY	423	993	6,739	27	427	53
54 RADIOLOGY-DIAGNOSTIC	1,411	3,308	61,620	640	10,291	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,559	3,663	17,684	48	767	57
58 MAGNETIC RESONANCE IMAGING (MRI)	647	1,518	12,106			58
60 LABORATORY	1,442	3,380	72,335	464	7,459	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	391	918	15,301	244	3,923	65
66 PHYSICAL THERAPY	200	469	13,563	568	9,136	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	390	915	11,651	209	3,367	71
72 IMPL. DEV. CHARGED TO PATIENT	120	282	12,209	50	809	72
73 DRUGS CHARGED TO PATIENTS	723	1,696	53,916			73
76.97 CARDIAC REHABILITATION	37	87	5,933	165	2,657	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,352	3,170	47,803	518	8,338	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	10,128	23,757	615,656	11,388	129,871	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1,232	35	557	190
192 PHYSICIANS' PRIVATE OFFICES			18,668	832	13,381	192
192.01 MEDICAL OFFICE BUILDING			628			192.01
194 OTHER NONALLOWABLE			5,508			194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	10,128	23,757	641,692	12,255	143,809	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINISTRATION 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 ADMIN & GENERAL						5.03
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	9,446					8
9 HOUSEKEEPING		26,667				9
10 DIETARY	73		63,463			10
11 CAFETERIA				28,935		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		312		216	37,161	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		180		1,590		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	4,791	9,153	63,463	8,278	19,385	30
43 NURSERY	211	309		218	511	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,259	3,125		3,207	7,510	50
52 DELIVERY ROOM & LABOR ROOM	389			1,369	3,207	52
53 ANESTHESIOLOGY		173				53
54 RADIOLOGY-DIAGNOSTIC	444	1,305		3,351		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	142	238		165		57
58 MAGNETIC RESONANCE IMAGING (MRI)	58			267		58
60 LABORATORY	93	585		2,537		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	59	787		1,172		65
66 PHYSICAL THERAPY	275	492		809		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		309				71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS		487		867		73
76.97 CARDIAC REHABILITATION		630		409		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,427	3,835		2,796	6,548	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	9,221	21,920	63,463	27,251	37,161	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		131				190
192 PHYSICIANS' PRIVATE OFFICES	225	4,616		1,444		192
192.01 MEDICAL OFFICE BUILDING						192.01
194 OTHER NONALLOWABLE				240		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	9,446	26,667	63,463	28,935	37,161	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 ADMIN & GENERAL						5.03
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	145,769					15
16 MEDICAL RECORDS & LIBRARY		46,356				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		2,495	311,685		311,685	30
43 NURSERY		122	8,377		8,377	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		3,325	285,637		285,637	50
52 DELIVERY ROOM & LABOR ROOM		603	32,581		32,581	52
53 ANESTHESIOLOGY		1,934	52,944		52,944	53
54 RADIOLOGY-DIAGNOSTIC		6,447	242,664		242,664	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		7,200	164,807		164,807	57
58 MAGNETIC RESONANCE IMAGING (MRI)		2,958	17,677		17,677	58
60 LABORATORY		6,586	169,010		169,010	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		1,788	67,630		67,630	65
66 PHYSICAL THERAPY		914	49,369		49,369	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,784	24,645		24,645	71
72 IMPL. DEV. CHARGED TO PATIENT		549	15,465		15,465	72
73 DRUGS CHARGED TO PATIENTS	145,769	3,304	207,649		207,649	73
76.97 CARDIAC REHABILITATION		169	29,547		29,547	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		6,178	107,240		107,240	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	145,769	46,356	1,786,927		1,786,927	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			3,421		3,421	190
192 PHYSICIANS' PRIVATE OFFICES			67,270		67,270	192
192.01 MEDICAL OFFICE BUILDING			628		628	192.01
194 OTHER NONALLOWABLE			12,609		12,609	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	145,769	46,356	1,870,855		1,870,855	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP	CAP	EMPLOYEE	ADMITTING	PATIENT
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT DOLLAR VALUE	BENEFITS GROSS SALARIES		
	1	2	4	5.01	5.02
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT	186,999				
2 CAP REL COSTS-MVBLE EQUIP		874,463			
4 EMPLOYEE BENEFITS	3,879	5,550	10,173,608		
5.01 ADMITTING	1,531	5,667	362,507	81,159,804	
5.02 PATIENT ACCOUNTING	8,650	1,233	282,965		81,159,804
5.03 ADMIN & GENERAL	34,909	175,690	1,437,412		
6 MAINTENANCE & REPAIRS			252,827		
7 OPERATION OF PLANT	37,372	8,574	67,232		
8 LAUNDRY & LINEN SERVICE	1,524				
9 HOUSEKEEPING	1,904	365	288,880		
10 DIETARY	10,392	11,375	104,698		
11 CAFETERIA	2,952		239,474		
12 MAINTENANCE OF PERSONNEL					
13 NURSING ADMINISTRATION	910	23,779	179,076		
14 CENTRAL SERVICES & SUPPLY					
15 PHARMACY	1,532	2,425	298,257		
16 MEDICAL RECORDS & LIBRARY	2,741	12,591	275,023		
17 SOCIAL SERVICE					
19 NONPHYSICIAN ANESTHETISTS					
20 NURSING SCHOOL					
21 I&R SRVCES-SALARY & FRINGES APPRVD					
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					
23 PARAMED ED PRGM-(SPECIFY)					
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	23,849	40,130	1,284,827	4,369,325	4,369,325
43 NURSERY	880		65,180	212,871	212,871
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	8,606	172,306	807,137	5,822,727	5,822,727
52 DELIVERY ROOM & LABOR ROOM	2,592		316,199	1,056,342	1,056,342
53 ANESTHESIOLOGY	299	40,754	3,387,406	3,387,406	3,387,406
54 RADIOLOGY-DIAGNOSTIC	7,203	134,130	868,143	11,290,068	11,290,068
57 COMPUTED TOMOGRAPHY (CT) SCAN	537	131,900	45,620	12,586,230	12,586,230
58 MAGNETIC RESONANCE IMAGING (MRI)			80,753	5,179,821	5,179,821
60 LABORATORY	5,221	51,511	687,451	11,534,484	11,534,484
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					
65 RESPIRATORY THERAPY	2,746	21,563	245,668	3,131,696	3,131,696
66 PHYSICAL THERAPY	6,395	6,248	237,650	1,600,444	1,600,444
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	2,357			3,123,966	3,123,966
72 IMPL. DEV. CHARGED TO PATIENT	566			961,705	961,705
73 DRUGS CHARGED TO PATIENTS			583,820	5,787,072	5,787,072
76.97 CARDIAC REHABILITATION	1,860	14,533	115,819	296,789	296,789
76.98 HYPERBARIC OXYGEN THERAPY					
76.99 LITHOTRIPSY					
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	5,836	9,136	811,757	10,818,858	10,818,858
92 OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	177,243	869,460	9,938,375	81,159,804	81,159,804
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	390	368			
192 PHYSICIANS' PRIVATE OFFICES	9,366	3,918	173,242		
192.01 MEDICAL OFFICE BUILDING					
194 OTHER NONALLOWABLE		717	61,991		
200 CROSS FOOT ADJUSTMENTS					
201 NEGATIVE COST CENTER					
202 COST TO BE ALLOC PER B PT I	477,635	874,463	3,420,972	598,193	593,366
203 UNIT COST MULT-WS B PT I	2.554212	1.000000	0.336259	0.007371	0.007311
204 COST TO BE ALLOC PER B PT II			15,458	10,128	23,757
205 UNIT COST MULT-WS B PT II			0.001519	0.000125	0.000293

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	RECON- CILIATION	ADMIN & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
	5A.03	5.03	6	7	8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 ADMIN & GENERAL	-4,976,814	19,692,707				5.03
6 MAINTENANCE & REPAIRS		364,317	138,030			6
7 OPERATION OF PLANT		1,076,291	37,372	100,658		7
8 LAUNDRY & LINEN SERVICE		99,466	1,524	1,524	192,071	8
9 HOUSEKEEPING		555,819	1,904	1,904		9
10 DIETARY		292,869	10,392	10,392	1,482	10
11 CAFETERIA		507,957	2,952	2,952		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		272,440	910	910		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		708,006	1,532	1,532		15
16 MEDICAL RECORDS & LIBRARY		626,581	2,741	2,741		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		1,936,584	23,849	23,849	97,412	30
43 NURSERY		99,267	880	880	4,291	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,723,719	8,606	8,606	25,605	50
52 DELIVERY ROOM & LABOR ROOM		476,812	2,592	2,592	7,907	52
53 ANESTHESIOLOGY		206,820	299	299		53
54 RADIOLOGY-DIAGNOSTIC		1,891,065	7,203	7,203	9,032	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		542,702	537	537	2,888	57
58 MAGNETIC RESONANCE IMAGING (MRI)		371,520			1,186	58
60 LABORATORY		2,219,695	5,221	5,221	1,896	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		469,568	2,746	2,746	1,203	65
66 PHYSICAL THERAPY		416,249	6,395	6,395	5,586	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		357,549	2,357	2,357		71
72 IMPL. DEV. CHARGED TO PATIENT		374,669	566	566		72
73 DRUGS CHARGED TO PATIENTS		1,654,638				73
76.97 CARDIAC REHABILITATION		182,073	1,860	1,860		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		1,467,029	5,836	5,836	29,008	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	-4,976,814	18,893,705	128,274	90,902	187,496	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		37,812	390	390		190
192 PHYSICIANS' PRIVATE OFFICES		572,888	9,366	9,366	4,575	192
192.01 MEDICAL OFFICE BUILDING		19,264				192.01
194 OTHER NONALLOWABLE		169,038				194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I		4,976,814	456,389	1,471,865	151,927	202
203 UNIT COST MULT-WS B PT I		0.252724	3.306448	14.622434	0.790994	203
204 COST TO BE ALLOC PER B PT II		641,692	12,255	143,809	9,446	204
205 UNIT COST MULT-WS B PT II		0.032585	0.088785	1.428689	0.049180	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
	HOURS OF SERVICE 9	MEALS SERVED 10	FTEs 11	FTEs 13	COSTED REQUIS. 15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 ADMIN & GENERAL						5.03
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	20,601					9
10 DIETARY		36,654				10
11 CAFETERIA			13,524			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	241		101	7,417		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY					100	15
16 MEDICAL RECORDS & LIBRARY	139		743			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	7,070	36,654	3,869	3,869		30
43 NURSERY	239		102	102		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,414		1,499	1,499		50
52 DELIVERY ROOM & LABOR ROOM			640	640		52
53 ANESTHESIOLOGY	134					53
54 RADIOLOGY-DIAGNOSTIC	1,008		1,566			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	184		77			57
58 MAGNETIC RESONANCE IMAGING (MRI)			125			58
60 LABORATORY	452		1,186			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	608		548			65
66 PHYSICAL THERAPY	380		378			66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	239					71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	376		405		100	73
76.97 CARDIAC REHABILITATION	487		191			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,963		1,307	1,307		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	16,934	36,654	12,737	7,417	100	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	101					190
192 PHYSICIANS' PRIVATE OFFICES	3,566		675			192
192.01 MEDICAL OFFICE BUILDING						192.01
194 OTHER NONALLOWABLE			112			194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	730,424	554,373	689,256	371,300	914,403	202
203 UNIT COST MULT-WS B PT I	35.455755	15.124488	50.965395	50.060671	9,144.030000	203
204 COST TO BE ALLOC PER B PT II	26,667	63,463	28,935	37,161	145,769	204
205 UNIT COST MULT-WS B PT II	1.294452	1.731407	2.139530	5.010247	1,457.690000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY GROSS SALARIES	
	16	
GENERAL SERVICE COST CENTERS		
1 CAP REL COSTS-BLDG & FIXT		1
2 CAP REL COSTS-MVBLE EQUIP		2
4 EMPLOYEE BENEFITS		4
5.01 ADMITTING		5.01
5.02 PATIENT ACCOUNTING		5.02
5.03 ADMIN & GENERAL		5.03
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	81,159,804	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	4,369,325	30
43 NURSERY	212,871	43
ANCILLARY SERVICE COST CENTERS		
50 OPERATING ROOM	5,822,727	50
52 DELIVERY ROOM & LABOR ROOM	1,056,342	52
53 ANESTHESIOLOGY	3,387,406	53
54 RADIOLOGY-DIAGNOSTIC	11,290,068	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	12,586,230	57
58 MAGNETIC RESONANCE IMAGING (MRI)	5,179,821	58
60 LABORATORY	11,534,484	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65 RESPIRATORY THERAPY	3,131,696	65
66 PHYSICAL THERAPY	1,600,444	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,123,966	71
72 IMPL. DEV. CHARGED TO PATIENT	961,705	72
73 DRUGS CHARGED TO PATIENTS	5,787,072	73
76.97 CARDIAC REHABILITATION	296,789	76.97
76.98 HYPERBARIC OXYGEN THERAPY		76.98
76.99 LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS		
91 EMERGENCY	10,818,858	91
92 OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS		
SPECIAL PURPOSE COST CENTERS		
118 SUBTOTALS (SUM OF LINES 1-117)	81,159,804	118
NONREIMBURSABLE COST CENTERS		
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192 PHYSICIANS' PRIVATE OFFICES		192
192.01 MEDICAL OFFICE BUILDING		192.01
194 OTHER NONALLOWABLE		194
200 CROSS FOOT ADJUSTMENTS		200
201 NEGATIVE COST CENTER		201
202 COST TO BE ALLOC PER B PT I	876,871	202
203 UNIT COST MULT-WS B PT I	0.010804	203
204 COST TO BE ALLOC PER B PT II	46,356	204
205 UNIT COST MULT-WS B PT II	0.000571	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	4,173,768		4,173,768		30
43 NURSERY	164,604		164,604		43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	2,633,830		2,633,830		50
52 DELIVERY ROOM & LABOR ROOM	726,109		726,109		52
53 ANESTHESIOLOGY	305,798		305,798		53
54 RADIOLOGY-DIAGNOSTIC	2,742,797		2,742,797		54
57 COMPUTED TOMOGRAPHY (CT) SC	838,216		838,216		57
58 MAGNETIC RESONANCE IMAGING	528,684		528,684		58
60 LABORATORY	3,076,857		3,076,857		60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	721,745		721,745		65
66 PHYSICAL THERAPY	690,547		690,547		66
71 MEDICAL SUPPLIES CHRGED TO	532,393		532,393		71
72 IMPL. DEV. CHARGED TO PATIE	489,894		489,894		72
73 DRUGS CHARGED TO PATIENTS	3,083,704		3,083,704		73
76.97 CARDIAC REHABILITATION	291,643		291,643		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	2,319,343		2,319,343		91
92 OBSERVATION BEDS	514,835		514,835		92
OTHER REIMBURSABLE COST CENTERS					
200 SUBTOTAL (SEE INSTRUCTIONS)	23,834,767		23,834,767		200
201 LESS OBSERVATION BEDS	514,835		514,835		201
202 TOTAL (SEE INSTRUCTIONS)	23,319,932		23,319,932		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	3,430,467		3,430,467			30
43 NURSERY	211,010		211,010			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	815,139	4,916,352	5,731,491	0.459537		50
52 DELIVERY ROOM & LABOR ROOM	557,686	482,606	1,040,292	0.697986		52
53 ANESTHESIOLOGY	549,377	2,793,438	3,342,815	0.091479		53
54 RADIOLOGY-DIAGNOSTIC	734,430	10,395,075	11,129,505	0.246444		54
57 COMPUTED TOMOGRAPHY (CT) SC	903,791	11,552,895	12,456,686	0.067290		57
58 MAGNETIC RESONANCE IMAGING	93,289	5,028,725	5,122,014	0.103218		58
60 LABORATORY	2,326,254	9,067,454	11,393,708	0.270049		60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	508,484	2,436,155	2,944,639	0.245105		65
66 PHYSICAL THERAPY	208,528	1,360,495	1,569,023	0.440113		66
71 MEDICAL SUPPLIES CHRGD TO	1,543,745	1,575,454	3,119,199	0.170683		71
72 IMPL. DEV. CHARGED TO PATIE	873,426	87,379	960,805	0.509879		72
73 DRUGS CHARGED TO PATIENTS	2,240,854	3,523,285	5,764,139	0.534981		73
76.97 CARDIAC REHABILITATION		292,328	292,328	0.997657		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	191,162	7,218,552	7,409,714	0.313014		91
92 OBSERVATION BEDS	20,663	895,356	916,019	0.562035		92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	15,208,305	61,625,549	76,833,854			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		61,625,549	76,833,854			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1350) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS				
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST			
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS	SERVICES SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS			
	1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.459537		1,785,035			820,290		50	
52 DELIVERY ROOM & LABOR ROOM	0.697986		2,260			1,577		52	
53 ANESTHESIOLOGY	0.091479		929,709			85,049		53	
54 RADIOLOGY-DIAGNOSTIC	0.246444		4,129,519			1,017,695		54	
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.067290		4,705,874			316,658		57	
58 MAGNETIC RESONANCE IMAGING (MRI)	0.103218		1,762,047			181,875		58	
60 LABORATORY	0.270049		4,333,430			1,170,238		60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30	
65 RESPIRATORY THERAPY	0.245105		1,087,361			266,518		65	
66 PHYSICAL THERAPY	0.440113		479,525			211,045		66	
71 MEDICAL SUPPLIES CHRGED TO PATI	0.170683		631,323			107,756		71	
72 IMPL. DEV. CHARGED TO PATIENT	0.509879		21,444			10,934		72	
73 DRUGS CHARGED TO PATIENTS	0.534981		1,604,255	380		858,246		203	73
76.97 CARDIAC REHABILITATION	0.997657		182,742			182,314		76.97	
76.98 HYPERBARIC OXYGEN THERAPY								76.98	
76.99 LITHOTRIPSY								76.99	
OUTPATIENT SERVICE COST CENTERS									
91 EMERGENCY	0.313014		2,565,281			802,969		91	
92 OBSERVATION BEDS	0.562035		514,137			288,963		92	
OTHER REIMBURSABLE COST CENTERS									
200 SUBTOTAL (SEE INSTRUCTIONS)			24,733,942	380		6,322,127		203	200
201 LESS PBP CLINIC LAB SERVICES									201
202 NET CHARGES (LINE 200 - LINE 201)			24,733,942	380		6,322,127		203	202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  S/B-SNF (14-Z350)  
 APPLICABLE  TITLE XVIII-PT B  IPF  SNF  S/B-NF  
 BOXES  TITLE XIX - O/P  IRF  NF  ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS				
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.459537						50
52 DELIVERY ROOM & LABOR ROOM	0.697986						52
53 ANESTHESIOLOGY	0.091479						53
54 RADIOLOGY-DIAGNOSTIC	0.246444						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.067290						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.103218						58
60 LABORATORY	0.270049						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.245105						65
66 PHYSICAL THERAPY	0.440113						66
71 MEDICAL SUPPLIES CHRGED TO PATI	0.170683						71
72 IMPL. DEV. CHARGED TO PATIENT	0.509879						72
73 DRUGS CHARGED TO PATIENTS	0.534981						73
76.97 CARDIAC REHABILITATION	0.997657						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.313014						91
92 OBSERVATION BEDS	0.562035						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 (14-1350) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,683	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,258	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	45	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,512	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	257	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)	168	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)	3,428	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)	256	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)	168	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	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,173,768	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)	312,133	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,861,635	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,326,746	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	36,353	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,290,393	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.160784	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	807.84	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	729.25	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	78.59	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	91.23	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	4,105	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,857,530	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1350) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 733.65 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,514,952 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) 2,514,952 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,344,974 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,859,926 49

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

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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 XVIII ONLY) 187,814 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 123,253 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 311,067 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) 701 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 734.43 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 514,835 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	311,685	3,861,635	0.080713	514,835	41,554 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
 11/28/2012 17:00

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-1350) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS					
ADULTS & PEDIATRICS		2,515,461			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.459537	423,503	194,615		50
52 DELIVERY ROOM & LABOR ROOM	0.697986				52
53 ANESTHESIOLOGY	0.091479	293,899	26,886		53
54 RADIOLOGY-DIAGNOSTIC	0.246444	591,155	145,687		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.067290	600,919	40,436		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.103218	69,364	7,160		58
60 LABORATORY	0.270049	1,744,683	471,150		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.245105	461,585	113,137		65
66 PHYSICAL THERAPY	0.440113	146,167	64,330		66
71 MEDICAL SUPPLIES CHRGED TO PATI	0.170683	1,095,275	186,945		71
72 IMPL. DEV. CHARGED TO PATIENT	0.509879	642,987	327,846		72
73 DRUGS CHARGED TO PATIENTS	0.534981	1,433,289	766,782		73
76.97 CARDIAC REHABILITATION	0.997657				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.313014				91
92 OBSERVATION BEDS	0.562035				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		7,502,826	2,344,974		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		7,502,826			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B SNF (14-Z350) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	(COL.1 x COL.2)
	1	2	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS				30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.459537	1,670	767	50
52 DELIVERY ROOM & LABOR ROOM	0.697986			52
53 ANESTHESIOLOGY	0.091479	5,952	544	53
54 RADIOLOGY-DIAGNOSTIC	0.246444	9,355	2,305	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.067290	6,740	454	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.103218			58
60 LABORATORY	0.270049	39,098	10,558	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.245105	12,842	3,148	65
66 PHYSICAL THERAPY	0.440113	45,844	20,177	66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.170683	45,415	7,752	71
72 IMPL. DEV. CHARGED TO PATIENT	0.509879			72
73 DRUGS CHARGED TO PATIENTS	0.534981	161,714	86,514	73
76.97 CARDIAC REHABILITATION	0.997657			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.313014			91
92 OBSERVATION BEDS	0.562035			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		328,630	132,219	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		328,630		202



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (14-1350) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,791,141		3,125,687
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				
	.01 09/23/2011	39,597		3.01
	.02 03/30/2012	125,989	03/30/2012	3.02
	PROGRAM .03			3.03
	TO .04			3.04
	PROVIDER .05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50 06/29/2012	455,136	09/23/2011	3.50
	.51		06/29/2012	3.51
	PROVIDER .52			3.52
	TO .53			3.53
	PROGRAM .54			3.54
	.55			3.55
	.56			3.56
	.57			3.57
	.58			3.58
	.59			3.59
	.99			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-289,550		-164,545
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		4,501,591		2,961,142

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

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-Z350)

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		418,394		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 03/30/2012	4,252		NONE 3.01
	.02			3.02
	PROGRAM .03			3.03
	TO .04			3.04
	PROVIDER .05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50			NONE 3.50
	.51 09/23/2011	1,539		3.51
	PROVIDER .52 06/22/2012	44,953		3.52
	TO .53			3.53
	PROGRAM .54			3.54
	.55			3.55
	.56			3.56
	.57			3.57
	.58			3.58
	.59			3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	-42,240		3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		376,154		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
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99			5.99
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: 14-1350 ST. FRANCIS HOSPITAL  
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
11/28/2012 17:00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK  HOSPITAL (14-1350)  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	1,351	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,428	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,557	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	76,833,854	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,606,708	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
 11/28/2012 17:00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-Z350)  
 APPLICABLE [XX] TITLE XVIII [ ] SWING BED - NF  
 BOXES [ ] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	314,178	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)	133,541	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	424	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)	447,719	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	447,719	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	447,719	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	9,700	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)	438,019	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)	438,019	19
20 INTERIM PAYMENTS	376,154	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	61,865	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	11,821	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART V

CHECK [XX] HOSPITAL (14-1350)  
APPLICABLE BOX: [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	4,859,926	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	4,859,926	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	4,908,525	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	4,908,525	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	652,052	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	4,256,473	22
23	COINSURANCE	1,156	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	4,255,317	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	109,282	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	109,282	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	73,915	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	4,364,599	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	4,364,599	30
31	INTERIM PAYMENTS	4,501,591	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-136,992	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	129,611	34

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	3,911,733			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,108,726			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,466,581			6
7	INVENTORY	370,729			7
8	PREPAID EXPENSES	273,811			8
9	OTHER CURRENT ASSETS	389,700			9
10	DUE FROM OTHER FUNDS	870,000			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	8,458,118			11
FIXED ASSETS					
12	LAND	99,383			12
13	LAND IMPROVEMENTS	1,257,842			13
14	ACCUMULATED DEPRECIATION	-1,014,879			14
15	BUILDINGS	11,373,477			15
16	ACCUMULATED DEPRECIATION	-4,838,128			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	12,578,714			19
20	ACCUMULATED DEPRECIATION	-8,444,095			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	16,643,006			23
24	ACCUMULATED DEPRECIATION	-14,011,803			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	13,643,517			30
OTHER ASSETS					
31	INVESTMENTS	29,345,813			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	108,787			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	29,454,600			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	51,556,235			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,177,470			37
38	SALARIES, WAGES & FEES PAYABLE	1,567,490			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	870,000			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,561,368			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	5,176,328			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	11,497,385			46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	12,546,661			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	24,044,046			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	29,220,374			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	22,335,861			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	22,335,861			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	51,556,235			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		23,338,140							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		2,965,714							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		26,303,854							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 CONTRIBUTIONS		784,518							5
6 INVESTMENT INCOME		34,294							6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		818,812							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		27,122,666							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 CHANGE IN TEMP RESTRICTED AS		1,224,000							13
14 CHANGE IN PENSION FUND STATU		3,562,805							14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		4,786,805							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		22,335,861							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	3,656,726		3,656,726	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)	3,656,726		3,656,726	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	3,656,726		3,656,726	18
19 ANCILLARY SERVICES	11,706,201	54,321,667	66,027,868	19
20 OUTPATIENT SERVICES		10,549,742	10,549,742	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
27.01 OBSERVATION BEDS	20,663	904,807	925,470	27.01
27.02 ROUNDING		3	3	27.02
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	15,383,590	65,776,219	81,159,809	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		29,242,086	29
30 ADD (SPECIFY)	2		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		2	36
37 DEDUCT (SPECIFY)			37
38 ROUNDING			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)		29,242,088	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	81,159,809	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	49,036,375	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	32,123,434	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	29,242,088	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	2,881,346	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	744,610	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	1,311	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	288	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	502	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	51,026	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	212,806	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS OPERATING REVENUE)	318,689	24
24.01	OTHER (INCOME FROM INVESTMENTS)		24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,329,232	25
26	TOTAL (LINE 5 PLUS LINE 25)	4,210,578	26
27	OTHER EXPENSES (GAIN/LOSS ON SALE OF EQUIPMENT)	3,194	27
27.01	OTHER EXPENSES (LOSS ON INVESMENTS)	1,241,670	27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	1,244,864	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	2,965,714	29

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
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 ADMIN & GENERAL						5.03
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
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (MR						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
71 MEDICAL SUPPLIES CHRGD TO PAT						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
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 MEDICAL OFFICE BUILDING						192.01
194 OTHER NONALLOWABLE						194
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