

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: 12-02-2013 TIME: 03:55\_\_\_\_  
 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. JOSEPH'S HOSPITAL (14-0145) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, 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		541,294	358,831	26,315	1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			335,908		10
10.01 HEALTH CLINIC - RHC II					10.01
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		541,294	694,739	26,315	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: 9515 HOLY CROSS LANE  
 2 CITY: BREESE

STATE: IL

P.O.BOX:  
 ZIP CODE: 62230

COUNTY: CLINTON

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-0145	41180	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-8503	41180		01/01/2009	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	14-8502	41180		01/01/2009	N	O	N	15.01
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012			TO: 06/30/2013				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		OUT-OF-STATE		MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6		
		MEDICAID PAID DAYS 1	ELIGIBLE UNPAID DAYS 2	MEDICAID PAID DAYS 3	MEDICAID ELIGIBLE UNPAID DAYS 4				
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.	742	63			140		24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				2			27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							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.				1			37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING: 07/01/2012		ENDING: 06/30/2013		38	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(iii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							1	2
								Y	Y 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 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

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 HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. )(SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME	61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
			UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
	PROGRAM NAME 1	PROGRAM CODE 2	3	4	61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				61.20
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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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.

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
64		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)

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

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
66		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)

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
-------------------	-------------------	--	---	---

INPATIENT PSYCHIATRIC FACILITY PPS

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

INPATIENT REHABILITATION FACILITY PPS

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

LONG TERM CARE HOSPITAL PPS

80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	80
----	--	---	----

TEFRA PROVIDERS

85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TITLE V AND XIX INPATIENT SERVICES		V	XIX	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97

RURAL PROVIDERS		1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	109

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: 57,175 PAID LOSSES: 145,350 SELF INSURANCE: 283,122			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	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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 148005 140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND  
 ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141 NAME: HOSPITAL SISTERS HEALTH SYSTE CONTRACTOR'S NAME: NGS CONTRACTOR'S NUMBER: 00131 141  
 142 STREET: 4936 LAVERNA ROAD P.O. BOX: 142  
 143 CITY: SPRINGFIELD STATE: IL ZIP CODE: 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		161
161.10 CORF				161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAS?  
 ENTER 'Y' FOR YES OR 'N' FOR NO. N 165

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN  
 COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167  
 168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),  
 ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168  
 169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH  
 (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 1.00 169  
 170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE  
 FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS) 07/01/2012 09/30/2012 170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
<b>FINANCIAL DATA AND REPORTS</b>					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N		2 6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			Y 15	
<b>PS&amp;R REPORT DATA</b>					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 N	2	3 N	4 16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	11/06/2013	Y	11/06/2013 17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: PATRICK	LAST NAME: SZAJKOVICS	TITLE: SENIOR CONSULTANT	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.			42
43	PHONE NUMBER: 630 530-7100, EXT. 111	E-MAIL ADDRESS: PATRICK.SZAJKOVICS@SRINC.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	15,080,616		15,080,616	661,058.00	22.81
2	NON-PHYSICIAN ANESTHETIST PART A						
3	NON-PHYSICIAN ANESTHETIST PART B		62,314	62,314	487.00	127.95	
4	PHYSICIAN-PART A ADMINISTRATIVE						
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B						
6	NON-PHYSICIAN-PART B						
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						
9	SNF	44					
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		132,326	25,725	158,051	11,652.00	13.56
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		76,652		76,652	710.00	107.96
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		381,670		381,670	3,206.00	119.05
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,581,128		1,581,128	23,149.00	68.30
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		6,071,051		6,071,051		
18	WAGE-RELATED COSTS (OTHER)						
19	EXCLUDED AREAS		53,967		53,967		
20	NON-PHYSICIAN ANESTHETIST PART A						
21	NON-PHYSICIAN ANESTHETIST PART B						
22	PHYSICIAN PART A - ADMINISTRATIVE						
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						
24	WAGE-RELATED COSTS (RHC/FQHC)						
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		122,067		122,067	3,828.00	31.89
27	ADMINISTRATIVE & GENERAL		2,074,687	-142,529	1,932,158	98,538.00	19.61
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		409,863		409,863	4,221.00	97.10
29	MAINTENANCE & REPAIRS						
30	OPERATION OF PLANT		487,194		487,194	20,677.00	23.56
31	LAUNDRY & LINEN SERVICE		100,061	16,767	116,828	9,288.00	12.58
32	HOUSEKEEPING		438,484	60,629	499,113	35,288.00	14.14
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						
34	DIETARY		502,826	-356,123	146,703	9,031.00	16.24
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						
36	CAFETERIA			356,123	356,123	27,590.00	12.91
37	MAINTENANCE OF PERSONNEL						
38	NURSING ADMINISTRATION		542,547		542,547	12,917.00	42.00
39	CENTRAL SERVICES AND SUPPLY						
40	PHARMACY						
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		607,837		607,837	33,013.00	18.41
42	SOCIAL SERVICE		73,076	-3,571	69,505	2,016.00	34.48
43	OTHER GENERAL SERVICE						

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	15,490,479	-62,314	15,428,165	664,792.00	23.21	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	132,326	25,725	158,051	11,652.00	13.56	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	15,358,153	-88,039	15,270,114	653,140.00	23.38	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	2,039,450		2,039,450	27,065.00	75.35	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	6,071,051		6,071,051		39.76	5
6	TOTAL (SUM OF LINES 3 THRU 5)	23,468,654	-88,039	23,380,615	680,205.00	34.37	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,358,642	-68,704	5,289,938	256,407.00	20.63	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)	3,273,438 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)	24,139 13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	134,137 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	935,821 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	-4,351 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	25,276 23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	4,388,460 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
12/02/2013 03:55

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	74,560	2
3	SUBPROVIDER - IPF	74,560	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II		14.01
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
12/02/2013 03:55

RHC I  
COMPONENT NO: 14-8503

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:

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

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. 1 2  
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0730	1830	0730	1830	0730	1830	0730	1730	0730	1700	0800	1130	11

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

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

14 PROVIDER NAME: CCN NUMBER: 14

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

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
12/02/2013 03:55

RHC II  
COMPONENT NO: 14-8502

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:

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

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. 1 2  
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

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

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

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

14 PROVIDER NAME: CCN NUMBER: 14

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.389561	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				2,877,378	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				10,308,697	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				4,015,866	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.				1,138,488	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,138,488	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	1,438,250	352,690	1,790,940		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	560,286	137,394	697,680		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0		22
23	COST OF CHARITY CARE	560,286	137,394	697,680		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)				785,039	25
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				120,976	26
27	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				664,063	27
28	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				258,693	28
29	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				956,373	29
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				2,094,861	30
31						31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,581,775	1,581,775		1
2	00200		1,734,622	1,734,622		2
3	00300					3
4	00400	122,067	6,384,548	6,506,615		4
5.01	00540				89,255	5.01
5.02	00550					5.02
5.03	00560	132,653	18,650	151,303	-77,396	5.03
5.04	00570	426,286	9,686	435,972	-14,542	5.04
5.05	00580	364,249	246,664	610,913	-61,059	5.05
5.06	00590	1,151,499	5,014,301	6,165,800	-65,133	5.06
6	00600					6
7	00700	487,194	1,217,637	1,704,831	42,874	7
8	00800	100,061	17,152	117,213	16,767	8
9	00900	438,484	129,807	568,291	60,629	9
10	01000	502,826	252,023	754,849	-497,972	10
11	01100				497,972	11
12	01200					12
13	01300	542,547	9,583	552,130		13
14	01400					14
15	01500					15
16	01600	607,837	139,251	747,088		16
17	01700	73,076	13,398	86,474	-3,571	17
19	01900				600,034	19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,453,035	100,377	1,553,412	-52,110	30
31	03100	5,594	365	5,959	1,323	31
43	04300	209,949	56,997	266,946	17,696	43
ANCILLARY SERVICE COST CENTERS						
50	05000	1,547,838	170,324	1,718,162	-13,797	50
51	05100	6,906	1,084	7,990	542	51
52	05200	412,385	40,825	453,210	40,138	52
53	05300	62,314	1,019,518	1,081,832	-600,034	53
54	05400	1,101,694	432,219	1,533,913	-16,971	54
57	05700	106,147	123,341	229,488	9,460	57
58	05800	80,643	94,275	174,918	6,479	58
60	06000	995,780	1,263,842	2,259,622		60
62.30	06250					62.30
63	06300		99,947	99,947		63
65	06500	346,519	169,622	516,141	-23,341	65
66	06600	1,049,932	410,489	1,460,421	23,050	66
69	06900	19,285	49,102	68,387	2,670	69
70	07000	57,526	9,176	66,702	6,827	70
71	07100	28,608	1,055,240	1,083,848	6,208	71
73	07300	348,787	1,168,542	1,517,329		73
74	07400					74
76.97	07697	102,881	2,840	105,721	13,844	76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	846,506	2,046,184	2,892,690	177,425	88
88.01	08801	100,343	78,425	178,768	-178,768	88.01
91	09100	800,019	1,598,022	2,398,041		91
91.01	09101	316,820	589,842	906,662	-14,496	91.01
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
SPECIAL PURPOSE COST CENTERS						
113	11300		135,208	135,208		113
118		14,948,290	27,692,171	42,640,461	-5,997	118
NONREIMBURSABLE COST CENTERS						
192	19200	129,327	528,990	658,317	2,426	192
194	07950	2,999	22,561	25,560	3,571	194
194.01	07951					194.01
200		15,080,616	28,243,722	43,324,338		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,581,775		1,581,775	1
2	00200	1,734,622		1,734,622	2
3	00300				3
4	00400	6,506,615	-1,242,833	5,263,782	4
5.01	00540	153,552		153,552	5.01
5.02	00550	142,971	2,142,164	2,285,135	5.02
5.03	00560	73,907	-8,020	65,887	5.03
5.04	00570	421,430		421,430	5.04
5.05	00580	549,854	-658	549,196	5.05
5.06	00590	6,100,667	-2,414,351	3,686,316	5.06
6	00600				6
7	00700	1,747,705		1,747,705	7
8	00800	133,980	-1,568	132,412	8
9	00900	628,920		628,920	9
10	01000	256,877	-6,902	249,975	10
11	01100	497,972	-6,929	491,043	11
12	01200				12
13	01300	552,130	-8,150	543,980	13
14	01400				14
15	01500				15
16	01600	747,088	-40,731	706,357	16
17	01700	82,903	-7,238	75,665	17
19	01900	600,034	-600,034		19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,501,302		1,501,302	30
31	03100	7,282		7,282	31
43	04300	284,642	-7,880	276,762	43
ANCILLARY SERVICE COST CENTERS					
50	05000	1,704,365	-29,500	1,674,865	50
51	05100	8,532		8,532	51
52	05200	493,348		493,348	52
53	05300	481,798	-415,121	66,677	53
54	05400	1,516,942	-492	1,516,450	54
57	05700	238,948		238,948	57
58	05800	181,397		181,397	58
60	06000	2,259,622	-52,977	2,206,645	60
62.30	06250				62.30
63	06300	99,947		99,947	63
65	06500	492,800	-22,422	470,378	65
66	06600	1,483,471	-135,559	1,347,912	66
69	06900	71,057	-38,529	32,528	69
70	07000	73,529		73,529	70
71	07100	1,090,056	-60,465	1,029,591	71
73	07300	1,517,329	-5,117	1,512,212	73
74	07400				74
76.97	07697	119,565	1,102	120,667	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800	3,070,115	-2,880	3,067,235	88
88.01	08801				88.01
91	09100	2,398,041	-1,522,382	875,659	91
91.01	09101	892,166	-518,244	373,922	91.01
92	09200				92
94	09400				94
SPECIAL PURPOSE COST CENTERS					
113	11300	135,208	-135,208		113
118		42,634,464	-5,140,924	37,493,540	118
NONREIMBURSABLE COST CENTERS					
192	19200	660,743	-249,990	410,753	192
194	07950	29,131		29,131	194
194.01	07951				194.01
200		43,324,338	-5,390,914	37,933,424	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 RECLASS NON-PHYSICIAN ANESTHETISTIS	A	NONPHYSICIAN ANESTHETISTS	19		62,314	537,720 1
500 TOTAL RECLASSIFICATIONS					62,314	537,720 500
CODE LETTER - A						
1 TO RECLASS CAFETERIA COST	B	CAFETERIA	11		356,123	141,849 1
500 TOTAL RECLASSIFICATIONS					356,123	141,849 500
CODE LETTER - B						
1 TO RECLASS MANAGERS SALARY	C	ADMITTING	5.04		61,059	1
2 TO RECLASS MANAGERS SALARY	C	LAUNDRY & LINEN SERVICE	8		16,767	2
3 TO RECLASS MANAGERS SALARY	C	HOUSEKEEPING	9		60,629	3
4 TO RECLASS MANAGERS SALARY	C	INTENSIVE CARE UNIT	31		1,323	4
5 TO RECLASS MANAGERS SALARY	C	NURSERY	43		17,696	5
6 TO RECLASS MANAGERS SALARY	C	RECOVERY ROOM	51		542	6
7 TO RECLASS MANAGERS SALARY	C	DELIVERY ROOM & LABOR ROOM	52		40,138	7
8 TO RECLASS MANAGERS SALARY	C	RADIOLOGY-DIAGNOSTIC	54		20,582	8
9 TO RECLASS MANAGERS SALARY	C	CT SCAN	57		9,460	9
10 TO RECLASS MANAGERS SALARY	C	MRI	58		6,479	10
11 TO RECLASS MANAGERS SALARY	C	PHYSICAL THERAPY	66		23,351	11
12 TO RECLASS MANAGERS SALARY	C	ELECTROCARDIOLOGY	69		2,670	12
13 TO RECLASS MANAGER SALARY	C	ELECTROENCEPHALOGRAPHY	70		6,827	13
14 TO RECLASS MANAGERS SALARY	C	MEDICAL SUPPLIES CHARGED TO P	71		6,208	14
15 TO RECLASS MANAGERS SALARY	C	CARDIAC REHABILITATION	76.97		13,844	15
16 TO RECLASS MANAGERS SALARY	C	PHYSICIANS' PRIVATE OFFICES	192		41,782	16
17 TO RECLASS MANAGERS SALARY	C	PRIORITY CARE CARLYLE	91.01		1,032	17
500 TOTAL RECLASSIFICATIONS					330,389	500
CODE LETTER - C						
1 RECLASS SOCIAL SERV SLRY TO LIFELIN	D	LIFELINE	194		3,571	1
500 TOTAL RECLASSIFICATIONS					3,571	500
CODE LETTER - D						
1 RECLASS CCRH GERMANTOWN TO CCRH BRE	F	RURAL HEALTH CLINIC	88		100,343	78,425 1
500 TOTAL RECLASSIFICATIONS					100,343	78,425 500
CODE LETTER - F						
1 RECLASS PLANT EXP TO PANT OPS	H	OPERATION OF PLANT	7			42,874 1
2 RECLAS PLNT EXP TO PLANT OPS	H					2
3 RECLASS	H					3
500 TOTAL RECLASSIFICATIONS						42,874 500
CODE LETTER - H						
1 RECLASS TELEPNE EXP TO TELEPHONE EX	I	COMMUNICATIONS	5.01			13,654 1
2 RECLASS TELEPHONE EXP TO TLPHN EXP	I					2
500 TOTAL RECLASSIFICATIONS						13,654 500
CODE LETTER - I						
1 RECLASS SWTCHBRD SAL TO FROM ADMT	J	COMMUNICATIONS	5.01		75,601	1
500 TOTAL RECLASSIFICATIONS					75,601	500
CODE LETTER - J						
1 RURAL HEALTH CLINIC HOUSEKEEPING	M	RURAL HEALTH CLINIC	88		19,628	1
500 TOTAL RECLASSIFICATIONS					19,628	500
CODE LETTER - M						
GRAND TOTAL (INCREASES)					947,969	814,522

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
	1	6	7	8	9	10
1 RECLASS NON-PHYSICIAN ANESTHETISTIS	A	ANESTHESIOLOGY	53	62,314	537,720	1
500 TOTAL RECLASSIFICATIONS				62,314	537,720	500
1 TO RECLASS CAFETERIA COST	B	DIETARY	10	356,123	141,849	1
500 TOTAL RECLASSIFICATIONS				356,123	141,849	500
1 TO RECLASS MANAGERS SALARY	C	PURCHASING	5.03	77,396		1
2 TO RECLASS MANAGERS SALARY	C	BUSINESS OFFICE	5.05	61,059		2
3 TO RECLASS MANAGERS SALARY	C	ADMIN & GENERAL	5.06	65,133		3
4 TO RECLASS MANAGERS SALARY	C	ADULTS & PEDIATRICS	30	52,110		4
5 TO RECLASS MANAGERS SALARY	C	OPERATING ROOM	50	13,797		5
6 TO RECLASS MANAGERS SALARY	C	RADIOLOGY-DIAGNOSTIC	54	37,553		6
7 TO RECLASS MANAGERS SALARY	C	RESPIRATORY THERAPY	65	23,341		7
8 TO RECLASS MANAGERS SALARY	C					8
9 TO RECLASS MANAGERS SALARY	C					9
10 TO RECLASS MANAGERS SALARY	C					10
11 TO RECLASS MANAGERS SALARY	C					11
12 TO RECLASS MANAGERS SALARY	C					12
13 TO RECLASS MANAGER SALARY	C					13
14 TO RECLASS MANAGERS SALARY	C					14
15 TO RECLASS MANAGERS SALARY	C					15
16 TO RECLASS MANAGERS SALARY	C					16
17 TO RECLASS MANAGERS SALARY	C					17
500 TOTAL RECLASSIFICATIONS				330,389		500
1 RECLASS SOCIAL SERV SLRY TO LIFELIN	D	SOCIAL SERVICE	17	3,571		1
500 TOTAL RECLASSIFICATIONS				3,571		500
1 RECLASS CCRH GERMANTOWN TO CCRH BRE	F	RHC II	88.01	100,343	78,425	1
500 TOTAL RECLASSIFICATIONS				100,343	78,425	500
1 RECLASS PLANT EXP TO PANT OPS	H	PRIORITY CARE CARLYLE	91.01		15,528	1
2 RECLAS PLNT EXP TO PLANT OPS	H	RURAL HEALTH CLINIC	88		7,618	2
3 RECLASS	H	PHYSICIANS' PRIVATE OFFICES	192		19,728	3
500 TOTAL RECLASSIFICATIONS					42,874	500
1 RECLASS TELEPNE EXP TO TELEPHONE EX	I	PHYSICAL THERAPY	66		301	1
2 RECLASS TELEPHONE EXP TO TLPHN EXP	I	RURAL HEALTH CLINIC	88		13,353	2
500 TOTAL RECLASSIFICATIONS					13,654	500
1 RECLASS SWTCHBRD SAL TO FROM ADMT	J	ADMITTING	5.04	75,601		1
500 TOTAL RECLASSIFICATIONS				75,601		500
1 RURAL HEALTH CLINIC HOUSEKEEPING	M	PHYSICIANS' PRIVATE OFFICES	192	19,628		1
500 TOTAL RECLASSIFICATIONS				19,628		500
GRAND TOTAL (DECREASES)				947,969	814,522	

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	1,454,337					1,454,337	1
2 LAND IMPROVEMENTS	3,644,829	163,999		163,999		3,808,828	2
3 BUILDINGS AND FIXTURES	31,698,140	85,802		85,802		31,783,942	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	21,475,551	670,854		670,854		22,146,405	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	58,272,857	920,655		920,655		59,193,512	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	58,272,857	920,655		920,655		59,193,512	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,581,775						1,581,775 1
2 CAP REL COSTS-MVBLE EQUIP	1,734,622						1,734,622 2
3 TOTAL (SUM OF LINES 1-2)	3,316,397						3,316,397 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	37,047,107		37,047,107	0.625864				1
2 CAP REL COSTS-MVBLE EQUIP	22,146,405		22,146,405	0.374136				2
3 TOTAL (SUM OF LINES 1-2)	59,193,512		59,193,512	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,581,775						1,581,775 1
2 CAP REL COSTS-MVBLE EQUIP	1,734,622						1,734,622 2
3 TOTAL	3,316,397						3,316,397 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-2,961	PURCHASING	5.03	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)	B	-5,117	DRUGS CHARGED TO PATIENTS	73	5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	B	-658	BUSINESS OFFICE	5.05	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,636,540			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-5,059	PURCHASING	5.03	11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	864,585			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-6,929	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	-40,731	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-4,335	DIETARY	10	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		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	A	-600,034	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 REBATES & REFUNDS	B	-60,465	MEDICAL SUPPLIES CHARGED TO PAT	71	33
33.01 REBATES AND REFUNDS	B	-492	RADIOLOGY-DIAGNOSTIC	54	33.01
33.02 REBATES AND REFUNDS	B	-2,567	DIETARY	10	33.02
34					34
35					35
36 MISCELLANEOUS INCOME	B	-18,000	INFORMATION SYSTEMS	5.02	36
36.01 MISCELLANEOUS INCOME	B	-60,983	ADMIN & GENERAL	5.06	36.01
36.02 MISCELLANEOUS INCOME	B	-8,150	NURSING ADMINISTRATION	13	36.02
36.03 MISCELLANEOUS INCOME	B	-23,702	EMPLOYEE BENEFITS DEPARTMENT	4	36.03
36.04 MISCELLANEOUS INCOME	B	1,102	CARDIAC REHABILITATION	76.97	36.04
36.05 MISC INCOME	B	-117,147	PHYSICAL THERAPY	66	36.05
36.06 MISC INCOME	B	-1,568	LAUNDRY & LINEN SERVICE	8	36.06
36.07 MISC INCOME	B	-1,061	NURSERY	43	36.07
36.08 MISC INCOME	B	-3,750	ADMIN & GENERAL	5.06	36.08
36.09 MISC INCOME	B	-2,880	RURAL HEALTH CLINIC	88	36.09
37					37
38 NON-ALLOW INTEREST	A	-135,208	INTEREST EXPENSE	113	38
39 MEDICAID TAX	A	-686,808	ADMIN & GENERAL	5.06	39
40 PHYSICIAN RECRUITMENT	A	-119,371	ADMIN & GENERAL	5.06	40
41 PHYSICIAN LEGAL FEES	A	-9,750	ADMIN & GENERAL	5.06	41
42 NON-ALLOW LOBBYING COST	A	-23,128	ADMIN & GENERAL	5.06	42
43 ADVERTISING COST	A	-272,658	ADMIN & GENERAL	5.06	43
44 MEDICAL GROUP EXPENSE	A	-249,990	PHYSICIANS' PRIVATE OFFICES	192	44
45 EMPLOYEE SELF INSURANCE	A	-1,146,519	EMPLOYEE BENEFITS DEPARTMENT	4	45
46 NON-ALLOW MEDICARE EXPENSE	A	-2,802	ADMIN & GENERAL	5.06	46
47 GRANT REVENUE LIFELINE	B	-7,238	SOCIAL SERVICE	17	47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-5,390,914			50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5.06	ADMIN & GENERAL	CONTRACTED SERVICES HSHS	1,049,123	2,272,090	-1,222,967	1
2	5.02	INFORMATION SYSTEMS	CONTRACTED SERVICES HSHS	2,160,164		2,160,164	2
3	4	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUMS	3,280,680	3,353,292	-72,612	3
4	88	RURAL HEALTH CLINIC	RURAL HEALTH CLINIC SERV	1,362,950	1,362,950		4
4.02	4	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SVS-SEB	1,568	1,568		4.02
4.03	5.02	INFORMATION SYSTEMS	RELATED PARTY SVS-SEB-SID	376,987	376,987		4.03
4.04	5.06	ADMIN & GENERAL	RELATED PARTY SVS-SID	378,000	378,000		4.04
4.05	5.06	ADMIN & GENERAL	RELATED SVS-SJH	1,052	1,052		4.05
4.06	17	SOCIAL SERVICE	RELATED SVS-SJH	143	143		4.06
4.07	30	ADULTS & PEDIATRICS	RELATED PARTY-SEB	2,489	2,489		4.07
4.08	50	OPERATING ROOM	RELATED PARTY SJH	268	268		4.08
4.09	53	ANESTHESIOLOGY	RELATED PARTY MEDICAL GRO	9,500	9,500		4.09
4.10	54	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SEB	401	401		4.10
4.11	66	PHYSICAL THERAPY	RELATED PARTY SJH	55,301	55,301		4.11
4.12	76.97	CARDIAC REHABILITATION	RELATED PARTY SEB	2,876	2,876		4.12
4.13	91	EMERGENCY	RELATED PARTY MEDICAL GRO	13,663	13,663		4.13
5		TOTALS (SUM OF LINES 1-4)		8,695,165	7,830,580	864,585	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6	B	100.00	HOSPITAL SISTERS HRLTH SYSTEM		CORPORATE OFFICE
7	G		HSHS MEDICAL GROUP		PHYSICIAN OFFICES
8	G		ST. ELIZABETH BELLEVILLE		SISTER HOSPITAL
9	G		ST. JOHN'S HOSPITAL		SISTER HOSPITAL
10					

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT		
LINE NO.	1	2	3	4	5	6	7	8	9		
1	5.06	ADMIN & GENERAL	VARIOUS	20,622		20,622	171,400	103	8,488	424	1
2	43	NURSERY	VARIOUS	19,427		19,427	171,400	153	12,608	630	2
3	50	OPERATING ROOM	VARIOUS	29,500	29,500		204,100				3
4	53	ANESTHESIOLOGY	VARIOUS	436,546	402,546	34,000	171,400	260	21,425	1,071	4
5	54	RADIOLOGY-DIAGNOSTIC	VARIOUS	6,000		6,000	171,400	734	60,484	3,024	5
6	60	LABORATORY	VARIOUS	119,671		119,671	219,500	632	66,694	3,335	6
7	65	RESPIRATORY THERAPY	VARIOUS	71,370		71,370	171,400	594	48,948	2,447	7
8	66	PHYSICAL THERAPY	VARIOUS	62,580		62,580	171,400	536	44,168	2,208	8
9	69	ELECTROCARDIOLOGY	VARIOUS	38,529	38,529		171,400				9
10	91	EMERGENCY	VARIOUS	1,538,286	1,490,286	48,000	171,400	193	15,904	795	10
11	91.01	PRIORITY CARE CARLYLE	VARIOUS	518,244	518,244		171,400				11
200		TOTAL		2,860,775	2,479,105	381,670		3,205	278,719	13,934	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
1	5.06 ADMIN & GENERAL	VARIOUS					8,488	12,134	12,134	1
2	43 NURSERY	VARIOUS					12,608	6,819	6,819	2
3	50 OPERATING ROOM	VARIOUS							29,500	3
4	53 ANESTHESIOLOGY	VARIOUS					21,425	12,575	415,121	4
5	54 RADIOLOGY-DIAGNOSTIC	VARIOUS					60,484			5
6	60 LABORATORY	VARIOUS					66,694	52,977	52,977	6
7	65 RESPIRATORY THERAPY	VARIOUS					48,948	22,422	22,422	7
8	66 PHYSICAL THERAPY	VARIOUS					44,168	18,412	18,412	8
9	69 ELECTROCARDIOLOGY	VARIOUS							38,529	9
10	91 EMERGENCY	VARIOUS					15,904	32,096	1,522,382	10
11	91.01 PRIORITY CARE CARLYLE	VARIOUS							518,244	11
200	TOTAL						278,719	157,435	2,636,540	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 DEPARTMENT 4	NON- PATIENT TELEPHONES 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,581,775	1,581,775				1
2 CAP REL COSTS-MVBLE EQUIP	1,734,622		1,734,622			2
4 EMPLOYEE BENEFITS DEPARTMENT	5,263,782	3,877	4,440	5,272,099		4
5.01 COMMUNICATIONS	153,552	2,415	13,989	28,143	198,099	5.01
5.02 INFORMATION SYSTEMS	2,285,135	16,694	335,401		10,859	5.02
5.03 PURCHASING	65,887	44,424	1,894	20,492	1,645	5.03
5.04 ADMITTING	421,430	11,129	4,676	154,131	987	5.04
5.05 BUSINESS OFFICE	549,196	11,609	3,941	103,702	9,543	5.05
5.06 ADMIN & GENERAL	3,686,316	326,460	22,004	361,417	15,795	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,747,705	84,568	32,451	191,141	8,556	7
8 LAUNDRY & LINEN SERVICE	132,412	23,218	4,808	45,523	329	8
9 HOUSEKEEPING	628,920	9,543	3,873	166,990	1,974	9
10 DIETARY	249,975	27,095	11,992	47,761	3,620	10
11 CAFETERIA	491,043	16,624		130,567		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	543,980	7,461	1,004	186,124	1,645	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	706,357	13,374	19,118	239,588	12,176	16
17 SOCIAL SERVICE	75,665	1,532	753	27,271	2,962	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,501,302	180,992	81,868	556,400	19,744	30
31 INTENSIVE CARE UNIT	7,282	16,175	152	9,179	1,974	31
43 NURSERY	276,762	6,377	13,220	89,264		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,674,865	86,224	113,349	554,507	11,846	50
51 RECOVERY ROOM	8,532	6,857	586	2,212		51
52 DELIVERY ROOM & LABOR ROOM	493,348	17,313	23,613	175,815		52
53 ANESTHESIOLOGY	66,677	4,288	20,910		329	53
54 RADIOLOGY-DIAGNOSTIC	1,516,450	45,569	243,919	400,366	7,898	54
57 CT SCAN	238,948	3,343	226,310	38,401		57
58 MRI	181,397	2,384	177,913	31,568		58
60 LABORATORY	2,206,645	30,942	86,051	359,751	5,923	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	99,947					63
65 RESPIRATORY THERAPY	470,378	10,069	5,536	117,192	2,962	65
66 PHYSICAL THERAPY	1,347,912	116,144	46,446	378,362	10,859	66
69 ELECTROCARDIOLOGY	32,528		1,860	8,131		69
70 ELECTROENCEPHALOGRAPHY	73,529	5,418	14,703	24,509		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,029,591	6,811	4,827	12,729		71
73 DRUGS CHARGED TO PATIENTS	1,512,212	6,238	81,102	126,614	1,645	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	120,667	12,677	9,811	41,382	1,316	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	3,067,235	82,571	25,260	188,733	22,377	88
88.01 RHC II						88.01
91 EMERGENCY	875,659	48,170	14,791	300,089	5,594	91
91.01 PRIORITY CARE CARLYLE	373,922	13,792	21,162	95,011		91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	37,493,540	1,302,377	1,673,733	5,213,065	162,558	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	410,753	279,398	60,889	56,858	35,541	192
194 LIFELINE	29,131			2,176		194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	37,933,424	1,581,775	1,734,622	5,272,099	198,099	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	DATA PRO-CESSING 5.02	PURCHASING RECEIVING AND STORES 5.03	ADMITTING 5.04	CASHIERING ACCTS REC & COLL 5.05	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS	2,648,089					5.02
5.03 PURCHASING		134,342				5.03
5.04 ADMITTING		401	592,754			5.04
5.05 BUSINESS OFFICE	2,648,089	1,288		3,327,368		5.05
5.06 ADMIN & GENERAL		1,425			4,413,417	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		1,830			2,066,251	7
8 LAUNDRY & LINEN SERVICE		721			207,011	8
9 HOUSEKEEPING		679			811,979	9
10 DIETARY		111			340,554	10
11 CAFETERIA		69			638,303	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		24			740,238	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		555			991,168	16
17 SOCIAL SERVICE		10			108,193	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		4,048	19,784	111,053	2,475,191	30
31 INTENSIVE CARE UNIT		10	89	502	35,363	31
43 NURSERY		1,388	4,381	24,590	415,982	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		4,333	69,522	390,236	2,904,882	50
51 RECOVERY ROOM		53	4,928	27,662	50,830	51
52 DELIVERY ROOM & LABOR ROOM		1,312	11,524	64,684	787,609	52
53 ANESTHESIOLOGY		1,155	38,493	216,068	347,920	53
54 RADIOLOGY-DIAGNOSTIC		2,040	70,965	398,340	2,685,547	54
57 CT SCAN		436	57,253	321,371	886,062	57
58 MRI		232	23,180	130,111	546,785	58
60 LABORATORY		34,730	121,563	682,498	3,528,103	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.		5,693	2,871	16,114	124,625	63
65 RESPIRATORY THERAPY		4,392	11,101	62,311	683,941	65
66 PHYSICAL THERAPY		2,010	26,903	151,013	2,079,649	66
69 ELECTROCARDIOLOGY		274	10,538	59,154	112,485	69
70 ELECTROENCEPHALOGRAPHY		184	3,489	19,582	141,414	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		41,812	14,823	83,203	1,193,796	71
73 DRUGS CHARGED TO PATIENTS		14,073	31,715	178,023	1,951,622	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		75	1,628	9,138	196,694	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC		4,413			3,390,589	88
88.01 RHC II						88.01
91 EMERGENCY		1,956	56,654	318,009	1,620,922	91
91.01 PRIORITY CARE CARLYLE		1,436	11,257	63,186	579,766	91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,648,089	133,168	592,661	3,326,848	37,056,891	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		1,174	93	520	845,226	192
194 LIFELINE					31,307	194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,648,089	134,342	592,754	3,327,368	37,933,424	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	5.06	7	8	9	10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL	4,413,417					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	272,053	2,338,304				7
8 LAUNDRY & LINEN SERVICE	27,256	50,134	284,401			8
9 HOUSEKEEPING	106,909	20,605	21,643	961,136		9
10 DIETARY	44,839	58,506	1,553	4,029	449,481	10
11 CAFETERIA	84,042	35,896	1,262	31,069		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	97,463	16,110		8,695		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	130,502	28,877		9,225		16
17 SOCIAL SERVICE	14,245	3,309		2,863		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	325,896	390,809	88,698	377,500	449,481	30
31 INTENSIVE CARE UNIT	4,656	34,926	537	3,393		31
43 NURSERY	54,770	13,770	3,192	12,778		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	382,471	186,180	61,319	120,513		50
51 RECOVERY ROOM	6,693	14,806				51
52 DELIVERY ROOM & LABOR ROOM	103,701	37,383	17,779	25,290		52
53 ANESTHESIOLOGY	45,809	9,258				53
54 RADIOLOGY-DIAGNOSTIC	353,593	98,396	24,171	69,986		54
57 CT SCAN	116,663	7,219				57
58 MRI	71,992	10,160				58
60 LABORATORY	464,534	66,812	9	55,829		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	16,409					63
65 RESPIRATORY THERAPY	90,051	21,741	1,404	12,141		65
66 PHYSICAL THERAPY	273,817	250,786	14,687	109,061		66
69 ELECTROCARDIOLOGY	14,810					69
70 ELECTROENCEPHALOGRAPHY	18,619	11,698				70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	157,181	14,706				71
73 DRUGS CHARGED TO PATIENTS	256,960	13,469		7,211		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	25,898	27,373		7,688		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	446,422	178,292				88
88.01 RHC II						88.01
91 EMERGENCY	213,419	104,011	28,409	95,859		91
91.01 PRIORITY CARE CARLYLE	76,335	29,779				91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	4,298,008	1,735,011	264,663	953,130	449,481	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	111,287	603,293	19,738	8,006		192
194 LIFELINE	4,122					194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,413,417	2,338,304	284,401	961,136	449,481	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
	11	13	16	17		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	790,572					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	22,470	884,976				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	63,159		1,222,931			16
17 SOCIAL SERVICE	4,069			132,679		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	109,713	262,667	295,840	102,259	4,878,054	30
31 INTENSIVE CARE UNIT	1,320	3,159	4,356		87,710	31
43 NURSERY	13,783	32,998	59,168		606,441	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	92,191	220,717	26,499		3,994,772	50
51 RECOVERY ROOM	367	878	1,815		75,389	51
52 DELIVERY ROOM & LABOR ROOM	30,975	74,158	1,089		1,077,984	52
53 ANESTHESIOLOGY			12,342		415,329	53
54 RADIOLOGY-DIAGNOSTIC	67,191		180,772		3,479,656	54
57 CT SCAN	6,342		141,568		1,157,854	57
58 MRI	4,362		56,627		689,926	58
60 LABORATORY	68,218		256,275		4,439,780	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			726		141,760	63
65 RESPIRATORY THERAPY	22,690		2,178		834,146	65
66 PHYSICAL THERAPY	80,131		16,698		2,824,829	66
69 ELECTROCARDIOLOGY	1,540		17,787		146,622	69
70 ELECTROENCEPHALOGRAPHY	3,776		1,452		176,959	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,032		6,171		1,375,886	71
73 DRUGS CHARGED TO PATIENTS	14,149		7,986		2,251,397	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	8,028		363		266,044	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	96,443	116,195	11,979		4,239,920	88
88.01 RHC II						88.01
91 EMERGENCY	44,611	106,804	117,973	30,420	2,362,428	91
91.01 PRIORITY CARE CARLYLE		42,037	3,267		731,184	91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	759,560	859,613	1,222,931	132,679	36,254,070	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	30,425	25,363			1,643,338	192
194 LIFELINE	587				36,016	194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	790,572	884,976	1,222,931	132,679	37,933,424	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS		TOTAL	
	25	26		
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS DEPARTMENT				4
5.01 COMMUNICATIONS				5.01
5.02 INFORMATION SYSTEMS				5.02
5.03 PURCHASING				5.03
5.04 ADMITTING				5.04
5.05 BUSINESS OFFICE				5.05
5.06 ADMIN & GENERAL				5.06
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SERVICES-SALARY & FRINGES APPRVD				21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS		4,878,054		30
31 INTENSIVE CARE UNIT		87,710		31
43 NURSERY		606,441		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM		3,994,772		50
51 RECOVERY ROOM		75,389		51
52 DELIVERY ROOM & LABOR ROOM		1,077,984		52
53 ANESTHESIOLOGY		415,329		53
54 RADIOLOGY-DIAGNOSTIC		3,479,656		54
57 CT SCAN		1,157,854		57
58 MRI		689,926		58
60 LABORATORY		4,439,780		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRANS.		141,760		63
65 RESPIRATORY THERAPY		834,146		65
66 PHYSICAL THERAPY		2,824,829		66
69 ELECTROCARDIOLOGY		146,622		69
70 ELECTROENCEPHALOGRAPHY		176,959		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,375,886		71
73 DRUGS CHARGED TO PATIENTS		2,251,397		73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION		266,044		76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC		4,239,920		88
88.01 RHC II				88.01
91 EMERGENCY		2,362,428		91
91.01 PRIORITY CARE CARLYLE		731,184		91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)		36,254,070		118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES		1,643,338		192
194 LIFELINE		36,016		194
194.01 DEVELOPMENT				194.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)		37,933,424		202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS DEPARTMENT	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT		3,877	4,440	8,317	8,317	4
5.01 COMMUNICATIONS		2,415	13,989	16,404	44	5.01
5.02 INFORMATION SYSTEMS	512,405	16,694	335,401	864,500		5.02
5.03 PURCHASING		44,424	1,894	46,318	32	5.03
5.04 ADMITTING		11,129	4,676	15,805	243	5.04
5.05 BUSINESS OFFICE	2,436	11,609	3,941	17,986	164	5.05
5.06 ADMIN & GENERAL	40,164	326,460	22,004	388,628	570	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4,540	84,568	32,451	121,559	301	7
8 LAUNDRY & LINEN SERVICE		23,218	4,808	28,026	72	8
9 HOUSEKEEPING		9,543	3,873	13,416	263	9
10 DIETARY		27,095	11,992	39,087	75	10
11 CAFETERIA		16,624		16,624	206	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		7,461	1,004	8,465	293	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		13,374	19,118	32,492	378	16
17 SOCIAL SERVICE		1,532	753	2,285	43	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,287	180,992	81,868	267,147	882	30
31 INTENSIVE CARE UNIT		16,175	152	16,327	14	31
43 NURSERY		6,377	13,220	19,597	141	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,500	86,224	113,349	201,073	874	50
51 RECOVERY ROOM		6,857	586	7,443	3	51
52 DELIVERY ROOM & LABOR ROOM		17,313	23,613	40,926	277	52
53 ANESTHESIOLOGY		4,288	20,910	25,198		53
54 RADIOLOGY-DIAGNOSTIC		45,569	243,919	289,488	631	54
57 CT SCAN		3,343	226,310	229,653	61	57
58 MRI		2,384	177,913	180,297	50	58
60 LABORATORY		30,942	86,051	116,993	567	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY		10,069	5,536	15,605	185	65
66 PHYSICAL THERAPY		116,144	46,446	162,590	597	66
69 ELECTROCARDIOLOGY			1,860	1,860	13	69
70 ELECTROENCEPHALOGRAPHY	360	5,418	14,703	20,481	39	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	66,960	6,811	4,827	78,598	20	71
73 DRUGS CHARGED TO PATIENTS		6,238	81,102	87,340	200	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		12,677	9,811	22,488	65	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	129	82,571	25,260	107,960	298	88
88.01 RHC II						88.01
91 EMERGENCY		48,170	14,791	62,961	473	91
91.01 PRIORITY CARE CARLYLE		13,792	21,162	34,954	150	91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	632,781	1,302,377	1,673,733	3,608,891	8,224	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		279,398	60,889	340,287	90	192
194 LIFELINE					3	194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	632,781	1,581,775	1,734,622	3,949,178	8,317	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	NON-PATIENT TELEPHONES 5.01	DATA PRO-CESSING 5.02	PURCHASING RECEIVING AND STORES 5.03	ADMITTING 5.04	CASHIERING ACCTS REC & COLL 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS	16,448					5.01
5.02 INFORMATION SYSTEMS	902	865,402				5.02
5.03 PURCHASING	137		46,487			5.03
5.04 ADMITTING	82		139	16,269		5.04
5.05 BUSINESS OFFICE	792	865,402	446		884,790	5.05
5.06 ADMIN & GENERAL	1,311		493			5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	710		633			7
8 LAUNDRY & LINEN SERVICE	27		250			8
9 HOUSEKEEPING	164		235			9
10 DIETARY	301		38			10
11 CAFETERIA			24			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	137		8			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,011		192			16
17 SOCIAL SERVICE	246		3			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1,639		1,401	542	29,530	30
31 INTENSIVE CARE UNIT	164		4	2	133	31
43 NURSERY			480	120	6,538	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	984		1,499	1,906	103,766	50
51 RECOVERY ROOM			18	135	7,355	51
52 DELIVERY ROOM & LABOR ROOM			454	316	17,200	52
53 ANESTHESIOLOGY	27		400	1,055	57,454	53
54 RADIOLOGY-DIAGNOSTIC	656		706	1,946	105,921	54
57 CT SCAN			151	1,570	85,454	57
58 MRI			80	636	34,597	58
60 LABORATORY	492		12,018	3,349	181,506	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			1,970	79	4,285	63
65 RESPIRATORY THERAPY	246		1,520	304	16,569	65
66 PHYSICAL THERAPY	902		695	738	40,155	66
69 ELECTROCARDIOLOGY			95	289	15,729	69
70 ELECTROENCEPHALOGRAPHY			64	96	5,207	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			14,468	406	22,124	71
73 DRUGS CHARGED TO PATIENTS	137		4,870	870	47,337	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	109		26	45	2,430	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	1,858		1,527			88
88.01 RHC II						88.01
91 EMERGENCY	464		677	1,553	84,560	91
91.01 PRIORITY CARE CARLYLE			497	309	16,802	91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	13,498	865,402	46,081	16,266	884,652	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2,950		406	3	138	192
194 LIFELINE						194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	16,448	865,402	46,487	16,269	884,790	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL	391,002					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	24,103	147,306				7
8 LAUNDRY & LINEN SERVICE	2,415	3,158	33,948			8
9 HOUSEKEEPING	9,472	1,298	2,583	27,431		9
10 DIETARY	3,973	3,686	185	115	47,460	10
11 CAFETERIA	7,446	2,261	151	887		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	8,635	1,015		248		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	11,562	1,819		263		16
17 SOCIAL SERVICE	1,262	208		82		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	28,873	24,620	10,589	10,774	47,460	30
31 INTENSIVE CARE UNIT	413	2,200	64	97		31
43 NURSERY	4,852	867	381	365		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	33,885	11,729	7,319	3,439		50
51 RECOVERY ROOM	593	933				51
52 DELIVERY ROOM & LABOR ROOM	9,187	2,355	2,122	722		52
53 ANESTHESIOLOGY	4,058	583				53
54 RADIOLOGY-DIAGNOSTIC	31,327	6,199	2,885	1,997		54
57 CT SCAN	10,336	455				57
58 MRI	6,378	640				58
60 LABORATORY	41,146	4,209	1	1,593		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	1,454					63
65 RESPIRATORY THERAPY	7,978	1,370	168	347		65
66 PHYSICAL THERAPY	24,259	15,799	1,753	3,113		66
69 ELECTROCARDIOLOGY	1,312					69
70 ELECTROENCEPHALOGRAPHY	1,650	737				70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,926	926				71
73 DRUGS CHARGED TO PATIENTS	22,766	849		206		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	2,294	1,724		219		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	39,551	11,232				88
88.01 RHC II						88.01
91 EMERGENCY	18,908	6,552	3,391	2,736		91
91.01 PRIORITY CARE CARLYLE	6,763	1,876				91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	380,777	109,300	31,592	27,203	47,460	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	9,860	38,006	2,356	228		192
194 LIFELINE	365					194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	391,002	147,306	33,948	27,431	47,460	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	27,599					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	784	19,585				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,205		49,922			16
17 SOCIAL SERVICE	142			4,271		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,833	5,814	12,076	3,292	448,472	30
31 INTENSIVE CARE UNIT	46	70	178		19,712	31
43 NURSERY	481	730	2,415		36,967	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,218	4,885	1,082		375,659	50
51 RECOVERY ROOM	13	19	74		16,586	51
52 DELIVERY ROOM & LABOR ROOM	1,081	1,641	44		76,325	52
53 ANESTHESIOLOGY			504		89,279	53
54 RADIOLOGY-DIAGNOSTIC	2,346		7,379		451,481	54
57 CT SCAN	221		5,779		333,680	57
58 MRI	152		2,312		225,142	58
60 LABORATORY	2,381		10,462		374,717	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			30		7,818	63
65 RESPIRATORY THERAPY	792		89		45,173	65
66 PHYSICAL THERAPY	2,797		682		254,080	66
69 ELECTROCARDIOLOGY	54		726		20,078	69
70 ELECTROENCEPHALOGRAPHY	132		59		28,465	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	141		252		130,861	71
73 DRUGS CHARGED TO PATIENTS	494		326		165,395	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	280		15		29,695	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	3,367	2,571	489		168,853	88
88.01 RHC II						88.01
91 EMERGENCY	1,557	2,364	4,816	979	191,991	91
91.01 PRIORITY CARE CARLYLE		930	133		62,414	91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	26,517	19,024	49,922	4,271	3,552,843	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	1,062	561			395,947	192
194 LIFELINE	20				388	194
194.01 DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	27,599	19,585	49,922	4,271	3,949,178	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	I&R COST &	TOTAL	
	POST STEP- DOWN ADJS 25		
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS DEPARTMENT			4
5.01 COMMUNICATIONS			5.01
5.02 INFORMATION SYSTEMS			5.02
5.03 PURCHASING			5.03
5.04 ADMITTING			5.04
5.05 BUSINESS OFFICE			5.05
5.06 ADMIN & GENERAL			5.06
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SERVICES-SALARY & FRINGES APPRVD			21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	448,472		30
31 INTENSIVE CARE UNIT	19,712		31
43 NURSERY	36,967		43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	375,659		50
51 RECOVERY ROOM	16,586		51
52 DELIVERY ROOM & LABOR ROOM	76,325		52
53 ANESTHESIOLOGY	89,279		53
54 RADIOLOGY-DIAGNOSTIC	451,481		54
57 CT SCAN	333,680		57
58 MRI	225,142		58
60 LABORATORY	374,717		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63 BLOOD STORING, PROCESSING & TRANS.	7,818		63
65 RESPIRATORY THERAPY	45,173		65
66 PHYSICAL THERAPY	254,080		66
69 ELECTROCARDIOLOGY	20,078		69
70 ELECTROENCEPHALOGRAPHY	28,465		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	130,861		71
73 DRUGS CHARGED TO PATIENTS	165,395		73
74 RENAL DIALYSIS			74
76.97 CARDIAC REHABILITATION	29,695		76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC	168,853		88
88.01 RHC II			88.01
91 EMERGENCY	191,991		91
91.01 PRIORITY CARE CARLYLE	62,414		91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
SPECIAL PURPOSE COST CENTERS			
113 INTEREST EXPENSE			113
118 SUBTOTALS (SUM OF LINES 1-117)	3,552,843		118
NONREIMBURSABLE COST CENTERS			
192 PHYSICIANS' PRIVATE OFFICES	395,947		192
194 LIFELINE	388		194
194.01 DEVELOPMENT			194.01
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)	3,949,178		202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON- PATIENT TELEPHONES PHONES	DATA PRO- CESSING TIME SPENT	
	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	204,381					1
2 CAP REL COSTS-MVBLE EQUIP		1,823,069				2
4 EMPLOYEE BENEFITS DEPARTMENT	501	4,666	14,162,485			4
5.01 COMMUNICATIONS	312	14,702	75,601	602		5.01
5.02 INFORMATION SYSTEMS	2,157	352,506		33	10,000	5.02
5.03 PURCHASING	5,740	1,991	55,049	5		5.03
5.04 ADMITTING	1,438	4,914	414,043	3		5.04
5.05 BUSINESS OFFICE	1,500	4,142	278,576	29	10,000	5.05
5.06 ADMIN & GENERAL	42,182	23,126	970,877	48		5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	10,927	34,106	513,464	26		7
8 LAUNDRY & LINEN SERVICE	3,000	5,053	122,290	1		8
9 HOUSEKEEPING	1,233	4,070	448,588	6		9
10 DIETARY	3,501	12,603	128,302	11		10
11 CAFETERIA	2,148		350,742			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	964	1,055	499,987	5		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,728	20,093	643,608	37		16
17 SOCIAL SERVICE	198	791	73,257	9		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	23,386	86,042	1,494,665	60		30
31 INTENSIVE CARE UNIT	2,090	160	24,657	6		31
43 NURSERY	824	13,894	239,790			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,141	119,128	1,489,576	36		50
51 RECOVERY ROOM	886	616	5,941			51
52 DELIVERY ROOM & LABOR ROOM	2,237	24,817	472,294			52
53 ANESTHESIOLOGY	554	21,976		1		53
54 RADIOLOGY-DIAGNOSTIC	5,888	256,356	1,075,506	24		54
57 CT SCAN	432	237,849	103,157			57
58 MRI	308	186,985	84,802			58
60 LABORATORY	3,998	90,439	966,401	18		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	1,301	5,818	314,813	9		65
66 PHYSICAL THERAPY	15,007	48,814	1,016,397	33		66
69 ELECTROCARDIOLOGY		1,955	21,842			69
70 ELECTROENCEPHALOGRAPHY	700	15,453	65,839			70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	880	5,073	34,193			71
73 DRUGS CHARGED TO PATIENTS	806	85,237	340,124	5		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	1,638	10,311	111,164	4		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	10,669	26,548	506,995	68		88
88.01 RHC II						88.01
91 EMERGENCY	6,224	15,545	806,133	17		91
91.01 PRIORITY CARE CARLYLE	1,782	22,241	255,228			91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	168,280	1,759,075	14,003,901	494	10,000	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	36,101	63,994	152,739	108		192
194 LIFELINE			5,845			194
194.01 DEVELOPMENT						194.01

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	NON- PATIENT TELEPHONES PHONES 5.01	DATA PRO- CESSING TIME SPENT 5.02	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,581,775	1,734,622	5,272,099	198,099	2,648,089	202
203	UNIT COST MULT-WS B PT I	7.739345	0.951485	0.372258	329.068106	264.808900	203
204	COST TO BE ALLOC PER B PT II			8,317	16,448	865,402	204
205	UNIT COST MULT-WS B PT II			0.000587	27.322259	86.540200	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING RECEIVING AND STORES SUPPLY EXP 5.03	ADMITTING REVENUE 5.04	CASHIERING ACCTS REC & COLL REVENUE 5.05	RECON- CILIATION 5A.06	ACCUM COST 5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING	3,109,280					5.03
5.04 ADMITTING	9,277	97,914,467				5.04
5.05 BUSINESS OFFICE	29,808		97,914,467			5.05
5.06 ADMIN & GENERAL	32,978			-4,413,417	33,520,007	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	42,355				2,066,251	7
8 LAUNDRY & LINEN SERVICE	16,694				207,011	8
9 HOUSEKEEPING	15,720				811,979	9
10 DIETARY	2,558				340,554	10
11 CAFETERIA	1,597				638,303	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	551				740,238	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	12,853				991,168	16
17 SOCIAL SERVICE	225				108,193	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	93,682	3,267,984	3,267,984		2,475,191	30
31 INTENSIVE CARE UNIT	238	14,765	14,765		35,363	31
43 NURSERY	32,114	723,604	723,604		415,982	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	100,291	11,483,600	11,483,600		2,904,882	50
51 RECOVERY ROOM	1,230	814,011	814,011		50,830	51
52 DELIVERY ROOM & LABOR ROOM	30,369	1,903,493	1,903,493		787,609	52
53 ANESTHESIOLOGY	26,739	6,358,299	6,358,299		347,920	53
54 RADIOLOGY-DIAGNOSTIC	47,217	11,722,081	11,722,081		2,685,547	54
57 CT SCAN	10,090	9,457,085	9,457,085		886,062	57
58 MRI	5,378	3,828,811	3,828,811		546,785	58
60 LABORATORY	803,796	20,083,018	20,083,018		3,528,103	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	131,766	474,206	474,206		124,625	63
65 RESPIRATORY THERAPY	101,658	1,833,646	1,833,646		683,941	65
66 PHYSICAL THERAPY	46,515	4,443,919	4,443,919		2,079,649	66
69 ELECTROCARDIOLOGY	6,330	1,740,738	1,740,738		112,485	69
70 ELECTROENCEPHALOGRAPHY	4,250	576,244	576,244		141,414	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	967,718	2,448,457	2,448,457		1,193,796	71
73 DRUGS CHARGED TO PATIENTS	325,714	5,238,734	5,238,734		1,951,622	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	1,739	268,904	268,904		196,694	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	102,141				3,390,589	88
88.01 RHC II						88.01
91 EMERGENCY	45,279	9,358,157	9,358,157		1,620,922	91
91.01 PRIORITY CARE CARLYLE	33,237	1,859,401	1,859,401		579,766	91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,082,107	97,899,157	97,899,157	-4,413,417	32,643,474	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	27,173	15,310	15,310		845,226	192
194 LIFELINE					31,307	194
194.01 DEVELOPMENT						194.01

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		PURCHASING RECEIVING AND STORES SUPPLY EXP	5.03	ADMITTING REVENUE	5.04	CASHIERING ACCTS REC & COLL REVENUE	5.05	RECON- CILIATION	5A.06	ACCUM COST	5.06
200	CROSS FOOT ADJUSTMENTS										200
201	NEGATIVE COST CENTER										201
202	COST TO BE ALLOC PER B PT I	134,342		592,754		3,327,368				4,413,417	202
203	UNIT COST MULT-WS B PT I	0.043207		0.006054		0.033982				0.131665	203
204	COST TO BE ALLOC PER B PT II	46,487		16,269		884,790				391,002	204
205	UNIT COST MULT-WS B PT II	0.014951		0.000166		0.009036				0.011665	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	HOURS OF	MEALS	FTE'S	
	FEET	POUNDS OF	SERVICE	SERVED		
	7	LAUNDRY	9	10	11	
		8				
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 BUSINESS OFFICE						5.05
5.06 ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	139,924					7
8 LAUNDRY & LINEN SERVICE	3,000	304,408				8
9 HOUSEKEEPING	1,233	23,165	18,128			9
10 DIETARY	3,501	1,662	76	17,327		10
11 CAFETERIA	2,148	1,351	586		21,567	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	964		164		613	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,728		174		1,723	16
17 SOCIAL SERVICE	198		54		111	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	23,386	94,937	7,120	17,327	2,993	30
31 INTENSIVE CARE UNIT	2,090	575	64		36	31
43 NURSERY	824	3,417	241		376	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,141	65,633	2,273		2,515	50
51 RECOVERY ROOM	886				10	51
52 DELIVERY ROOM & LABOR ROOM	2,237	19,030	477		845	52
53 ANESTHESIOLOGY	554					53
54 RADIOLOGY-DIAGNOSTIC	5,888	25,871	1,320		1,833	54
57 CT SCAN	432				173	57
58 MRI	608				119	58
60 LABORATORY	3,998	10	1,053		1,861	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	1,301	1,503	229		619	65
66 PHYSICAL THERAPY	15,007	15,720	2,057		2,186	66
69 ELECTROCARDIOLOGY					42	69
70 ELECTROENCEPHALOGRAPHY	700				103	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	880				110	71
73 DRUGS CHARGED TO PATIENTS	806		136		386	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	1,638		145		219	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	10,669				2,631	88
88.01 RHC II						88.01
91 EMERGENCY	6,224	30,407	1,808		1,217	91
91.01 PRIORITY CARE CARLYLE	1,782					91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	103,823	283,281	17,977	17,327	20,721	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	36,101	21,127	151		830	192
194 LIFELINE					16	194
194.01 DEVELOPMENT						194.01

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	HOURS OF SERVICE	MEALS SERVED	FTE'S	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,338,304	284,401	961,136	449,481	790,572	202
203	UNIT COST MULT-WS B PT I	16.711243	0.934276	53.019417	25.941075	36.656559	203
204	COST TO BE ALLOC PER B PT II	147,306	33,948	27,431	47,460	27,599	204
205	UNIT COST MULT-WS B PT II	1.052757	0.111521	1.513184	2.739078	1.279687	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS DEPARTMENT				4
5.01 COMMUNICATIONS				5.01
5.02 INFORMATION SYSTEMS				5.02
5.03 PURCHASING				5.03
5.04 ADMITTING				5.04
5.05 BUSINESS OFFICE				5.05
5.06 ADMIN & GENERAL				5.06
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION	10,084			13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY		3,369		16
17 SOCIAL SERVICE			567	17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SERVICES-SALARY & FRINGES APPRVD				21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	2,993	815	437	30
31 INTENSIVE CARE UNIT	36	12		31
43 NURSERY	376	163		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	2,515	73		50
51 RECOVERY ROOM	10	5		51
52 DELIVERY ROOM & LABOR ROOM	845	3		52
53 ANESTHESIOLOGY		34		53
54 RADIOLOGY-DIAGNOSTIC		498		54
57 CT SCAN		390		57
58 MRI		156		58
60 LABORATORY		706		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRANS.		2		63
65 RESPIRATORY THERAPY		6		65
66 PHYSICAL THERAPY		46		66
69 ELECTROCARDIOLOGY		49		69
70 ELECTROENCEPHALOGRAPHY		4		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		17		71
73 DRUGS CHARGED TO PATIENTS		22		73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION		1		76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC	1,324	33		88
88.01 RHC II				88.01
91 EMERGENCY	1,217	325	130	91
91.01 PRIORITY CARE CARLYLE	479	9		91.01
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	9,795	3,369	567	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES	289			192
194 LIFELINE				194
194.01 DEVELOPMENT				194.01

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
12/02/2013 03:55

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	884,976	1,222,931	132,679	202
203 UNIT COST MULT-WS B PT I	87.760413	362.995251	234.001764	203
204 COST TO BE ALLOC PER B PT II	19,585	49,922	4,271	204
205 UNIT COST MULT-WS B PT II	1.942186	14.818047	7.532628	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,878,054		4,878,054		4,878,054	30
31 INTENSIVE CARE UNIT	87,710		87,710		87,710	31
43 NURSERY	606,441		606,441	6,819	613,260	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,994,772		3,994,772		3,994,772	50
51 RECOVERY ROOM	75,389		75,389		75,389	51
52 DELIVERY ROOM & LABOR ROOM	1,077,984		1,077,984		1,077,984	52
53 ANESTHESIOLOGY	415,329		415,329	12,575	427,904	53
54 RADIOLOGY-DIAGNOSTIC	3,479,656		3,479,656		3,479,656	54
57 CT SCAN	1,157,854		1,157,854		1,157,854	57
58 MRI	689,926		689,926		689,926	58
60 LABORATORY	4,439,780		4,439,780	52,977	4,492,757	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	141,760		141,760		141,760	63
65 RESPIRATORY THERAPY	834,146		834,146	22,422	856,568	65
66 PHYSICAL THERAPY	2,824,829		2,824,829	18,412	2,843,241	66
69 ELECTROCARDIOLOGY	146,622		146,622		146,622	69
70 ELECTROENCEPHALOGRAPHY	176,959		176,959		176,959	70
71 MEDICAL SUPPLIES CHARGED TO	1,375,886		1,375,886		1,375,886	71
73 DRUGS CHARGED TO PATIENTS	2,251,397		2,251,397		2,251,397	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	266,044		266,044		266,044	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	4,239,920		4,239,920		4,239,920	88
88.01 RHC II						88.01
91 EMERGENCY	2,362,428		2,362,428	32,096	2,394,524	91
91.01 PRIORITY CARE CARLYLE	731,184		731,184		731,184	91.01
92 OBSERVATION BEDS (NON-DISTI	407,448		407,448		407,448	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	36,661,518		36,661,518	145,301	36,806,819	200
201 LESS OBSERVATION BEDS	407,448		407,448		407,448	201
202 TOTAL (SEE INSTRUCTIONS)	36,254,070		36,254,070		36,399,371	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	2,832,891		2,832,891			30
31 INTENSIVE CARE UNIT	14,765		14,765			31
43 NURSERY	707,200		707,200			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,782,199	9,334,016	11,116,215	0.359364	0.359364	0.359364 50
51 RECOVERY ROOM	143,716	644,007	787,723	0.095705	0.095705	0.095705 51
52 DELIVERY ROOM & LABOR ROOM	1,480,645	398,210	1,878,855	0.573745	0.573745	0.573745 52
53 ANESTHESIOLOGY	352,835	1,454,178	1,807,013	0.229843	0.229843	0.236802 53
54 RADIOLOGY-DIAGNOSTIC	769,799	10,682,598	11,452,397	0.303836	0.303836	0.303836 54
57 CT SCAN	1,191,285	8,100,890	9,292,175	0.124605	0.124605	0.124605 57
58 MRI	90,568	3,622,686	3,713,254	0.185801	0.185801	0.185801 58
60 LABORATORY	2,214,846	17,481,867	19,696,713	0.225407	0.225407	0.228097 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	187,753	278,725	466,478	0.303894	0.303894	0.303894 63
65 RESPIRATORY THERAPY	1,242,338	568,207	1,810,545	0.460715	0.460715	0.473100 65
66 PHYSICAL THERAPY	92,703	4,220,444	4,313,147	0.654935	0.654935	0.659203 66
69 ELECTROCARDIOLOGY	122,352	1,405,697	1,528,049	0.095954	0.095954	0.095954 69
70 ELECTROENCEPHALOGRAPHY		551,480	551,480	0.320880	0.320880	0.320880 70
71 MEDICAL SUPPLIES CHARGED TO	694,455	1,666,075	2,360,530	0.582872	0.582872	0.582872 71
73 DRUGS CHARGED TO PATIENTS	1,701,073	3,472,136	5,173,209	0.435203	0.435203	0.435203 73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		268,904	268,904	0.989364	0.989364	0.989364 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC		5,308,639	5,308,639			88
88.01 RHC II						88.01
91 EMERGENCY	863,694	5,515,247	6,378,941	0.370348	0.370348	0.375380 91
91.01 PRIORITY CARE CARLYLE	10,315	1,202,597	1,212,912	0.602834	0.602834	0.602834 91.01
92 OBSERVATION BEDS (NON-DISTI	44,717	347,110	391,827	1.039867	1.039867	1.039867 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	16,540,149	76,523,713	93,063,862			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	16,540,149	76,523,713	93,063,862			202

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 + COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	448,472		448,472	130.07	1,564	203,429	30
31 INTENSIVE CARE UNIT	19,712		19,712	2,464.00	8	19,712	31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	36,967		36,967	37.04			43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	505,151		505,151		1,572	223,141	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

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

[XX] PPS  
 [ ] TEFRA

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	375,659	11,116,215	0.033794	589,888	19,935	50
51 RECOVERY ROOM	16,586	787,723	0.021056	49,201	1,036	51
52 DELIVERY ROOM & LABOR ROOM	76,325	1,878,855	0.040623	630	26	52
53 ANESTHESIOLOGY	89,279	1,807,013	0.049407	114,608	5,662	53
54 RADIOLOGY-DIAGNOSTIC	451,481	11,452,397	0.039422	524,838	20,690	54
57 CT SCAN	333,680	9,292,175	0.035910	740,516	26,592	57
58 MRI	225,142	3,713,254	0.060632	64,557	3,914	58
60 LABORATORY	374,717	19,696,713	0.019024	1,394,286	26,525	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T	7,818	466,478	0.016760	84,887	1,423	63
65 RESPIRATORY THERAPY	45,173	1,810,545	0.024950	947,227	23,633	65
66 PHYSICAL THERAPY	254,080	4,313,147	0.058908	79,245	4,668	66
69 ELECTROCARDIOLOGY	20,078	1,528,049	0.013140	98,342	1,292	69
70 ELECTROENCEPHALOGRAPHY	28,465	551,480	0.051616			70
71 MEDICAL SUPPLIES CHARGED TO P	130,861	2,360,530	0.055437	323,615	17,940	71
73 DRUGS CHARGED TO PATIENTS	165,395	5,173,209	0.031971	832,229	26,607	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	29,695	268,904	0.110430			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	168,853	5,308,639	0.031807			88
88.01 RHC II						88.01
91 EMERGENCY	191,991	6,378,941	0.030098	588,197	17,704	91
91.01 PRIORITY CARE CARLYLE	62,414	1,212,912	0.051458	1,948	100	91.01
92 OBSERVATION BEDS (NON-DISTINC	37,460	391,827	0.095603	24,150	2,309	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	3,085,152	89,509,006		6,458,364	200,056	200

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL. 5 + COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	3,448		1,564		30
31 INTENSIVE CARE UNIT	8		8		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	998				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	4,454		1,572		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS. 1-4) 5	TOTAL O/P COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 CT SCAN						57
58 MRI						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC						88
88.01 RHC II						88.01
91 EMERGENCY						91
91.01 PRIORITY CARE CARLYLE						91.01
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[XX] HOSPITAL (14-0145) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] NF	[ ] ICF/MR	[XX] PPS [ ] TEFRA	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES PGM 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS												
50	OPERATING ROOM	11,116,215							589,888		3,479,362	50
51	RECOVERY ROOM	787,723							49,201		193,167	51
52	DELIVERY ROOM & LABOR ROOM	1,878,855							630			52
53	ANESTHESIOLOGY	1,807,013							114,608		461,818	53
54	RADIOLOGY-DIAGNOSTIC	11,452,397							524,838		3,583,974	54
57	CT SCAN	9,292,175							740,516		3,080,504	57
58	MRI	3,713,254							64,557		1,063,870	58
60	LABORATORY	19,696,713							1,394,286		504,881	60
62.30	BLOOD CLOTTING FOR HEMOPHILI											62.30
63	BLOOD STORING, PROCESSING &	466,478							84,887		144,374	63
65	RESPIRATORY THERAPY	1,810,545							947,227		284,796	65
66	PHYSICAL THERAPY	4,313,147							79,245		1,505,770	66
69	ELECTROCARDIOLOGY	1,528,049							98,342		774,460	69
70	ELECTROENCEPHALOGRAPHY	551,480									224,885	70
71	MEDICAL SUPPLIES CHARGED TO	2,360,530							323,615		477,996	71
73	DRUGS CHARGED TO PATIENTS	5,173,209							832,229		1,432,361	73
74	RENAL DIALYSIS											74
76.97	CARDIAC REHABILITATION	268,904									162,238	76.97
76.98	HYPERBARIC OXYGEN THERAPY											76.98
76.99	LITHOTRIPSY											76.99
OUTPATIENT SERVICE COST CENTERS												
88	RURAL HEALTH CLINIC	5,308,639										88
88.01	RHC II											88.01
91	EMERGENCY	6,378,941							588,197		1,689,373	91
91.01	PRIORITY CARE CARLYLE	1,212,912							1,948		51,721	91.01
92	OBSERVATION BEDS (NON-DISTIN	391,827							24,150		105,182	92
OTHER REIMBURSABLE COST CENTERS												
94	HOME PROGRAM DIALYSIS											94
200	TOTAL (SUM OF LINES 50-199)	89,509,006							6,458,364		19,220,732	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.359364	3,479,362			1,250,357			50
51 RECOVERY ROOM	0.095705	193,167			18,487			51
52 DELIVERY ROOM & LABOR ROOM	0.573745							52
53 ANESTHESIOLOGY	0.229843	461,818			106,146			53
54 RADIOLOGY-DIAGNOSTIC	0.303836	3,583,974			1,088,940			54
57 CT SCAN	0.124605	3,080,504			383,846			57
58 MRI	0.185801	1,063,870			197,668			58
60 LABORATORY	0.225407	504,881	1,964		113,804	443		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63 BLOOD STORING, PROCESSING & TRA	0.303894	144,374			43,874			63
65 RESPIRATORY THERAPY	0.460715	284,796	26,880		131,210	12,384		65
66 PHYSICAL THERAPY	0.654935	1,505,770			986,181			66
69 ELECTROCARDIOLOGY	0.095954	774,460			74,313			69
70 ELECTROENCEPHALOGRAPHY	0.320880	224,885			72,161			70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.582872	477,996	4,127		278,610	2,406		71
73 DRUGS CHARGED TO PATIENTS	0.435203	1,432,361		18,855	623,368		8,206	73
74 RENAL DIALYSIS								74
76.97 CARDIAC REHABILITATION	0.989364	162,238			160,512			76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC								88
88.01 RHC II								88.01
91 EMERGENCY	0.370348	1,689,373			625,656			91
91.01 PRIORITY CARE CARLYLE	0.602834	51,721			31,179			91.01
92 OBSERVATION BEDS (NON-DISTINCT)	1.039867	105,182			109,375			92
OTHER REIMBURSABLE COST CENTERS								
94 HOME PROGRAM DIALYSIS								94
200 SUBTOTAL (SEE INSTRUCTIONS)		19,220,732	32,971	18,855	6,295,687	15,233	8,206	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		19,220,732	32,971	18,855	6,295,687	15,233	8,206	202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3		5		7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	448,472		448,472	3,448	130.07	465	60,483	30
31 INTENSIVE CARE UNIT	19,712		19,712	8	2,464.00			31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	36,967		36,967	998	37.04	277	10,260	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	505,151		505,151	4,454		742	70,743	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

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

[ ] PPS  
 [ ] TEFRA  
 [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT PROGRAM CHARGES	CAPITAL
	COST (FROM WKST B, PT. II, COL. 26)	CHARGES (FROM WKST C, PT. I, COL. 8)	COST TO CHARGES (COL.1 ÷ COL.2)		(COL.3 x COL.4)
	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	375,659	11,116,215	0.033794		50
51 RECOVERY ROOM	16,586	787,723	0.021056		51
52 DELIVERY ROOM & LABOR ROOM	76,325	1,878,855	0.040623		52
53 ANESTHESIOLOGY	89,279	1,807,013	0.049407		53
54 RADIOLOGY-DIAGNOSTIC	451,481	11,452,397	0.039422		54
57 CT SCAN	333,680	9,292,175	0.035910		57
58 MRI	225,142	3,713,254	0.060632		58
60 LABORATORY	374,717	19,696,713	0.019024		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
63 BLOOD STORING, PROCESSING & T	7,818	466,478	0.016760		63
65 RESPIRATORY THERAPY	45,173	1,810,545	0.024950		65
66 PHYSICAL THERAPY	254,080	4,313,147	0.058908		66
69 ELECTROCARDIOLOGY	20,078	1,528,049	0.013140		69
70 ELECTROENCEPHALOGRAPHY	28,465	551,480	0.051616		70
71 MEDICAL SUPPLIES CHARGED TO P	130,861	2,360,530	0.055437		71
73 DRUGS CHARGED TO PATIENTS	165,395	5,173,209	0.031971		73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION	29,695	268,904	0.110430		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC	168,853	5,308,639	0.031807		88
88.01 RHC II					88.01
91 EMERGENCY	191,991	6,378,941	0.030098		91
91.01 PRIORITY CARE CARLYLE	62,414	1,212,912	0.051458		91.01
92 OBSERVATION BEDS (NON-DISTINC	37,460	391,827	0.095603		92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-199)	3,085,152	89,509,006			200

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
 12/02/2013 03:55

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL. 5 + COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	3,448		465		30
31 INTENSIVE CARE UNIT	8				31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	998		277		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	4,454		742		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS. 1-4) 5	TOTAL O/P COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 CT SCAN						57
58 MRI						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC						88
88.01 RHC II						88.01
91 EMERGENCY						91
91.01 PRIORITY CARE CARLYLE						91.01
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0145) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] NF	[ ] ICF/MR	[ ] PPS [ ] TEFRA [XX] OTHER	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES PGM 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS												
50						OPERATING ROOM	11,116,215					50
51						RECOVERY ROOM	787,723					51
52						DELIVERY ROOM & LABOR ROOM	1,878,855					52
53						ANESTHESIOLOGY	1,807,013					53
54						RADIOLOGY-DIAGNOSTIC	11,452,397					54
57						CT SCAN	9,292,175					57
58						MRI	3,713,254					58
60						LABORATORY	19,696,713					60
62.30						BLOOD CLOTTING FOR HEMOPHILI						62.30
63						BLOOD STORING, PROCESSING &	466,478					63
65						RESPIRATORY THERAPY	1,810,545					65
66						PHYSICAL THERAPY	4,313,147					66
69						ELECTROCARDIOLOGY	1,528,049					69
70						ELECTROENCEPHALOGRAPHY	551,480					70
71						MEDICAL SUPPLIES CHARGED TO	2,360,530					71
73						DRUGS CHARGED TO PATIENTS	5,173,209					73
74						RENAL DIALYSIS						74
76.97						CARDIAC REHABILITATION	268,904					76.97
76.98						HYPERBARIC OXYGEN THERAPY						76.98
76.99						LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS												
88						RURAL HEALTH CLINIC	5,308,639					88
88.01						RHC II						88.01
91						EMERGENCY	6,378,941					91
91.01						PRIORITY CARE CARLYLE	1,212,912					91.01
92						OBSERVATION BEDS (NON-DISTIN	391,827					92
OTHER REIMBURSABLE COST CENTERS												
94						HOME PROGRAM DIALYSIS						94
200						TOTAL (SUM OF LINES 50-199)	89,509,006					200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	----- PROGRAM CHARGES -----				----- PROGRAM COSTS -----		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.359364					50
51	RECOVERY ROOM	0.095705					51
52	DELIVERY ROOM & LABOR ROOM	0.573745					52
53	ANESTHESIOLOGY	0.229843					53
54	RADIOLOGY-DIAGNOSTIC	0.303836					54
57	CT SCAN	0.124605					57
58	MRI	0.185801					58
60	LABORATORY	0.225407					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRA	0.303894					63
65	RESPIRATORY THERAPY	0.460715					65
66	PHYSICAL THERAPY	0.654935					66
69	ELECTROCARDIOLOGY	0.095954					69
70	ELECTROENCEPHALOGRAPHY	0.320880					70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.582872					71
73	DRUGS CHARGED TO PATIENTS	0.435203					73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	0.989364					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
91	EMERGENCY	0.370348					91
91.01	PRIORITY CARE CARLYLE	0.602834					91.01
92	OBSERVATION BEDS (NON-DISTINCT	1.039867					92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	SUBTOTAL (SEE INSTRUCTIONS)						200
201	LESS PBP CLINIC LAB SERVICES						201
202	NET CHARGES (LINE 200 - LINE 201)						202

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,448	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,448	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	306	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,854	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,564	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,878,054	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,878,054	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,730,354	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	215,730	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,514,624	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1.786601	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	705.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	881.09	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,878,054	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,414.75 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,212,669 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) 2,212,669 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	87,710	8	10,963.75	8	87,710 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)					2,159,462 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,459,841 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 223,141 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 200,056 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 423,197 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 4,036,644 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) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 288 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,414.75 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 407,448 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	448,472	4,878,054	0.091937	407,448	37,460 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,448	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,448	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	306	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,854	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	465	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	998	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	277	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,878,054	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,878,054	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,730,354	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	215,730	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,514,624	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1.786601	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	705.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	881.09	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,878,054	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)					1,414.75 38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)					657,859 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)					657,859 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	606,441	998	607.66	277	168,322 42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	87,710	8	10,963.75		43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					826,181 49

PASS-THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					70,743 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					70,743 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)					64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					65
66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					66
67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)					67
68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)					68
69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)					69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)					288 87
88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2)					88
89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)					89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,293,469		30
31 INTENSIVE CARE UNIT		13,041		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.359364	589,888	211,985	50
51 RECOVERY ROOM	0.095705	49,201	4,709	51
52 DELIVERY ROOM & LABOR ROOM	0.573745	630	361	52
53 ANESTHESIOLOGY	0.236802	114,608	27,139	53
54 RADIOLOGY-DIAGNOSTIC	0.303836	524,838	159,465	54
57 CT SCAN	0.124605	740,516	92,272	57
58 MRI	0.185801	64,557	11,995	58
60 LABORATORY	0.228097	1,394,286	318,032	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.303894	84,887	25,797	63
65 RESPIRATORY THERAPY	0.473100	947,227	448,133	65
66 PHYSICAL THERAPY	0.659203	79,245	52,239	66
69 ELECTROCARDIOLOGY	0.095954	98,342	9,436	69
70 ELECTROENCEPHALOGRAPHY	0.320880			70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.582872	323,615	188,626	71
73 DRUGS CHARGED TO PATIENTS	0.435203	832,229	362,189	73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION	0.989364			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC				88
88.01 RHC II				88.01
91 EMERGENCY	0.375380	588,197	220,797	91
91.01 PRIORITY CARE CARLYLE	0.602834	1,948	1,174	91.01
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	1.039867	24,150	25,113	92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		6,458,364	2,159,462	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		6,458,364		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	(COL.1 x COL.2) 3
INPATIENT ROUTINE SERVICE COST CENTERS			
30 ADULTS & PEDIATRICS			30
31 INTENSIVE CARE UNIT			31
43 NURSERY			43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	0.359364		50
51 RECOVERY ROOM	0.095705		51
52 DELIVERY ROOM & LABOR ROOM	0.573745		52
53 ANESTHESIOLOGY	0.229843		53
54 RADIOLOGY-DIAGNOSTIC	0.303836		54
57 CT SCAN	0.124605		57
58 MRI	0.185801		58
60 LABORATORY	0.225407		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63 BLOOD STORING, PROCESSING & TRA	0.303894		63
65 RESPIRATORY THERAPY	0.460715		65
66 PHYSICAL THERAPY	0.654935		66
69 ELECTROCARDIOLOGY	0.095954		69
70 ELECTROENCEPHALOGRAPHY	0.320880		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.582872		71
73 DRUGS CHARGED TO PATIENTS	0.435203		73
74 RENAL DIALYSIS			74
76.97 CARDIAC REHABILITATION	0.989364		76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC			88
88.01 RHC II			88.01
91 EMERGENCY	0.370348		91
91.01 PRIORITY CARE CARLYLE	0.602834		91.01
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	1.039867		92
94 HOME PROGRAM DIALYSIS			94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)			200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			201
202 NET CHARGES (LINE 200 MINUS LINE 201)			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	3,164,658	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	15,743	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	41,134	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	48.61	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0054	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.2111	31
32	SUM OF LINES 30 AND 31	0.2165	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0707	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	223,741	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)	568	40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	3,404,142	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	3,923,823	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	3,793,903	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	251,802	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	4,045,705	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	4,045,705	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	491,828	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	1,184	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	81,929	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	57,350	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	73,648	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	3,610,043	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.93	HVBP PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	11,215	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-1,187	70.94
70.96	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2012)	153,373	70.96
70.97	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2013)	455,084	70.97
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	4,228,528	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	21,143	71.01
72	INTERIM PAYMENTS	3,666,091	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	541,294	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	145,258	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

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

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,678,501		3,860,838	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	3.01
					3.02
					3.03
					3.04
					3.05
					3.06
					3.07
					3.08
					3.09
					3.50
	01/31/2013	12,410	01/31/2013	11,227	3.51
					3.52
					3.53
					3.54
					3.55
					3.56
					3.57
					3.58
					3.59
					3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-12,410		-11,227	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		3,666,091		3,849,611	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.		NONE		NONE	5.01
					5.02
					5.03
					5.04
					5.05
					5.06
					5.07
					5.08
					5.09
					5.50
		NONE		NONE	5.51
					5.52
					5.53
					5.54
					5.55
					5.56
					5.57
					5.58
					5.59
					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		562,437		379,979	6.01
					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		4,228,528		4,229,590	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-0145 ST. JOSEPH'S HOSPITAL  
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11  
12/02/2013 03:55

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-0145) [ ] 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	1,412	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,572	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	11	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,168	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	93,063,862	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,790,940	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)	1,045,800	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,019,485	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	26,315	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES	826,181	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	826,181	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	826,181	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11) CUSTOMARY CHARGES		12
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	826,181	18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	3,545,768			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	12,505,862			4
5	OTHER RECEIVABLES	34,860			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,776,764			6
7	INVENTORY	627,663			7
8	PREPAID EXPENSES	241,328			8
9	OTHER CURRENT ASSETS	2,571,889			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	14,750,606			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	22,082,300			15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				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)	22,082,300			30
OTHER ASSETS					
31	INVESTMENTS	84,826,295			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	166,166			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	84,992,461			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	121,825,367			36
LIABILITIES AND FUND BALANCES		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,198,881			37
38	SALARIES, WAGES & FEES PAYABLE	2,361,337			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	2,571,889			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	3,077,508			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	9,209,615			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	6,132,418			46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	7,308,659			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	13,441,077			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	22,650,692			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	99,174,675			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)	99,174,675			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	121,825,367			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		85,287,645							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		11,874,967							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		97,162,612							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 RESTRICTED GRANT									5
6 CHANGE IN TEMP RESTRICTED ASSET		97,615							6
7 DIFF IN ACCRUED PENSION		3,000,618							7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		3,098,233							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		100,260,845							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 DIFF ACCRUED BENFT LIAB PENSION									13
14 TRANSFERS		1,086,165							14
15 CHANGE IN TEMP RESTRICTED ASSETS									15
16 ROUNDING		5							16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		1,086,170							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		99,174,675							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	3,540,091		3,540,091	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	3,540,091		3,540,091	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	14,765		14,765	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	14,765		14,765	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	3,554,856		3,554,856	17
18 ANCILLARY SERVICES	15,089,801	79,269,811	94,359,612	18
19 OUTPATIENT SERVICES				19
20 RHC		5,308,639	5,308,639	20
20.01 RHC II				20.01
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	18,644,657	84,578,450	103,223,107	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		43,324,338	29
30 ADD (SPECIFY)			30
31 BAD DEBT EXPENSE	785,039		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		785,039	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		44,109,377	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	103,223,107	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	54,657,052	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	48,566,055	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	44,109,377	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	4,456,678	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	5,013,406	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS INCOME)	2,395,984	24
24.01	OTHER (NET ASSETS RELEASED)	8,899	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	7,418,289	25
26	TOTAL (LINE 5 PLUS LINE 25)	11,874,967	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	11,874,967	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT			
2	CAPITAL DRG OTHER THAN OUTLIER	249,924		1
3	CAPITAL DRG OUTLIER PAYMENTS	1,878		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	8.91		3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)			4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)			5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)			6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)			7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)			8
10	SUM OF LINES 7 AND 8			9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)			10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)			11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	251,802		12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5.01 COMMUNICATIONS					5.01
5.02 INFORMATION SYSTEMS					5.02
5.03 PURCHASING					5.03
5.04 ADMITTING					5.04
5.05 BUSINESS OFFICE					5.05
5.06 ADMIN & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 CT SCAN					57
58 MRI					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
63 BLOOD STORING, PROCESSING & TR					63
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHARGED TO PA					71
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC					88
88.01 RHC II					88.01
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
91.01 PRIORITY CARE CARLYLE					91.01
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					92
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
194 LIFELINE					194
194.01 DEVELOPMENT					194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-1

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

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	251,714	1,404,805	1,656,519		1,656,519		1,656,519	1
2	28,147		28,147		28,147		28,147	2
3	63,819		63,819		63,819		63,819	3
4								4
5				11,220	11,220		11,220	5
6								6
7								7
8								8
9	203,435	236,667	440,102	29,002	469,104		469,104	9
10	547,115	1,641,472	2,188,587	40,222	2,228,809		2,228,809	10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
OTHER HEALTH CARE COSTS								
15		13,867	13,867	32,567	46,434		46,434	15
16								16
17								17
18								18
19		3,133	3,133	1,480	4,613		4,613	19
20								20
21		17,000	17,000	34,047	51,047		51,047	21
22	547,115	1,658,472	2,205,587	74,269	2,279,856		2,279,856	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23		173,843	173,843	16,202	190,045		190,045	23
24								24
25								25
26								26
27								27
28		173,843	173,843	16,202	190,045		190,045	28
FACILITY OVERHEAD								
29				4,380	4,380		4,380	29
30	299,391	213,869	513,260	82,574	595,834	-2,880	592,954	30
31	299,391	213,869	513,260	86,954	600,214	-2,880	597,334	31
32	846,506	2,046,184	2,892,690	177,425	3,070,115	-2,880	3,067,235	32

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL. 1 x COL. 3)	GREATER OF COL. 2 OR COL. 4	
1	PHYSICIANS	4.91	23,221	4,200	20,622	1
2	PHYSICIAN ASSISTANTS	1.33	4,442	2,100	2,793	2
3	NURSE PRACTITIONERS	1.25	2,856	2,100	2,625	3
4	SUBTOTAL (SUM OF LINES 1-3)	7.49	30,519		26,040	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	7.49	30,519			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				2,279,856	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				190,045	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				2,469,901	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				0.923056	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				597,334	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,172,685	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,770,019	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,770,019	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,633,827	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				3,913,683	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	3,913,683	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	92,885	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	3,820,798	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	30,519	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	30,519	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	125.19	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)	78.54	79.17	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	125.19	125.19	125.19 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	4,464	4,465	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	558,848	558,973	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)			15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)		1,117,821	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		1,205,998	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		790,506	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		790,506	16.05
17	PRIMARY PAYOR PAYMENTS		571	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		129,689	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		215,262	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		789,935	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		1,980	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		791,915	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		791,915	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		3,960	26.01
27	INTERIM PAYMENTS		452,047	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		335,908	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2			30

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

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	2,228,809	2,228,809	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.002545	0.005521	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	5,672	12,305	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	24,586	9,726	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	30,258	22,031	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	2,279,856	2,279,856	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,770,019	1,770,019	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.013272	0.009663	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	23,492	17,104	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	53,750	39,135	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	408	885	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	131.74	44.22	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	10	15	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,317	663	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		92,885	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		1,980	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER  
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I  
 COMPONENT NO: 14-8503

WORKSHEET M-5

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		449,885	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 01/31/2013	2,162	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		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	2,162	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		452,047	4
TO BE COMPLETED BY INTERMEDIARY			
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	NONE	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	NONE	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 (SEE INSTR.	PROGRAM TO .01	339,868	6.01
	PROVIDER PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		791,915	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	8
		NPR DATE:	

RHC II  
 COMPONENT NO: 14-8502

WORKSHEET M-1

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

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1								1
2								2
3								3
4								4
5								5
6	11,220		11,220	-11,220				6
7								7
8								8
9	29,002		29,002	-29,002				9
10	40,222		40,222	-40,222				10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
OTHER HEALTH CARE COSTS								
15		32,567	32,567	-32,567				15
16								16
17								17
18								18
19		1,480	1,480	-1,480				19
20								20
21		34,047	34,047	-34,047				21
22	40,222	34,047	74,269	-74,269				22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29		11,998	11,998	-11,998				29
30	60,121	32,380	92,501	-92,501				30
31	60,121	44,378	104,499	-104,499				31
32	100,343	78,425	178,768	-178,768				32

RHC II  
 COMPONENT NO: 14-8502

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS		4,200			1
2	PHYSICIAN ASSISTANTS		2,100			2
3	NURSE PRACTITIONERS		2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)					4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)					8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)					10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)					12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)					13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)					14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)					15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)					16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16					18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)					19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)					20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC II  
 COMPONENT NO: 14-8502

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

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

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)	15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	16.05
17	PRIMARY PAYOR PAYMENTS	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	26.01
27	INTERIM PAYMENTS	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2	30

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

RHC II  
COMPONENT NO: 14-8502

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

PNEUMOCOCCAL SEASONAL  
1 INFLUENZA  
2

1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)	16

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4)

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period		
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)		
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
If this date occurs after the period shown on line 2, stop here and see instructions.		
STEP 3: Average Pension Contributions During the Averaging Period		
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
STEP 4: Total Pension Cost for Wage Index		
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	10/01/2011 through 09/30/2012 (3)	(3.01)	10/01/2012 through 09/30/2013 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments	3,164,658	865,011		2,299,647		3,164,658	1
2	Outlier payments for discharges	15,743	12,812		2,931		15,743	2
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	41,134			41,134		41,134	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21							5
6	IME payment adjustment							6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27							7
8	IME add-on adjustment							8
9	Total IME payment							9
DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable disproportionate share percentage	0.0707	0.0707	0.0707	0.0707	0.0707	0.0707	10
11	Disproportionate share adjustment	223,741		61,156		162,585	223,741	11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD additional payment							12
13	Subtotal	3,404,142		938,979		2,465,163	3,404,142	13
14	Hospital specific payments	3,923,823		1,082,308		2,841,515	3,923,823	14
15	Total payment for inpatient operating costs - E Part A Line 49	3,793,903		1,046,476		2,747,427	3,793,903	15
16	Payment for inpatient program capital	251,802		63,200		188,602	251,802	16
17	Special add-on payments for new technologies							17
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL			1,109,676		2,936,029	4,045,705	19
CAPITAL PAYMENTS								
20	Capital DRG other than outlier	249,924		63,106		186,818	249,924	20
21	Capital DRG outlier payments	1,878		94		1,784	1,878	21
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments	251,802		63,200		188,602	251,802	26
LOW VOLUME ADJUSTMENT								
27	Low volume adjustment factor			0.138214		0.155000		27
28	Low Volume Adjustment			153,373			153,373	28
29	Low Volume Adjustment					455,084	455,084	29