

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 11-25-2013 TIME: 12:42____
 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-HIGHLAND IL (14-1336) (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 PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1 HOSPITAL		579,462	-206,466		63,659	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		167,475				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		746,937	-206,466		63,659	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.

PART III AND L-1, PARTS I THROUGH III.

47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56 IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57 IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58 IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59 ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60 ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
	Y/N	IME	DIRECT GME	
61 DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. (SEE INSTRUCTIONS)	N			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.				
	PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 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	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)			64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)).
 (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
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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	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)			66

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
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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
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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)

		V	XIX	
TITLE V AND XIX INPATIENT SERVICES		1	2	
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)?	Y		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.	N		106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.	N	N	107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	109
			PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	
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: 35,184 PAID LOSSES: SELF INSURANCE: 389,754			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121
TRANSPLANT CENTER INFORMATION				
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

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

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
		1	2	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1
		Y/N	DATE	V/I
		1	2	3
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3

FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
		1	2	3
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5

APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N
		1	2
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	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	Y/N
		1	2
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14

BED COMPLEMENT			
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N 15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	10/08/2013	Y	10/08/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: SUSAN	LAST NAME: HORST	TITLE: DIRECTOR OF THIRD PA	41
42	EMPLOYER: ST. JOHN'S HOSPITAL			42
43	PHONE NUMBER: 2178144395	E-MAIL ADDRESS: SUSAN.HORST@ST-JOHNS.ORG		43

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

LINE	AMOUNT	RECLASS	ADJUSTED	PAID HOURS	AVERAGE
		OF SALARIES	SALARIES	RELATED	HOURLY WAGE
WKST A	REPORTED	(FROM	(COL. 2 +	TO SALARIES	(COL. 4 +
NUMBER		WKST A-6)	COL. 3)	IN COL. 4	COL. 5)
1	2	3	4	5	6
SALARIES					
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200			1
2	NON-PHYSICIAN ANESTHETIST PART A				2
3	NON-PHYSICIAN ANESTHETIST PART B				3
4	PHYSICIAN-PART A ADMINISTRATIVE				4
4.01	PHYSICIAN-PART A - TEACHING				4.01
5	PHYSICIAN-PART B				5
6	NON-PHYSICIAN-PART B				6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21			7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)				7.01
8	HOME OFFICE PERSONNEL				8
9	SNF	44			9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)				10
OTHER WAGES & RELATED COSTS					
11	CONTRACT LABOR (SEE INSTRUCTIONS)				11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES				12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE				13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS				14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE				15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING				16
WAGE-RELATED COSTS					
17	WAGE-RELATED COSTS (CORE)				17
18	WAGE-RELATED COSTS (OTHER)				18
19	EXCLUDED AREAS				19
20	NON-PHYSICIAN ANESTHETIST PART A				20
21	NON-PHYSICIAN ANESTHETIST PART B				21
22	PHYSICIAN PART A - ADMINISTRATIVE				22
22.01	PHYSICIAN PART A - TEACHING				22.01
23	PHYSICIAN PART B				23
24	WAGE-RELATED COSTS (RHC/FQHC)				24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)				25
OVERHEAD COSTS - DIRECT SALARIES					
26	EMPLOYEE BENEFITS DEPARTMENT				26
27	ADMINISTRATIVE & GENERAL				27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)				28
29	MAINTENANCE & REPAIRS				29
30	OPERATION OF PLANT				30
31	LAUNDRY & LINEN SERVICE				31
32	HOUSEKEEPING				32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)				33
34	DIETARY				34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)				35
36	CAFETERIA				36
37	MAINTENANCE OF PERSONNEL				37
38	NURSING ADMINISTRATION				38
39	CENTRAL SERVICES AND SUPPLY				39
40	PHARMACY				40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY				41
42	SOCIAL SERVICE				42
43	OTHER GENERAL SERVICE				43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5
6	TOTAL (SUM OF LINES 3 THRU 5)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

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

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

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

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

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.356175	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,011,350	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				5,279,004	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				1,880,249	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.				868,899	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				44,112	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				868,899	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	2,021,170	529,304	2,550,474		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	719,890	188,525	908,415		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	1,990,386	1,298,531	3,288,917		22
23	COST OF CHARITY CARE	-1,270,496	-1,110,006	-2,380,502		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			939,099		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			319,315		27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			619,784		28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			220,752		29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			-2,159,750		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			-1,290,851		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		171,081	171,081	167,928	1
1.01	00101					1.01
2	00200		834,237	834,237	68,929	2
2.01	00201				3,809	2.01
3	00300					3
4	00400	114,459	4,297,943	4,412,402		4
5.01	00540		36,624	36,624	-732	5.01
5.02	00550		65,080	65,080		5.02
5.03	00560	112,982	36,736	149,718	-17,145	5.03
5.04	00570	179,635	14,873	194,508		5.04
5.05	00580	226,542	78,644	305,186	-2,908	5.05
5.06	00590	782,223	3,022,790	3,805,013	-29,893	5.06
6	00600	178,964	24,422	203,386	-3,496	6
7	00700	187,799	540,099	727,898	-50,817	7
7.01	00701				53,567	7.01
8	00800		90,185	90,185		8
9	00900	307,270	71,059	378,329	6,488	9
10	01000	354,040	132,598	486,638	-159,071	10
11	01100	-708	379	-329	159,071	11
12	01200					12
13	01300	429,493	4,094	433,587		13
14	01400					14
15	01500					15
16	01600	424,657	87,264	511,921	-129	16
17	01700	48,728	6,226	54,954		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,190,719	85,934	1,276,653	-212,432	30
31	03100	23,170	788	23,958	-2,068	31
ANCILLARY SERVICE COST CENTERS						
50	05000	700,796	1,061,606	1,762,402	-874,063	50
53	05300		492,601	492,601	-13,052	53
54	05400	651,038	636,980	1,288,018	-126,113	54
60	06000	537,991	895,520	1,433,511	-2,807	60
62.30	06250					62.30
65	06500	151,081	95,738	246,819	-23,773	65
66	06600	469,780	12,606	482,386	-5,625	66
67	06700	76,680	809	77,489		67
68	06800	8,883	11,633	20,516		68
68.01	03040				-223	68.01
71	07100	70,468	115,272	185,740		71
72	07200	72,945	100,382	173,327	304,895	72
73	07300				676,503	73
74	07400	315,696	477,355	793,051	275,806	74
76.97	07697	118,144	5,409	123,553	-120	76.97
76.98	07698	59,916	146,108	206,024		76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	628,883	1,590,369	2,219,252	-55,288	91
92	09200					92
93	04950		435,374	435,374		93
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
SPECIAL PURPOSE COST CENTERS						
113	11300		134,942	134,942	-134,942	113
118		8,422,274	15,813,760	24,236,034	2,299	118
NONREIMBURSABLE COST CENTERS						
190	19000		14,775	14,775		190
192	19200	46,755	1,532,476	1,579,231	-2,132	192
194	07950	21,362	8,029	29,391	-167	194
194.01	07951					194.01
200		8,490,391	17,369,040	25,859,431		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	CAP REL COSTS-BLDG & FIXT	339,009	109,606	448,615	1
1.01	00101	CAP REL COSTS-MAB BUILDING				1.01
2	00200	CAP REL COSTS-MVBLE EQUIP	903,166	206,183	1,109,349	2
2.01	00201	CAP REL COSTS-MAB EQUIPMENT	3,809		3,809	2.01
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	4,412,402	-590,224	3,822,178	4
5.01	00540	COMMUNICATIONS	35,892		35,892	5.01
5.02	00550	INFORMATION SYSTEMS	65,080	-2,071	63,009	5.02
5.03	00560	PURCHASING/RECEIVENG/STORES	132,573	4,225	136,798	5.03
5.04	00570	ADMITTING	194,508		194,508	5.04
5.05	00580	PATIENT ACCOUNTING	302,278	1,289,317	1,591,595	5.05
5.06	00590	OTHER ADMIN & GENERAL	3,775,120	-1,215,049	2,560,071	5.06
6	00600	MAINTENANCE & REPAIRS	199,890	-759	199,131	6
7	00700	OPERATION OF PLANT	677,081	-135	676,946	7
7.01	00701	PLANT OPS-MAB BUILDING	53,567		53,567	7.01
8	00800	LAUNDRY & LINEN SERVICE	90,185	-3,650	86,535	8
9	00900	HOUSEKEEPING	384,817	-23	384,794	9
10	01000	DIETARY	327,567	-68,798	258,769	10
11	01100	CAFETERIA	158,742	-16,107	142,635	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	433,587		433,587	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY				15
16	01600	MEDICAL RECORDS & LIBRARY	511,792	-3,443	508,349	16
17	01700	SOCIAL SERVICE	54,954		54,954	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,064,221	-2,284	1,061,937	30
31	03100	INTENSIVE CARE UNIT	21,890		21,890	31
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	888,339	-1,875	886,464	50
53	05300	ANESTHESIOLOGY	479,549	-420,331	59,218	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,161,905	-602	1,161,303	54
60	06000	LABORATORY	1,430,704	-28,668	1,402,036	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	223,046	-21,957	201,089	65
66	06600	PHYSICAL THERAPY	476,761	-2,300	474,461	66
67	06700	OCCUPATIONAL THERAPY	77,489		77,489	67
68	06800	SPEECH PATHOLOGY	20,516		20,516	68
68.01	03040	AUDIOLOGY	185,517	-790	184,727	68.01
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	478,222	-1,109	477,113	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	676,503		676,503	72
73	07300	DRUGS CHARGED TO PATIENTS	1,068,857	-4,802	1,064,055	73
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION	123,433		123,433	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	206,024		206,024	76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	EMERGENCY	2,163,964	-1,167,241	996,723	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
93	04950	O/P GERIATRIC PSYCH CENTER	435,374		435,374	93
OTHER REIMBURSABLE COST CENTERS						
94	09400	HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	24,238,333	-1,942,887	22,295,446	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,775		14,775	190
192	19200	PHYSICIANS' PRIVATE OFFICES	1,577,099	-1,501,670	75,429	192
194	07950	TRANSPORTATION	29,224		29,224	194
194.01	07951	FUND DEVELOPMENT				194.01
200		TOTAL (SUM OF LINES 118-199)	25,859,431	-3,444,557	22,414,874	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- COST CENTER	INCREASE LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 CAFETERIA EXPENSE	A	CAFETERIA	11	154,346	4,725	1
500 TOTAL RECLASSIFICATIONS				154,346	4,725	500
CODE LETTER - A						
1 RENTAL EXPENSE	B	CAP REL COSTS-MVBLE EQUIP	2		72,738	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
500 TOTAL RECLASSIFICATIONS					72,738	500
CODE LETTER - B						
1 TELEPHONE EXPENSE	C	COMMUNICATIONS	5.01		167	1
2						2
500 TOTAL RECLASSIFICATIONS					167	500
CODE LETTER - C						
1 POSTAGE EXPENSE	D	OTHER ADMIN & GENERAL	5.06		19,406	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
500 TOTAL RECLASSIFICATIONS					19,406	500
CODE LETTER - D						
1 INTEREST EXPENSE	E	CAP REL COSTS-BLDG & FIXT	1		134,942	1
500 TOTAL RECLASSIFICATIONS					134,942	500
CODE LETTER - E						
1 MEDICAL SUPPLIES EXPENSE	F	MEDICAL SUPPLIES CHARGED TO P	71		304,924	1
2		IMPL. DEV. CHARGED TO PATIENT	72		676,503	2
3						3
4						4
5						5
6						6
7						7
500 TOTAL RECLASSIFICATIONS					981,427	500
CODE LETTER - F						
1 PHARMACY EXPENSE	G	DRUGS CHARGED TO PATIENTS	73		123,022	1
500 TOTAL RECLASSIFICATIONS					123,022	500
CODE LETTER - G						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 MAB EXPENSE	H					1
2		CAP REL COSTS-MAB EQUIPMENT	2.01		3,809	2
3		PLANT OPS-MAB BUILDING	7.01		53,567	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					57,376	500
1 PROPERTY INSURANCE	I	CAP REL COSTS-BLDG & FIXT	1		32,986	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					32,986	500
1 SURG PROCEDURES & DRUG ADMIN	J	OPERATING ROOM	50	52,600	20,142	1
2		DRUGS CHARGED TO PATIENTS	73	147,678	9,343	2
3						3
4						4
5						5
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				200,278	29,485	500
1 SHARED COLLEAGUE	K	OTHER ADMIN & GENERAL	5.06	38		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - K				38		500
1 SHARED DIRECTOR	L	MAINTENANCE & REPAIRS	6	3,306		1
2		OPERATION OF PLANT	7	3,400		2
3		HOUSEKEEPING	9	6,488		3
500 TOTAL RECLASSIFICATIONS CODE LETTER - L				13,194		500
GRAND TOTAL (INCREASES)				367,856	1,456,274	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 CAFETERIA EXPENSE	A	DIETARY	10	154,346	4,725	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				154,346	4,725	500
1 RENTAL EXPENSE	B	COMMUNICATIONS	5.01		899	10 1
2		PURCHASING/RECEIVENG/STORES	5.03		2,044	10 2
3						3
4		OTHER ADMIN & GENERAL	5.06		3,157	4
5		MAINTENANCE & REPAIRS	6		6,802	5
6		OPERATION OF PLANT	7		650	6
7		ADULTS & PEDIATRICS	30		10,127	7
8		OPERATING ROOM	50		37,211	8
9		ANESTHESIOLOGY	53		869	9
10		RADIOLOGY-DIAGNOSTIC	54		120	10
11		LABORATORY	60		2,349	11
12		RESPIRATORY THERAPY	65		937	12
13		PHYSICAL THERAPY	66		2,860	13
14						14
15		CARDIAC REHABILITATION	76.97		120	15
16		EMERGENCY	91		2,461	16
17		PHYSICIANS' PRIVATE OFFICES	192		2,132	17
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					72,738	500
1 TELEPHONE EXPENSE	C					1
2		TRANSPORTATION	194		167	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					167	500
1 POSTAGE EXPENSE	D					1
2		PURCHASING/RECEIVENG/STORES	5.03		15,101	2
3		PATIENT ACCOUNTING	5.05		2,908	3
4						4
5						5
6						6
7		MEDICAL RECORDS & LIBRARY	16		129	7
8						8
9		OPERATING ROOM	50		330	9
10		ANESTHESIOLOGY	53		248	10
11		RADIOLOGY-DIAGNOSTIC	54		128	11
12		LABORATORY	60		280	12
13						13
14						14
15						15
16		AUDIOLOGY	68.01		125	16
17		MEDICAL SUPPLIES CHARGED TO P	71		29	17
18		DRUGS CHARGED TO PATIENTS	73		77	18
19		EMERGENCY	91		51	19
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					19,406	500
1 INTEREST EXPENSE	E	INTEREST EXPENSE	113		134,942	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					134,942	500
1 MEDICAL SUPPLIES EXPENSE	F	OPERATING ROOM	50		909,264	1
2		ANESTHESIOLOGY	53		11,935	2
3		RESPIRATORY THERAPY	65		22,836	3
4		PHYSICAL THERAPY	66		2,765	4
5		AUDIOLOGY	68.01		60	5
6		DRUGS CHARGED TO PATIENTS	73		4,160	6
7		EMERGENCY	91		30,407	7
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					981,427	500
1 PHARMACY EXPENSE	G	RADIOLOGY-DIAGNOSTIC	54		123,022	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					123,022	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 MAB EXPENSE	H					1
2		CAP REL COSTS-MVBLE EQUIP	2		3,809	9 2
3		OPERATION OF PLANT	7		53,567	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					57,376	500
1 PROPERTY INSURANCE	I	OTHER ADMIN & GENERAL	5.06		32,986	12 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					32,986	500
1 SURG PROCEDURES & DRUG ADMIN	J	ADULTS & PEDIATRICS	30	190,196	12,109	1
2		INTENSIVE CARE UNIT	31	2,000	68	2
3		RADIOLOGY-DIAGNOSTIC	54	1,589	1,254	3
4		LABORATORY	60	67	111	4
5		EMERGENCY	91	6,426	15,943	5
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				200,278	29,485	500
1 SHARED COLLEAGUE	K	AUDIOLOGY	68.01	38		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - K				38		500
1 SHARED DIRECTOR	L	OTHER ADMIN & GENERAL	5.06	13,194		1
2						2
3						3
500 TOTAL RECLASSIFICATIONS CODE LETTER - L				13,194		500
GRAND TOTAL (DECREASES)				367,856	1,456,274	

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	1,510,827				18,000	1,492,827		1
2 LAND IMPROVEMENTS	178,290				178,290			2
3 BUILDINGS AND FIXTURES	5,951,526	33,635,606		33,635,606		39,587,132		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	11,467,627				7,664,734	3,802,893		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	19,108,270	33,635,606		33,635,606	7,861,024	44,882,852		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	19,108,270	33,635,606		33,635,606	7,861,024	44,882,852		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	171,081						171,081	1
1.01 CAP REL COSTS-MAB BUILDING								1.01
2 CAP REL COSTS-MVBLE EQUIP	834,237						834,237	2
2.01 CAP REL COSTS-MAB EQUIPMENT								2.01
3 TOTAL (SUM OF LINES 1-2)	1,005,318						1,005,318	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

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	39,624,383		39,624,383	0.912431				1
1.01 CAP REL COSTS-MAB BUILDING								1.01
2 CAP REL COSTS-MVBLE EQUIP	3,802,893		3,802,893	0.087569				2
2.01 CAP REL COSTS-MAB EQUIPMENT								2.01
3 TOTAL (SUM OF LINES 1-2)	43,427,276		43,427,276	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	280,687			134,942	32,986		448,615	1
1.01 CAP REL COSTS-MAB BUILDING								1.01
2 CAP REL COSTS-MVBLE EQUIP	1,036,611	72,738					1,109,349	2
2.01 CAP REL COSTS-MAB EQUIPMENT	3,809						3,809	2.01
3 TOTAL	1,321,107	72,738	134,942	32,986			1,561,773	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)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)	B	-6,240	LABORATORY	60	6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-2,715	OTHER ADMIN & GENERAL	5.06	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,609,524			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	725,457			12
13 LAUNDRY AND LINEN SERVICE	B	-3,650	LAUNDRY & LINEN SERVICE	8	13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-16,107	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	-3,443	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 XRAY FILM REVENUE	B	-55	RADIOLOGY-DIAGNOSTIC	54	33
34 EDUCATIONAL CLASSES	B	-1,824	OTHER ADMIN & GENERAL	5.06	34
35 SANITARY MACHINES	B	-23	HOUSEKEEPING	9	35
36					36
37 MEALS ON WHEELS	B	-55,644	DIETARY	10	37
38 MASSAGE REVENUE	B	420	PHYSICAL THERAPY	66	38
38.01 EMPLOYEE FITNESS	B	-830	PHYSICAL THERAPY	66	38.01
39					39
40 MISCELLANEOUS REVENUE	B	-360	EMPLOYEE BENEFITS DEPARTMENT	4	40
40.02 MISCELLANEOUS REVENUE	B	-1,103	PURCHASING/RECEIVENG/STORES	5.03	40.02
40.04 MISCELLANEOUS REVENUE	B	-1,877	OTHER ADMIN & GENERAL	5.06	40.04
40.05 MISCELLANEOUS REVENUE	B	-759	MAINTENANCE & REPAIRS	6	40.05
40.07 MISCELLANEOUS REVENUE	B	-10,682	DIETARY	10	40.07
40.08 MISCELLANEOUS REVENUE	B	-18,032	LABORATORY	60	40.08
40.09 MISCELLANEOUS REVENUE	B	-1,890	PHYSICAL THERAPY	66	40.09
40.11 MISCELLANEOUS REVENUE	B	-790	AUDIOLOGY	68.01	40.11
40.12 MISCELLANEOUS REVENUE	B	-980	MEDICAL SUPPLIES CHARGED TO PAT	71	40.12
40.14 MISCELLANEOUS REVENUE	B	-198	DRUGS CHARGED TO PATIENTS	73	40.14
40.15 VENDOR REBATES	B	-2,071	INFORMATION SYSTEMS	5.02	40.15
40.16 VENDOR REBATES	B	5,328	PURCHASING/RECEIVENG/STORES	5.03	40.16
40.17 VENDOR REBATES	B	-135	OPERATION OF PLANT	7	40.17
40.18 VENDOR REBATES	B	-2,472	DIETARY	10	40.18
40.19 VENDOR REBATES	B	-2,284	ADULTS & PEDIATRICS	30	40.19
40.20 VENDOR REBATES	B	-1,875	OPERATING ROOM	50	40.20
40.21 VENDOR REBATES	B	-547	RADIOLOGY-DIAGNOSTIC	54	40.21
40.22 VENDOR REBATES	B	-4,396	LABORATORY	60	40.22
40.23 VENDOR REBATES	B	-5	RESPIRATORY THERAPY	65	40.23
40.24 VENDOR REBATES	B	-129	MEDICAL SUPPLIES CHARGED TO PAT	71	40.24
40.25 VENDOR REBATES	B	-4,604	DRUGS CHARGED TO PATIENTS	73	40.25

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
41 PHYSICIAN RECRUITMENT EXPENSE	A	-171,433	OTHER ADMIN & GENERAL	5.06	41
41.01 HEALTH FAIR EXPENSE	A	-38,270	OTHER ADMIN & GENERAL	5.06	41.01
41.02 PUBLIC RELATIONS EXPENSE	A	-102	OTHER ADMIN & GENERAL	5.06	41.02
41.04 LOBBYING DUES	A	-11,617	OTHER ADMIN & GENERAL	5.06	41.04
42 COMMUNITY REL SALARY EXPENSE	A	-81,181	OTHER ADMIN & GENERAL	5.06	42
42.01 COMMUNITY REL BENEFIT EXPENSE	A	-39,911	EMPLOYEE BENEFITS DEPARTMENT	4	42.01
42.02 COMMUNITY REL OTHER EXPENSE	A	-136,278	OTHER ADMIN & GENERAL	5.06	42.02
43					43
44 DEPRECIATION LAPSING SCHEDULE	A	-568	CAP REL COSTS-BLDG & FIXT	1	9 44
45 NON REIMBURSABLE EXPENSE	A	-6,673	OTHER ADMIN & GENERAL	5.06	45
46 MEDICAID TAX ASSESSMENT	A	-236,287	OTHER ADMIN & GENERAL	5.06	46
47 SELF-INSURANCE EXPENSE	A	-512,885	EMPLOYEE BENEFITS DEPARTMENT	4	47
48 MEDICAL GROUP PURCHASE SVC EXPE	A	-1,501,670	PHYSICIANS' PRIVATE OFFICES	192	48
49 DEPRECIATION ADD BACK	A	110,174	CAP REL COSTS-BLDG & FIXT	1	9 49
49.01 DEPRECIATION ADD BACK	A	206,183	CAP REL COSTS-MVBLE EQUIP	2	9 49.01
50 TOTAL (SUM OF LINES 1 THRU 49)		-3,444,557			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	4	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUMS	1,665,700	1,702,768	-37,068	1
2	5.05	PATIENT ACCOUNTING	COMPUTER FEES	1,289,317		1,289,317	2
3	5.06	OTHER ADMIN & GENERAL	MANAGEMENT FEES	858,550	1,385,342	-526,792	3
4							4
5		TOTALS (SUM OF LINES 1-4)		3,813,567	3,088,110	725,457	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		HOSPITAL SISTERS HEALTH SYSTEM	100.00	CORPORATE OFFICE	6
7						7
8						8
9						9
10						10

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	VARIOUS	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2		3	4	5	6	7	8	9
1	53 ANESTHESIOLOGY	VARIOUS	420,331	420,331					1
2	60 LABORATORY	VARIOUS	77,530		77,530				2
3	65 RESPIRATORY THERAPY	VARIOUS	21,952	21,952					3
4	91 EMERGENCY	VARIOUS	1,382,074	1,014,391	367,683				4
5	91 EMERGENCY	VARIOUS	152,850	152,850					5
200	TOTAL		2,054,737	1,609,524	445,213				200

PROVIDER CCN: 14-1336 ST. JOSEPH'S HOSPITAL-HIGHLAND
 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
 11/25/2013 12:42

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. 10	11		12	13	14	15	16	17	18		
1	53	ANESTHESIOLOGY								420,331	1
2	60	LABORATORY									2
3	65	RESPIRATORY THERAPY								21,952	3
4	91	EMERGENCY								1,014,391	4
5	91	EMERGENCY								152,850	5
200		TOTAL								1,609,524	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	CAP REL MAB EQUIPMENT 2.01	EMPLOYEE BENEFITS DEPARTMENT 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	448,615	448,615				1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP	1,109,349		1,109,349			2
2.01 CAP REL COSTS-MAB EQUIPMENT	3,809			3,809		2.01
4 EMPLOYEE BENEFITS DEPARTMENT	3,822,178	2,926	106		3,825,210	4
5.01 COMMUNICATIONS	35,892	419	52,680			5.01
5.02 INFORMATION SYSTEMS	63,009	11,840	313,650			5.02
5.03 PURCHASING/RECEIVENG/STORES	136,798	13,518	598		51,598	5.03
5.04 ADMITTING	194,508	1,889	6,188		82,038	5.04
5.05 PATIENT ACCOUNTING	1,591,595	6,408	1,263		103,460	5.05
5.06 OTHER ADMIN & GENERAL	2,560,071	39,635			351,226	5.06
6 MAINTENANCE & REPAIRS	199,131	21,843	623		83,241	6
7 OPERATION OF PLANT	676,946	34,296	53,367		87,319	7
7.01 PLANT OPS-MAB BUILDING	53,567					7.01
8 LAUNDRY & LINEN SERVICE	86,535	11,605				8
9 HOUSEKEEPING	384,794	9,174	1,514		143,290	9
10 DIETARY	258,769	16,171	2,922		91,198	10
11 CAFETERIA	142,635	14,587	1,028		70,165	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	433,587	3,496	198		196,146	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	508,349	11,789	1,623		193,937	16
17 SOCIAL SERVICE	54,954	1,451			22,254	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	1,061,937	48,761	59,259		456,926	30
31 INTENSIVE CARE UNIT	21,890	12,128	798		9,668	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	886,464	58,050	95,300		344,069	50
53 ANESTHESIOLOGY	59,218		5,906			53
54 RADIOLOGY-DIAGNOSTIC	1,161,303	21,019	314,996		296,598	54
60 LABORATORY	1,402,036	18,625	43,559		245,665	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	201,089	10,790	10,072		68,997	65
66 PHYSICAL THERAPY	474,461	9,183	3,071		214,544	66
67 OCCUPATIONAL THERAPY	77,489	3,072			35,019	67
68 SPEECH PATHOLOGY	20,516		410		4,057	68
68.01 AUDIOLOGY	184,727		1,550		32,165	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	477,113	10,243	9,782		33,313	71
72 IMPL. DEV. CHARGED TO PATIENTS	676,503					72
73 DRUGS CHARGED TO PATIENTS	1,064,055	5,927	50,176		211,619	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	123,433		9,523		53,955	76.97
76.98 HYPERBARIC OXYGEN THERAPY	206,024		6,510		27,363	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	996,723	20,981	27,052		284,271	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	435,374	21,184	1,814			93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	22,295,446	441,010	1,075,538		3,794,101	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,775	1,263	329			190
192 PHYSICIANS' PRIVATE OFFICES	75,429	4,113	33,482	3,809	21,353	192
194 TRANSPORTATION	29,224				9,756	194
194.01 FUND DEVELOPMENT		2,229				194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	22,414,874	448,615	1,109,349	3,809	3,825,210	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	COMMUNICAT 5.01	INFORMATIO TECHNOLOGY 5.02	PURCHASING RECEIVING STORES 5.03	ADMITTING 5.04	PATIENT ACCOUNTING 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS	88,991					5.01
5.02 INFORMATION SYSTEMS	4,603	393,102				5.02
5.03 PURCHASING/RECEIVENG/STORES	2,046	4,138	208,696			5.03
5.04 ADMITTING	1,279	24,827	1,014	311,743		5.04
5.05 PATIENT ACCOUNTING	3,069	20,690	706		1,727,191	5.05
5.06 OTHER ADMIN & GENERAL	10,229	45,517	681			5.06
6 MAINTENANCE & REPAIRS	3,580	4,138	177			6
7 OPERATION OF PLANT			80			7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE	256		107			8
9 HOUSEKEEPING	1,279	4,138	304			9
10 DIETARY	1,534	8,276				10
11 CAFETERIA		4,138	11			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		4,138	19			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	3,324	41,379	181			16
17 SOCIAL SERVICE	511	4,138	1			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	5,114	37,241	6,835	43,479	71,048	30
31 INTENSIVE CARE UNIT	1,279		81	1,464	2,007	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,882	24,827	2,022	23,721	153,075	50
53 ANESTHESIOLOGY			11	8,523	33,938	53
54 RADIOLOGY-DIAGNOSTIC	4,347	28,965	12,921	37,279	502,771	54
60 LABORATORY	4,859	28,965	54,735	53,743	391,938	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,046	4,138	365	13,302	50,497	65
66 PHYSICAL THERAPY	4,859	8,276	290	8,851	44,285	66
67 OCCUPATIONAL THERAPY	256		71	3,471	7,396	67
68 SPEECH PATHOLOGY			20	419	1,224	68
68.01 AUDIOLOGY	256		11,806		7,697	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	767		41,707	25,116	60,302	71
72 IMPL. DEV. CHARGED TO PATIENTS			69,398	18,231	38,134	72
73 DRUGS CHARGED TO PATIENTS	1,534	4,138	116	52,856	134,140	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	767	4,138	492		6,881	76.97
76.98 HYPERBARIC OXYGEN THERAPY	1,279	8,276	2,089		3,914	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	4,603	24,827	621	21,288	203,253	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	2,813	4,138	233		14,691	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	72,371	343,446	207,094	311,743	1,727,191	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	256		1,146			190
192 PHYSICIANS' PRIVATE OFFICES	15,852	49,656	455			192
194 TRANSPORTATION	256		1			194
194.01 FUND DEVELOPMENT	256					194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	88,991	393,102	208,696	311,743	1,727,191	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL (COLS. 0-4) 4A	OTHER ADMIN & GENERAL 5.06	MAIN- TENANCE + REPAIRS 6	OPERATION OF PLANT 7	PLANT OPS MAB BUILDING 7.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING						5.05
5.06 OTHER ADMIN & GENERAL	3,007,359	3,007,359				5.06
6 MAINTENANCE & REPAIRS	312,733	48,460	361,193			6
7 OPERATION OF PLANT	852,008	132,025		984,033		7
7.01 PLANT OPS-MAB BUILDING	53,567	8,301			61,868	7.01
8 LAUNDRY & LINEN SERVICE	98,503	15,264	3,003	36,156		8
9 HOUSEKEEPING	544,493	84,374	17,839	28,582	151	9
10 DIETARY	378,870	58,709	42,743	50,381		10
11 CAFETERIA	232,564	36,038	6,888	45,449		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	637,584	98,799	6,535	10,892		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	760,582	117,858	6,358	36,729		16
17 SOCIAL SERVICE	83,309	12,909	177	4,521		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	1,790,600	277,468	75,593	151,922		30
31 INTENSIVE CARE UNIT	49,315	7,642	3,886	37,786		31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,593,410	246,912	26,140	180,856		50
53 ANESTHESIOLOGY	107,596	16,673				53
54 RADIOLOGY-DIAGNOSTIC	2,380,199	368,838	13,247	65,487	1,645	54
60 LABORATORY	2,244,125	347,745	33,912	58,029		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	361,296	55,986	6,182	33,617		65
66 PHYSICAL THERAPY	767,820	118,980	16,426	28,611	16,787	66
67 OCCUPATIONAL THERAPY	126,774	19,645		9,571	1,314	67
68 SPEECH PATHOLOGY	26,646	4,129				68
68.01 AUDIOLOGY	238,201	36,911	530		1,645	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	658,343	102,016	10,244	31,914		71
72 IMPL. DEV. CHARGED TO PATIENTS	802,266	124,318				72
73 DRUGS CHARGED TO PATIENTS	1,524,561	236,243	706	18,467		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	199,189	30,866	9,891		2,734	76.97
76.98 HYPERBARIC OXYGEN THERAPY	255,455	39,585				76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,583,619	245,394	28,613	65,369	352	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	480,247	74,418	4,592	66,001		93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	22,151,234	2,966,506	313,505	960,340	24,628	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,769	2,753		3,934		190
192 PHYSICIANS' PRIVATE OFFICES	204,149	31,635	47,688	12,815	37,240	192
194 TRANSPORTATION	39,237	6,080				194
194.01 FUND DEVELOPMENT	2,485	385		6,944		194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	22,414,874	3,007,359	361,193	984,033	61,868	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINIS- TRATION 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING						5.05
5.06 OTHER ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE	152,926					8
9 HOUSEKEEPING		675,439				9
10 DIETARY	4,434	539	535,676			10
11 CAFETERIA	562	26,113		347,614		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		494		14,644	768,948	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		5,304		32,818		16
17 SOCIAL SERVICE		225		3,117		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	64,799	187,511	441,040	64,165	336,527	30
31 INTENSIVE CARE UNIT	555	4,899		970	9,734	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	25,822	56,317	22,094	44,345	216,423	50
53 ANESTHESIOLOGY		135				53
54 RADIOLOGY-DIAGNOSTIC	14,676	31,597		30,024		54
60 LABORATORY	84	38,249		38,611		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,046	18,787		14,056		65
66 PHYSICAL THERAPY	12,346	23,641		23,672		66
67 OCCUPATIONAL THERAPY		360		2,941		67
68 SPEECH PATHOLOGY				765		68
68.01 AUDIOLOGY		3,910		3,205		68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,262	7,146		5,558		71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS		7,461		21,231		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		6,652		5,323	38,353	76.97
76.98 HYPERBARIC OXYGEN THERAPY	603	5,978		4,088		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	24,192	68,182	7,417	31,259	167,911	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	20	15,956	65,125			93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	151,401	509,456	535,676	340,792	768,948	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	1,525	165,983		4,264		192
194 TRANSPORTATION				2,558		194
194.01 FUND DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	152,926	675,439	535,676	347,614	768,948	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING						5.05
5.06 OTHER ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 PLANT OPS-MAB BUILDING						7.01
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	959,649					16
17 SOCIAL SERVICE		104,258				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	188,929	101,996	3,680,550		3,680,550	30
31 INTENSIVE CARE UNIT	7,162	984	122,933		122,933	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	101,285		2,513,604		2,513,604	50
53 ANESTHESIOLOGY			124,404		124,404	53
54 RADIOLOGY-DIAGNOSTIC	199,160		3,104,873		3,104,873	54
60 LABORATORY	77,413		2,838,168		2,838,168	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			491,970		491,970	65
66 PHYSICAL THERAPY	86,280		1,094,563		1,094,563	66
67 OCCUPATIONAL THERAPY			160,605		160,605	67
68 SPEECH PATHOLOGY			31,540		31,540	68
68.01 AUDIOLOGY			284,402		284,402	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			816,483		816,483	71
72 IMPL. DEV. CHARGED TO PATIENTS			926,584		926,584	72
73 DRUGS CHARGED TO PATIENTS			1,808,669		1,808,669	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	9,208		302,216		302,216	76.97
76.98 HYPERBARIC OXYGEN THERAPY			305,709		305,709	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	272,138	344	2,494,790		2,494,790	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	18,074		724,433		724,433	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	959,649	103,324	21,826,496		21,826,496	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			24,456		24,456	190
192 PHYSICIANS' PRIVATE OFFICES		934	506,233		506,233	192
194 TRANSPORTATION			47,875		47,875	194
194.01 FUND DEVELOPMENT			9,814		9,814	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	959,649	104,258	22,414,874		22,414,874	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	CAP REL MAB EQUIPMENT 2.01	SUBTOTAL 2A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT		2,926		106	3,032	4
5.01 COMMUNICATIONS		419		52,680	53,099	5.01
5.02 INFORMATION SYSTEMS		11,840		313,650	325,490	5.02
5.03 PURCHASING/RECEIVENG/STORES		13,518		598	14,116	5.03
5.04 ADMITTING		1,889		6,188	8,077	5.04
5.05 PATIENT ACCOUNTING	387,518	6,408		1,263	395,189	5.05
5.06 OTHER ADMIN & GENERAL	19,360	39,635			58,995	5.06
6 MAINTENANCE & REPAIRS		21,843		623	22,466	6
7 OPERATION OF PLANT		34,296		53,367	87,663	7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE		11,605			11,605	8
9 HOUSEKEEPING		9,174		1,514	10,688	9
10 DIETARY		16,171		2,922	19,093	10
11 CAFETERIA		14,587		1,028	15,615	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,496		198	3,694	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		11,789		1,623	13,412	16
17 SOCIAL SERVICE		1,451			1,451	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		48,761		59,259	108,020	30
31 INTENSIVE CARE UNIT		12,128		798	12,926	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		58,050		95,300	153,350	50
53 ANESTHESIOLOGY				5,906	5,906	53
54 RADIOLOGY-DIAGNOSTIC		21,019		314,996	336,015	54
60 LABORATORY		18,625		43,559	62,184	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		10,790		10,072	20,862	65
66 PHYSICAL THERAPY		9,183		3,071	12,254	66
67 OCCUPATIONAL THERAPY		3,072			3,072	67
68 SPEECH PATHOLOGY				410	410	68
68.01 AUDIOLOGY				1,550	1,550	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		10,243		9,782	20,025	71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS		5,927		50,176	56,103	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION				9,523	9,523	76.97
76.98 HYPERBARIC OXYGEN THERAPY				6,510	6,510	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		20,981		27,052	48,033	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER		21,184		1,814	22,998	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	406,878	441,010	1,075,538		1,923,426	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,263		329	1,592	190
192 PHYSICIANS' PRIVATE OFFICES		4,113		33,482	41,404	192
194 TRANSPORTATION						194
194.01 FUND DEVELOPMENT		2,229			2,229	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	406,878	448,615	1,109,349	3,809	1,968,651	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	EMPLOYEE BENEFITS DEPARTMENT 4	COMMUNICAT 5.01	INFORMATIO TECHNOLOGY 5.02	PURCHASING RECEIVING STORES 5.03	ADMITTING 5.04	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT	3,032					4
5.01 COMMUNICATIONS		53,099				5.01
5.02 INFORMATION SYSTEMS		2,746	328,236			5.02
5.03 PURCHASING/RECEIVENG/STORES	41	1,221	3,455	18,833		5.03
5.04 ADMITTING	65	763	20,731	92	29,728	5.04
5.05 PATIENT ACCOUNTING	82	1,831	17,276	64		5.05
5.06 OTHER ADMIN & GENERAL	278	6,103	38,006	61		5.06
6 MAINTENANCE & REPAIRS	66	2,136	3,455	16		6
7 OPERATION OF PLANT	69			7		7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE		153		10		8
9 HOUSEKEEPING	114	763	3,455	27		9
10 DIETARY	72	915	6,910			10
11 CAFETERIA	56		3,455	1		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	155		3,455	2		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	154	1,984	34,551	16		16
17 SOCIAL SERVICE	18	305	3,455			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	361	3,052	31,096	617	4,147	30
31 INTENSIVE CARE UNIT	8	763		7	140	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	273	3,509	20,731	182	2,262	50
53 ANESTHESIOLOGY				1	813	53
54 RADIOLOGY-DIAGNOSTIC	235	2,594	24,186	1,166	3,555	54
60 LABORATORY	195	2,899	24,186	4,939	5,122	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	55	1,221	3,455	33	1,269	65
66 PHYSICAL THERAPY	170	2,899	6,910	26	844	66
67 OCCUPATIONAL THERAPY	28	153		6	331	67
68 SPEECH PATHOLOGY	3			2	40	68
68.01 AUDIOLOGY	25	153		1,065		68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	26	458		3,764	2,395	71
72 IMPL. DEV. CHARGED TO PATIENTS				6,265	1,739	72
73 DRUGS CHARGED TO PATIENTS	168	915	3,455	10	5,041	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	43	458	3,455	44		76.97
76.98 HYPERBARIC OXYGEN THERAPY	22	763	6,910	189		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	225	2,746	20,731	56	2,030	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER		1,678	3,455	21		93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	3,007	43,181	286,774	18,689	29,728	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		153		103		190
192 PHYSICIANS' PRIVATE OFFICES	17	9,459	41,462	41		192
194 TRANSPORTATION	8	153				194
194.01 FUND DEVELOPMENT		153				194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	3,032	53,099	328,236	18,833	29,728	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	PATIENT ACCOUNTING 5.05	OTHER ADMIN & GENERAL 5.06	MAIN- TENANCE + REPAIRS 6	OPERATION OF PLANT 7	PLANT OPS MAB BUILDING 7.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING	414,442					5.05
5.06 OTHER ADMIN & GENERAL		103,443				5.06
6 MAINTENANCE & REPAIRS		1,667	29,806			6
7 OPERATION OF PLANT		4,541		92,280		7
7.01 PLANT OPS-MAB BUILDING		286			286	7.01
8 LAUNDRY & LINEN SERVICE		525	248	3,391		8
9 HOUSEKEEPING		2,902	1,472	2,680	1	9
10 DIETARY		2,019	3,527	4,725		10
11 CAFETERIA		1,240	568	4,262		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,398	539	1,021		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		4,054	525	3,444		16
17 SOCIAL SERVICE		444	15	424		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	17,048	9,544	6,240	14,247		30
31 INTENSIVE CARE UNIT	482	263	321	3,543		31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	36,731	8,493	2,157	16,961		50
53 ANESTHESIOLOGY	8,144	573				53
54 RADIOLOGY-DIAGNOSTIC	120,640	12,686	1,093	6,141	8	54
60 LABORATORY	94,046	11,961	2,798	5,442		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	12,117	1,926	510	3,152		65
66 PHYSICAL THERAPY	10,626	4,092	1,355	2,683	78	66
67 OCCUPATIONAL THERAPY	1,775	676		898	6	67
68 SPEECH PATHOLOGY	294	142				68
68.01 AUDIOLOGY	1,847	1,270	44		8	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	14,469	3,509	845	2,993		71
72 IMPL. DEV. CHARGED TO PATIENTS	9,150	4,276				72
73 DRUGS CHARGED TO PATIENTS	32,187	8,126	58	1,732		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	1,651	1,062	816		13	76.97
76.98 HYPERBARIC OXYGEN THERAPY	939	1,362				76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	48,771	8,441	2,361	6,130	2	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	3,525	2,560	379	6,189		93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	414,442	102,038	25,871	90,058	116	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		95		369		190
192 PHYSICIANS' PRIVATE OFFICES		1,088	3,935	1,202	170	192
194 TRANSPORTATION		209				194
194.01 FUND DEVELOPMENT		13		651		194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	414,442	103,443	29,806	92,280	286	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINISTRATION 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING						5.05
5.06 OTHER ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE	15,932					8
9 HOUSEKEEPING		22,102				9
10 DIETARY	462	18	37,741			10
11 CAFETERIA	59	854		26,110		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		16		1,100	13,380	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		174		2,465		16
17 SOCIAL SERVICE		7		234		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	6,751	6,135	31,073	4,820	5,856	30
31 INTENSIVE CARE UNIT	58	160		73	169	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,690	1,843	1,557	3,331	3,766	50
53 ANESTHESIOLOGY		4				53
54 RADIOLOGY-DIAGNOSTIC	1,529	1,034		2,255		54
60 LABORATORY	9	1,252		2,900		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	213	615		1,056		65
66 PHYSICAL THERAPY	1,286	774		1,778		66
67 OCCUPATIONAL THERAPY		12		221		67
68 SPEECH PATHOLOGY				57		68
68.01 AUDIOLOGY		128		241		68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	131	234		417		71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS		244		1,595		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		218		400	667	76.97
76.98 HYPERBARIC OXYGEN THERAPY	63	196		307		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,520	2,231	523	2,348	2,922	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	2	522	4,588			93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	15,773	16,671	37,741	25,598	13,380	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	159	5,431		320		192
194 TRANSPORTATION				192		194
194.01 FUND DEVELOPMENT						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	15,932	22,102	37,741	26,110	13,380	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING						5.05
5.06 OTHER ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 PLANT OPS-MAB BUILDING						7.01
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	60,779					16
17 SOCIAL SERVICE		6,353				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	11,966	6,215	267,188		267,188	30
31 INTENSIVE CARE UNIT	454	60	19,427		19,427	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,415		264,251		264,251	50
53 ANESTHESIOLOGY			15,441		15,441	53
54 RADIOLOGY-DIAGNOSTIC	12,614		525,751		525,751	54
60 LABORATORY	4,903		222,836		222,836	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			46,484		46,484	65
66 PHYSICAL THERAPY	5,464		51,239		51,239	66
67 OCCUPATIONAL THERAPY			7,178		7,178	67
68 SPEECH PATHOLOGY			948		948	68
68.01 AUDIOLOGY			6,331		6,331	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			49,266		49,266	71
72 IMPL. DEV. CHARGED TO PATIENTS			21,430		21,430	72
73 DRUGS CHARGED TO PATIENTS			109,634		109,634	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	583		18,933		18,933	76.97
76.98 HYPERBARIC OXYGEN THERAPY			17,261		17,261	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	17,235	21	167,326		167,326	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	1,145		47,062		47,062	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	60,779	6,296	1,857,986		1,857,986	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			2,312		2,312	190
192 PHYSICIANS' PRIVATE OFFICES		57	104,745		104,745	192
194 TRANSPORTATION			562		562	194
194.01 FUND DEVELOPMENT			3,046		3,046	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	60,779	6,353	1,968,651		1,968,651	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP REL MAB BUILDING SQUARE FOOTAGE 1.01	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	CAP REL MAB EQUIPMENT DEPREC EXP 2.01	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	95,213					1
1.01 CAP REL COSTS-MAB BUILDING		15,774				1.01
2 CAP REL COSTS-MVBLE EQUIP			927,758			2
2.01 CAP REL COSTS-MAB EQUIPMENT				1		2.01
4 EMPLOYEE BENEFITS DEPARTMENT	621		89		8,375,932	4
5.01 COMMUNICATIONS	89		44,057			5.01
5.02 INFORMATION SYSTEMS	2,513		262,308			5.02
5.03 PURCHASING/RECEIVENG/STORES	2,869		500		112,982	5.03
5.04 ADMITTING	401		5,175		179,635	5.04
5.05 PATIENT ACCOUNTING	1,360		1,056		226,542	5.05
5.06 OTHER ADMIN & GENERAL	8,412	388			769,067	5.06
6 MAINTENANCE & REPAIRS	4,636		521		182,270	6
7 OPERATION OF PLANT	7,279	268	44,631		191,199	7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE	2,463					8
9 HOUSEKEEPING	1,947	37	1,266		313,758	9
10 DIETARY	3,432		2,444		199,694	10
11 CAFETERIA	3,096		860		153,638	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	742		166		429,493	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,502		1,357		424,657	16
17 SOCIAL SERVICE	308				48,728	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	10,349		49,559		1,000,523	30
31 INTENSIVE CARE UNIT	2,574		667		21,170	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,320		79,700		753,396	50
53 ANESTHESIOLOGY			4,939			53
54 RADIOLOGY-DIAGNOSTIC	4,461	402	263,435		649,449	54
60 LABORATORY	3,953		36,429		537,924	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,290		8,423		151,081	65
66 PHYSICAL THERAPY	1,949	4,102	2,568		469,780	66
67 OCCUPATIONAL THERAPY	652	321			76,680	67
68 SPEECH PATHOLOGY			343		8,883	68
68.01 AUDIOLOGY		402	1,296		70,430	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,174		8,181		72,945	71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS	1,258		41,963		463,374	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		668	7,964		118,144	76.97
76.98 HYPERBARIC OXYGEN THERAPY			5,444		59,916	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	4,453	86	22,624		622,457	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	4,496		1,517			93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	93,599	6,674	899,482		8,307,815	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	268		275			190
192 PHYSICIANS' PRIVATE OFFICES	873	9,100	28,001	1	46,755	192
194 TRANSPORTATION					21,362	194
194.01 FUND DEVELOPMENT	473					194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP REL MAB BUILDING SQUARE FOOTAGE 1.01	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	CAP REL MAB EQUIPMENT DEPREC EXP 2.01	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	448,615		1,109,349	3,809	3,825,210	202
203 UNIT COST MULT-WS B PT I	4.711699		1.195731	3,809.000000	0.456691	203
204 COST TO BE ALLOC PER B PT II					3,032	204
205 UNIT COST MULT-WS B PT II					0.000362	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	COMMUNICAT TELEPHONES 5.01	INFORMATIO TECHNOLOGY TIME SPENT 5.02	PURCHASING RECEIVING STORES SUPPLY EXPENSE 5.03	ADMITTING INPATIENT REVENUE 5.04	PATIENT ACCOUNTING GROSS REVENUE 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS	348					5.01
5.02 INFORMATION SYSTEMS	18	95				5.02
5.03 PURCHASING/RECEIVENG/STORES	8	1	2,034,382			5.03
5.04 ADMITTING	5	6	9,886	15,161,285		5.04
5.05 PATIENT ACCOUNTING	12	5	6,880		61,280,313	5.05
5.06 OTHER ADMIN & GENERAL	40	11	6,636			5.06
6 MAINTENANCE & REPAIRS	14	1	1,724			6
7 OPERATION OF PLANT			779			7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE	1		1,045			8
9 HOUSEKEEPING	5	1	2,965			9
10 DIETARY	6	2				10
11 CAFETERIA		1	107			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		1	190			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	13	10	1,763			16
17 SOCIAL SERVICE	2	1	6			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	20	9	66,624	2,114,545	2,520,791	30
31 INTENSIVE CARE UNIT	5		788	71,197	71,197	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	23	6	19,706	1,153,655	5,431,096	50
53 ANESTHESIOLOGY			109	414,482	1,204,130	53
54 RADIOLOGY-DIAGNOSTIC	17	7	125,951	1,813,006	17,837,949	54
60 LABORATORY	19	7	533,561	2,613,761	13,905,906	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	8	1	3,562	646,926	1,791,626	65
66 PHYSICAL THERAPY	19	2	2,827	430,459	1,571,240	66
67 OCCUPATIONAL THERAPY	1		696	168,826	262,424	67
68 SPEECH PATHOLOGY			194	20,392	43,410	68
68.01 AUDIOLOGY	1		115,087		273,102	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	3		406,562	1,221,492	2,139,503	71
72 IMPL. DEV. CHARGED TO PATIENTS			676,503	886,655	1,353,005	72
73 DRUGS CHARGED TO PATIENTS	6	1	1,126	2,570,575	4,759,276	73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	3	1	4,797		244,154	76.97
76.98 HYPERBARIC OXYGEN THERAPY	5	2	20,364		138,871	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	18	6	6,050	1,035,314	7,211,398	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	11	1	2,274		521,235	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	283	83	2,018,762	15,161,285	61,280,313	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1		11,173			190
192 PHYSICIANS' PRIVATE OFFICES	62	12	4,439			192
194 TRANSPORTATION	1		8			194
194.01 FUND DEVELOPMENT	1					194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		COMMUNICAT TELEPHONES 5.01	INFORMATIO TECHNOLOGY TIME SPENT 5.02	PURCHASING RECEIVING STORES SUPPLY EXPENSE 5.03	ADMITTING INPATIENT REVENUE 5.04	PATIENT ACCOUNTING GROSS REVENUE 5.05	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	88,991	393,102	208,696	311,743	1,727,191	202
203	UNIT COST MULT-WS B PT I	255.721264	4,137.915789	0.102584	0.020562	0.028185	203
204	COST TO BE ALLOC PER B PT II	53,099	328,236	18,833	29,728	414,442	204
205	UNIT COST MULT-WS B PT II	152.583333	3,455.115789	0.009257	0.001961	0.006763	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	RECON- CILIATION	OTHER ADMIN & GENERAL ACCUM COST	MAIN- TENANCE + REPAIRS TIME SPENT	OPERATION OF PLANT SQUARE FEET	PLANT OPS MAB BUILDING SQUARE FOOTAGE	
	5A.06	5.06	6	7	7.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING						5.05
5.06 OTHER ADMIN & GENERAL	-3,007,359	19,407,515				5.06
6 MAINTENANCE & REPAIRS		312,733	2,045			6
7 OPERATION OF PLANT		852,008		67,033		7
7.01 PLANT OPS-MAB BUILDING		53,567			15,118	7.01
8 LAUNDRY & LINEN SERVICE		98,503	17	2,463		8
9 HOUSEKEEPING		544,493	101	1,947	37	9
10 DIETARY		378,870	242	3,432		10
11 CAFETERIA		232,564	39	3,096		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		637,584	37	742		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		760,582	36	2,502		16
17 SOCIAL SERVICE		83,309	1	308		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		1,790,600	428	10,349		30
31 INTENSIVE CARE UNIT		49,315	22	2,574		31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,593,410	148	12,320		50
53 ANESTHESIOLOGY		107,596				53
54 RADIOLOGY-DIAGNOSTIC		2,380,199	75	4,461	402	54
60 LABORATORY		2,244,125	192	3,953		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		361,296	35	2,290		65
66 PHYSICAL THERAPY		767,820	93	1,949	4,102	66
67 OCCUPATIONAL THERAPY		126,774		652	321	67
68 SPEECH PATHOLOGY		26,646				68
68.01 AUDIOLOGY		238,201	3		402	68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		658,343	58	2,174		71
72 IMPL. DEV. CHARGED TO PATIENTS		802,266				72
73 DRUGS CHARGED TO PATIENTS		1,524,561	4	1,258		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		199,189	56		668	76.97
76.98 HYPERBARIC OXYGEN THERAPY		255,455				76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		1,583,619	162	4,453	86	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER		480,247	26	4,496		93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	-3,007,359	19,143,875	1,775	65,419	6,018	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		17,769		268		190
192 PHYSICIANS' PRIVATE OFFICES		204,149	270	873	9,100	192
194 TRANSPORTATION		39,237				194
194.01 FUND DEVELOPMENT		2,485		473		194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	RECON- CILIATION	OTHER ADMIN & GENERAL ACCUM COST	MAIN- TENANCE + REPAIRS TIME SPENT	OPERATION OF PLANT SQUARE FEET	PLANT OPS MAB BUILDING SQUARE FOOTAGE	
	5A.06	5.06	6	7	7.01	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I		3,007,359	361,193	984,033	61,868	202
203 UNIT COST MULT-WS B PT I		0.154958	176.622494	14.679829	4.092340	203
204 COST TO BE ALLOC PER B PT II		103,443	29,806	92,280	286	204
205 UNIT COST MULT-WS B PT II		0.005330	14.575061	1.376635	0.018918	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS FTES 11	NURSING ADMINISTRATION DIRECT NRSING HRS 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 CAP REL COSTS-MAB BUILDING						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 CAP REL COSTS-MAB EQUIPMENT						2.01
4 EMPLOYEE BENEFITS DEPARTMENT						4
5.01 COMMUNICATIONS						5.01
5.02 INFORMATION SYSTEMS						5.02
5.03 PURCHASING/RECEIVENG/STORES						5.03
5.04 ADMITTING						5.04
5.05 PATIENT ACCOUNTING						5.05
5.06 OTHER ADMIN & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 PLANT OPS-MAB BUILDING						7.01
8 LAUNDRY & LINEN SERVICE	122,153					8
9 HOUSEKEEPING		15,028				9
10 DIETARY	3,542	12	17,117			10
11 CAFETERIA	449	581		11,821		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		11		498	68,569	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		118		1,116		16
17 SOCIAL SERVICE		5		106		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	51,759	4,172	14,093	2,182	30,009	30
31 INTENSIVE CARE UNIT	443	109		33	868	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	20,626	1,253	706	1,508	19,299	50
53 ANESTHESIOLOGY		3				53
54 RADIOLOGY-DIAGNOSTIC	11,723	703		1,021		54
60 LABORATORY	67	851		1,313		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,634	418		478		65
66 PHYSICAL THERAPY	9,862	526		805		66
67 OCCUPATIONAL THERAPY		8		100		67
68 SPEECH PATHOLOGY				26		68
68.01 AUDIOLOGY		87		109		68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,008	159		189		71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS		166		722		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		148		181	3,420	76.97
76.98 HYPERBARIC OXYGEN THERAPY	482	133		139		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	19,324	1,517	237	1,063	14,973	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 O/P GERIATRIC PSYCH CENTER	16	355	2,081			93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	120,935	11,335	17,117	11,589	68,569	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	1,218	3,693		145		192
194 TRANSPORTATION				87		194
194.01 FUND DEVELOPMENT						194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS FTES 11	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	152,926	675,439	535,676	347,614	768,948	202
203	UNIT COST MULT-WS B PT I	1.251922	44.945369	31.294970	29.406480	11.214222	203
204	COST TO BE ALLOC PER B PT II	15,932	22,102	37,741	26,110	13,380	204
205	UNIT COST MULT-WS B PT II	0.130427	1.470721	2.204884	2.208781	0.195132	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL	SOCIAL	
	RECORDS & LIBRARY TIME SPENT 16	SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
1.01 CAP REL COSTS-MAB BUILDING			1.01
2 CAP REL COSTS-MVBLE EQUIP			2
2.01 CAP REL COSTS-MAB EQUIPMENT			2.01
4 EMPLOYEE BENEFITS DEPARTMENT			4
5.01 COMMUNICATIONS			5.01
5.02 INFORMATION SYSTEMS			5.02
5.03 PURCHASING/RECEIVENG/STORES			5.03
5.04 ADMITTING			5.04
5.05 PATIENT ACCOUNTING			5.05
5.06 OTHER ADMIN & GENERAL			5.06
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
7.01 PLANT OPS-MAB BUILDING			7.01
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	2,814		16
17 SOCIAL SERVICE		2,120	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	554	2,074	30
31 INTENSIVE CARE UNIT	21	20	31
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	297		50
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC	584		54
60 LABORATORY	227		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY	253		66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
68.01 AUDIOLOGY			68.01
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENTS			72
73 DRUGS CHARGED TO PATIENTS			73
74 RENAL DIALYSIS			74
76.97 CARDIAC REHABILITATION	27		76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
91 EMERGENCY	798	7	91
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
93 O/P GERIATRIC PSYCH CENTER	53		93
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	2,814	2,101	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
192 PHYSICIANS' PRIVATE OFFICES		19	192
194 TRANSPORTATION			194
194.01 FUND DEVELOPMENT			194.01

PROVIDER CCN: 14-1336 ST. JOSEPH'S HOSPITAL-HIGHLAND
PERIOD FROM 07/01/2012 TO 06/30/2013

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	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	959,649	104,258	202
203 UNIT COST MULT-WS B PT I	341.026652	49.178302	203
204 COST TO BE ALLOC PER B PT II	60,779	6,353	204
205 UNIT COST MULT-WS B PT II	21.598792	2.996698	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	3,680,550		3,680,550		30
31 INTENSIVE CARE UNIT	122,933		122,933		31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	2,513,604		2,513,604		50
53 ANESTHESIOLOGY	124,404		124,404		53
54 RADIOLOGY-DIAGNOSTIC	3,104,873		3,104,873		54
60 LABORATORY	2,838,168		2,838,168		60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	491,970		491,970		65
66 PHYSICAL THERAPY	1,094,563		1,094,563		66
67 OCCUPATIONAL THERAPY	160,605		160,605		67
68 SPEECH PATHOLOGY	31,540		31,540		68
68.01 AUDIOLOGY	284,402		284,402		68.01
71 MEDICAL SUPPLIES CHARGED TO	816,483		816,483		71
72 IMPL. DEV. CHARGED TO PATIE	926,584		926,584		72
73 DRUGS CHARGED TO PATIENTS	1,808,669		1,808,669		73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION	302,216		302,216		76.97
76.98 HYPERBARIC OXYGEN THERAPY	305,709		305,709		76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	2,494,790		2,494,790		91
92 OBSERVATION BEDS (NON-DISTI	320,090		320,090		92
93 O/P GERIATRIC PSYCH CENTER	724,433		724,433		93
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
113 INTEREST EXPENSE					113
200 SUBTOTAL (SEE INSTRUCTIONS)	22,146,586		22,146,586		200
201 LESS OBSERVATION BEDS	320,090		320,090		201
202 TOTAL (SEE INSTRUCTIONS)	21,826,496		21,826,496		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	2,114,545		2,114,545			30
31 INTENSIVE CARE UNIT	71,197		71,197			31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,153,655	4,277,441	5,431,096	0.462817		50
53 ANESTHESIOLOGY	414,482	789,648	1,204,130	0.103314		53
54 RADIOLOGY-DIAGNOSTIC	1,813,006	16,024,943	17,837,949	0.174060		54
60 LABORATORY	2,613,761	11,292,145	13,905,906	0.204098		60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	646,926	1,144,700	1,791,626	0.274594		65
66 PHYSICAL THERAPY	430,459	1,140,781	1,571,240	0.696624		66
67 OCCUPATIONAL THERAPY	168,826	93,598	262,424	0.612006		67
68 SPEECH PATHOLOGY	20,392	23,018	43,410	0.726561		68
68.01 AUDIOLOGY		273,102	273,102	1.041376		68.01
71 MEDICAL SUPPLIES CHARGED TO	1,221,492	918,011	2,139,503	0.381623		71
72 IMPL. DEV. CHARGED TO PATIE	886,655	466,350	1,353,005	0.684834		72
73 DRUGS CHARGED TO PATIENTS	2,570,575	2,188,701	4,759,276	0.380030		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		244,154	244,154	1.237809		76.97
76.98 HYPERBARIC OXYGEN THERAPY		138,871	138,871	2.201388		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,035,314	6,176,084	7,211,398	0.345951		91
92 OBSERVATION BEDS (NON-DISTI	89,968	316,278	406,246	0.787922		92
93 O/P GERIATRIC PSYCH CENTER		521,235	521,235	1.389840		93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	15,251,253	46,029,060	61,280,313			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		46,029,060	61,280,313			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1336) [] 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	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS			
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.462817		1,888,887			874,209		50	
53 ANESTHESIOLOGY	0.103314		229,118			23,671		53	
54 RADIOLOGY-DIAGNOSTIC	0.174060		6,088,269			1,059,724		54	
60 LABORATORY	0.204098		4,616,971			942,315		60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30	
65 RESPIRATORY THERAPY	0.274594		499,641			137,198		65	
66 PHYSICAL THERAPY	0.696624		444,845			309,890		66	
67 OCCUPATIONAL THERAPY	0.612006		38,632			23,643		67	
68 SPEECH PATHOLOGY	0.726561		8,412			6,112		68	
68.01 AUDIOLOGY	1.041376		37,815			39,380		68.01	
71 MEDICAL SUPPLIES CHARGED TO PAT	0.381623		423,047			161,444		71	
72 IMPL. DEV. CHARGED TO PATIENTS	0.684834		236,779			162,154		72	
73 DRUGS CHARGED TO PATIENTS	0.380030		1,000,373	11,006		380,172	4,183	73	
74 RENAL DIALYSIS								74	
76.97 CARDIAC REHABILITATION	1.237809		150,226			185,951		76.97	
76.98 HYPERBARIC OXYGEN THERAPY	2.201388		3,305			7,276		76.98	
76.99 LITHOTRIPSY								76.99	
OUTPATIENT SERVICE COST CENTERS									
91 EMERGENCY	0.345951		1,680,668			581,429		91	
92 OBSERVATION BEDS (NON-DISTINCT	0.787922		215,834			170,060		92	
93 O/P GERIATRIC PSYCH CENTER	1.389840		494,860			687,776		93	
OTHER REIMBURSABLE COST CENTERS									
94 HOME PROGRAM DIALYSIS								94	
200 SUBTOTAL (SEE INSTRUCTIONS)			18,057,682	11,006		5,752,404	4,183	200	
201 LESS PBP CLINIC LAB SERVICES								201	
202 NET CHARGES (LINE 200 - LINE 201)			18,057,682	11,006		5,752,404	4,183	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 DIEM (COL.3 ÷ COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)					
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	267,188		177,041	2,720	65.09		4,621	30
31 INTENSIVE CARE UNIT	19,427	90,147	19,427	39	498.13			31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	286,615		196,468	2,759		71	4,621	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1336) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	264,251	5,431,096	0.048655		50
53 ANESTHESIOLOGY	15,441	1,204,130	0.012823		53
54 RADIOLOGY-DIAGNOSTIC	525,751	17,837,949	0.029474		54
60 LABORATORY	222,836	13,905,906	0.016025		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	46,484	1,791,626	0.025945		65
66 PHYSICAL THERAPY	51,239	1,571,240	0.032611		66
67 OCCUPATIONAL THERAPY	7,178	262,424	0.027353		67
68 SPEECH PATHOLOGY	948	43,410	0.021838		68
68.01 AUDIOLOGY	6,331	273,102	0.023182		68.01
71 MEDICAL SUPPLIES CHARGED TO P	49,266	2,139,503	0.023027		71
72 IMPL. DEV. CHARGED TO PATIENT	21,430	1,353,005	0.015839		72
73 DRUGS CHARGED TO PATIENTS	109,634	4,759,276	0.023036		73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION	18,933	244,154	0.077545		76.97
76.98 HYPERBARIC OXYGEN THERAPY	17,261	138,871	0.124295		76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	167,326	7,211,398	0.023203		91
92 OBSERVATION BEDS (NON-DISTINC	35,069	406,246	0.086325		92
93 O/P GERIATRIC PSYCH CENTER	47,062	521,235	0.090289		93
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-199)	1,606,440	59,094,571			200

PROVIDER CCN: 14-1336 ST. JOSEPH'S HOSPITAL-HIGHLAND
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

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	2,720		71		30
31 INTENSIVE CARE UNIT	39				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)	2,759		71		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1336) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
68.01 AUDIOLOGY						68.01
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
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						
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
93 O/P GERIATRIC PSYCH CENTER						93
OTHER REIMBURSABLE COST CENTERS						
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 [] TITLE V [XX] HOSPITAL (14-1336) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 ÷	(COL. 6 ÷	CHARGES	(COL. 8 x		(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	10	COL. 10)	12	COL. 12)
	7	8	9		11		13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	5,431,096						50
53 ANESTHESIOLOGY	1,204,130						53
54 RADIOLOGY-DIAGNOSTIC	17,837,949						54
60 LABORATORY	13,905,906						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	1,791,626						65
66 PHYSICAL THERAPY	1,571,240						66
67 OCCUPATIONAL THERAPY	262,424						67
68 SPEECH PATHOLOGY	43,410						68
68.01 AUDIOLOGY	273,102						68.01
71 MEDICAL SUPPLIES CHARGED TO	2,139,503						71
72 IMPL. DEV. CHARGED TO PATIEN	1,353,005						72
73 DRUGS CHARGED TO PATIENTS	4,759,276						73
74 RENAL DIALYSIS							74
76.97 CARDIAC REHABILITATION	244,154						76.97
76.98 HYPERBARIC OXYGEN THERAPY	138,871						76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	7,211,398						91
92 OBSERVATION BEDS (NON-DISTIN	406,246						92
93 O/P GERIATRIC PSYCH CENTER	521,235						93
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	59,094,571						200

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[XX]	HOSPITAL (14-1336)	[]	SUB (OTHER)	[]	ICF/MR	[]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[]	IRF	[]	NF	[]		[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS										
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,325	1							
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,720	2							
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3							
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,363	4							
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	674	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)	673	6							
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	129	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)	129	8							
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,588	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)	674	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)	673	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	132.03	19							
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	20							
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,680,550	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)	17,032	24							
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	17,032	25							
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,241,784	26							
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,438,766	27							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28							
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29							
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30							
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31							
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32							
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33							
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34							
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35							
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36							
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,438,766	37							

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1336) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 896.60 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,423,801 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,423,801 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	122,933	39	3,152.13	39	122,933	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)					1,690,283	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					3,237,017	49

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

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 604,308 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 603,412 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 1,207,720 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) 357 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 896.61 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 320,090 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	267,188	2,438,766	0.109559	320,090	35,069	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 (14-1336) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,325	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,720	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,363	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	674	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)	673	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	129	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)	129	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	71	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	132.03	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,680,550	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)	17,032	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	17,032	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,241,784	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,438,766	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,438,766	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1336) [] 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) 896.60 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 63,659 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) 63,659 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	122,933	39	3,152.13		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)					63,659 49
PASS-THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					4,621 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					4,621 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) 357 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 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
90 CAPITAL-RELATED COST					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 (14-1336) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,150,408		30
31 INTENSIVE CARE UNIT		60,362		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.462817	540,027	249,934	50
53 ANESTHESIOLOGY	0.103314	173,249	17,899	53
54 RADIOLOGY-DIAGNOSTIC	0.174060	598,127	104,110	54
60 LABORATORY	0.204098	999,325	203,960	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.274594	260,885	71,637	65
66 PHYSICAL THERAPY	0.696624	109,389	76,203	66
67 OCCUPATIONAL THERAPY	0.612006	23,765	14,544	67
68 SPEECH PATHOLOGY	0.726561	7,712	5,603	68
68.01 AUDIOLOGY	1.041376			68.01
71 MEDICAL SUPPLIES CHARGED TO PAT	0.381623	568,937	217,119	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.684834	475,818	325,856	72
73 DRUGS CHARGED TO PATIENTS	0.380030	1,056,604	401,541	73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION	1.237809			76.97
76.98 HYPERBARIC OXYGEN THERAPY	2.201388			76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.345951	1,788	619	91
92 OBSERVATION BEDS (NON-DISTINCT	0.787922	1,597	1,258	92
93 O/P GERIATRIC PSYCH CENTER	1.389840			93
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,817,223	1,690,283	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,817,223		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z336) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.462817	2,600	1,203	50
53 ANESTHESIOLOGY	0.103314			53
54 RADIOLOGY-DIAGNOSTIC	0.174060	78,458	13,656	54
60 LABORATORY	0.204098	360,585	73,595	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.274594	158,400	43,496	65
66 PHYSICAL THERAPY	0.696624	226,159	157,548	66
67 OCCUPATIONAL THERAPY	0.612006	114,052	69,801	67
68 SPEECH PATHOLOGY	0.726561	9,560	6,946	68
68.01 AUDIOLOGY	1.041376			68.01
71 MEDICAL SUPPLIES CHARGED TO PAT	0.381623	191,915	73,239	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.684834			72
73 DRUGS CHARGED TO PATIENTS	0.380030	673,927	256,112	73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION	1.237809			76.97
76.98 HYPERBARIC OXYGEN THERAPY	2.201388			76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.345951			91
92 OBSERVATION BEDS (NON-DISTINCT	0.787922			92
93 O/P GERIATRIC PSYCH CENTER	1.389840			93
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,815,656	695,596	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,815,656		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1336) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST		INPATIENT	
	TO CHARGES	INPATIENT	PROGRAM	COSTS
	1	2	(COL.1 x	COL.2)
			3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.462817			50
53 ANESTHESIOLOGY	0.103314			53
54 RADIOLOGY-DIAGNOSTIC	0.174060			54
60 LABORATORY	0.204098			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.274594			65
66 PHYSICAL THERAPY	0.696624			66
67 OCCUPATIONAL THERAPY	0.612006			67
68 SPEECH PATHOLOGY	0.726561			68
68.01 AUDIOLOGY	1.041376			68.01
71 MEDICAL SUPPLIES CHARGED TO PAT	0.381623			71
72 IMPL. DEV. CHARGED TO PATIENTS	0.684834			72
73 DRUGS CHARGED TO PATIENTS	0.380030			73
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION	1.237809			76.97
76.98 HYPERBARIC OXYGEN THERAPY	2.201388			76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.345951			91
92 OBSERVATION BEDS (NON-DISTINCT	0.787922			92
93 O/P GERIATRIC PSYCH CENTER	1.389840			93
OTHER REIMBURSABLE COST CENTERS				
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 B

CHECK APPLICABLE BOX: HOSPITAL (14-1336) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,756,587	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	5,756,587	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	5,814,153	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	25,442	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	2,683,431	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,105,280	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	3,105,280	30
31	PRIMARY PAYER PAYMENTS	139	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,105,141	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	154,137	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	154,137	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	17,201	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	3,259,278	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	3,259,278	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	16,296	40.01
41	INTERIM PAYMENTS	3,449,448	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	-206,466	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	61,298	44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER) INPATIENT
 APPLICABLE [] IPF [] SNF PART A PART B
 BOX: [] IRF [XX] SWING BED SNF (14-Z336)

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,632,043		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE 2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 01/18/2013	82,088		NONE 3.01
	.02			3.02
	PROGRAM .03			3.03
	TO .04			3.04
	PROVIDER .05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50	NONE		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
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	82,088		3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,714,131		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		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		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
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99			5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	176,930		6.01
	TO .02			6.02
	PROVIDER .03			6.03
	PROVIDER .04			6.04
	TO .05			6.05
	PROGRAM .06			6.06
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,891,061		7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1336) [] 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	942 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,627 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	2,402 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	61,280,313 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,550,474 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8 8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	9 9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	10 10
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30 30
31	OTHER ADJUSTMENTS (SPECIFY)	31 31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	32 32

PROVIDER CCN: 14-1336 ST. JOSEPH'S HOSPITAL-HIGHLAND
 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
 11/25/2013 12:42

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z336)
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	1,219,797	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	702,552	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	1,347	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	1,922,349	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	1,922,349	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	1,922,349	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	31,288	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,891,061	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		17
17.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17.01
18 ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SEE INSTRUCTIONS)	1,891,061	19
19.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	9,455	19.01
20 INTERIM PAYMENTS	1,714,131	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	167,475	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	20,427	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

CHECK [XX] HOSPITAL (14-1336)
APPLICABLE BOX: [] SUB (OTHER)

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

1	INPATIENT SERVICES	3,237,017	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	3,237,017	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	3,269,387	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	3,269,387	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	351,298	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	2,918,089	22
23	COINSURANCE	8,761	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	2,909,328	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	165,178	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	165,178	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	123,777	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	3,074,506	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	3,074,506	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	15,373	30.01
31	INTERIM PAYMENTS	2,479,671	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	579,462	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	34,650	34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-1336) [] 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	63,659	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	63,659	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	63,659	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	63,659	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	63,659	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)	63,659	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)	63,659	36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)	63,659	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)	63,659	40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	63,659	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	-1,681,732			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	9,498,706			4
5 OTHER RECEIVABLES	231,849			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-5,382,682			6
7 INVENTORY	468,176			7
8 PREPAID EXPENSES	176,992			8
9 OTHER CURRENT ASSETS				9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	3,311,309			11
FIXED ASSETS				
12 LAND	1,492,827			12
13 LAND IMPROVEMENTS				13
14 ACCUMULATED DEPRECIATION				14
15 BUILDINGS	39,587,132			15
16 ACCUMULATED DEPRECIATION	-73,379			16
17 LEASEHOLD IMPROVEMENTS	37,251			17
18 ACCUMULATED AMORTIZATION	-3,713			18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	3,802,893			23
24 ACCUMULATED DEPRECIATION	-2,334,138			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)	42,508,873			30
OTHER ASSETS				
31 INVESTMENTS	7,839,372			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	173,447			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,012,819			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	53,833,001			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	1,977,889			37
38 SALARIES, WAGES & FEES PAYABLE	1,117,791			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	15,141,158			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	825,402			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	19,062,240			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	30,570,466			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	8,030,296			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	38,600,762			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	57,663,002			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	-3,830,001			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)	-3,830,001			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	53,833,001			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		-4,281,909							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-138,781							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		-4,420,690							3
4 ADDITIONS (CREDIT ADJUSTMENTS)		590,689							4
5									5
6 INVESTMENT INCOME									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		590,689							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		-3,830,001							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 TRANSFER TO AFFILIATES									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		-3,830,001							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	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	2,487,488		2,487,488	1
2 SUBPROVIDER IPF				2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,487,488		2,487,488	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT	71,197		71,197	11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	71,197		71,197	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,558,685		2,558,685	17
18 ANCILLARY SERVICES	12,835,583		12,835,583	18
19 OUTPATIENT SERVICES		46,931,935	46,931,935	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
27.01 PROFESSIONAL CHARGES	252,120	501,348	753,468	27.01
27.02 DIABETIC EDUCATION		7,456	7,456	27.02
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	15,646,388	47,440,739	63,087,127	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		25,859,431	29
30 PROVISION FOR BAD DEBT	954,254		30
31 ROUNDING			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		954,254	36
37 DEDUCT (SPECIFY)			37
38		-1	38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-1	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		26,813,684	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	63,087,127	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	37,432,205	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,654,922	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	26,813,684	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,158,762	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	4,177	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,103	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	3,650	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	24,060	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	6,240	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	823	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3,443	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	17,734	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	113,753	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS OPERATING REVENUE)	75,933	24
24.01	OTHER (HEALTH FAIR)	83,759	24.01
24.02	OTHER (EDUCATIONAL CLASSES)	1,824	24.02
24.03	OTHER (VAN SERVICE)	2,733	24.03
24.04	OTHER (MEALS ON WHEELS)	55,644	24.04
24.05	OTHER (MASSAGE REVENUE)		24.05
24.06	OTHER (EMPLOYEE FITNESS)	830	24.06
24.07	OTHER (BENEFIT INTEREST)	4,675	24.07
24.08	OTHER (GRANT REVENUE)	41,307	24.08
24.09	OTHER (LOSS ON INVESTMENTS)	578,293	24.09
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,019,981	25
26	TOTAL (LINE 5 PLUS LINE 25)	-138,781	26
27	OTHER EXPENSES (LOSS ON INVESTMENTS)		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)	-138,781	29

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

COMPONENT NO: -

WORKSHEET I-1

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	TOTAL COSTS	BASIS	STATISTICS	FTES PER 2080 HOURS	
	1	2	3	4	
1 REGISTERED NURSES		HOURS OF SERVICE			1
2 LICENSED PRACTICAL NURSES		HOURS OF SERVICE			2
3 NURSES AIDES		HOURS OF SERVICE			3
4 TECHNICIANS		HOURS OF SERVICE			4
5 SOCIAL WORKERS		HOURS OF SERVICE			5
6 DIETICIANS		HOURS OF SERVICE			6
7 PHYSICIANS		ACCUMULATED COST			7
8 NON-PATIENT CARE SALARY		ACCUMULATED COST			8
9 SUBTOTAL (SUM OF LINES 1-8)					9
10 EMPLOYEE BENEFITS		SALARY			10
11 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			11
12 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			12
13 MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME			13
14 SUPPLIES		REQUISITIONS			14
15 DRUGS		REQUISITIONS			15
16 OTHER		ACCUMULATED COST			16
17 SUBTOTAL (SUM OF LINES 9-16)					17
18 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			18
19 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			19
20 EMPLOYEE BENEFITS DEPARTMENT		SALARY			20
21 ADMINISTRATIVE AND GENERAL		ACCUMULATED COST			21
22 MAINT./REPAIRS-OPERATION-HOUSEKEEPING		SQUARE FEET			22
23 MEDICAL EDUCATION PROGRAM COSTS					23
24 CENTRAL SERVICES & SUPPLIES		REQUISITIONS			24
25 PHARMACY		REQUISITIONS			25
26 OTHER ALLOCATED COSTS		ACCUMULATED COST			26
27 SUBTOTAL (SUM OF LINES 17-26)					27
28 LABORATORY		CHARGES			28
29 RESPIRATORY THERAPY		CHARGES			29
30 OTHER ANCILLARY (SPECIFY)		CHARGES			30
30.97 CARDIAC REHABILITATION		CHARGES			30.97
30.98 HYPERBARIC OXYGEN THERAPY		CHARGES			30.98
30.99 LITHOTRIPSY		CHARGES			30.99
31 TOTAL COSTS (SUM OF LINES 27-30)					31

PROVIDER CCN: 14-1336 ST. JOSEPH'S HOSPITAL-HIGHLAND
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
11/25/2013 12:42

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE	SALARY	EMPLOYEE		
	BUILDING	EQUIPMENT	RNs	OTHER	BENEFITS	DRUGS	
	1	2	3	4	DEPARTMENT	5	6
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS						2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS						12
13	METHOD II HOME PATIENT						13
14	EPO (INCL IN RENAL DEPT)						14
15	ARANESP (INCL IN RENAL DEPT)						15
16	OTHER						16
17	TOTAL (SUM OF LINES 2-16)						17
18	MEDICAL EDUC PGM COSTS						18
19	TOTAL RENAL COSTS (LINES 17+18)						19

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2
 (CONTINUED)

CHECK APPLICABLE BOX:

[XX] RENAL DIALYSIS DEPARTMENT

[] HOME PROGRAM DIALYSIS

	MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL.9 + COL.10) 11	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
 STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3

CHECK APPLICABLE BOX:

[XX] RENAL DIALYSIS DEPARTMENT

[] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE RNS (HOURS)	SALARY OTHER (HOURS)	EMPLOYEE BENEFITS DEPARTMENT (SALARY)	
	BUILDING (SQUARE FEET) 1	EQUIPMENT (% OF TIME) 2				
1	TOTAL RENAL DEPT COSTS					1
	MAINTENANCE					
2	HEMODIALYSIS					2
3	INTERMITTENT PERITONEAL TRAINING					3
4	HEMODIALYSIS					4
5	INTERMITTENT PERITONEAL					5
6	CAPD					6
7	CCPD					7
	HOME					
8	HEMODIALYSIS					8
9	INTERMITTENT PERITONEAL					9
10	CAPD					10
11	CCPD					11
	OTHER BILLABLE SERVICES					
12	INPT DIAL TRTMNTS					13
13	METHOD II HOME PATIENT					14
14	EPO					15
15	ARANESP					16
16	OTHER					17
17	TOTAL STATISTICAL BASIS					18
18	UNIT COST MULTIPLIER (LINE 1 ÷ LINE 17)					

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

COMPONENT NO: -

WORKSHEET I-4
 (CONTINUED)

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (COL. 6 ÷ COL. 4)	AVERAGE PAYMENT RATE (COL. 6.01 ÷ COL. 4.01)	AVERAGE PAYMENT RATE (COL. 6.02 ÷ COL. 4.02)	
	6	6.01	6.02	7	7.01	7.02	
1 MAINTENANCE - HEMODIALYSIS							1
2 MAINTENANCE - PERITONEAL DIALYSIS							2
3 TRAINING - HEMODIALYSIS							3
4 TRAINING - PERITONEAL DIALYSIS							4
5 TRAINING - CAPD							5
6 TRAINING - CCPD							6
7 HOME PROGRAM - HEMODIALYSIS							7
8 HOME PROGRAM - PERITONEAL DIALYSIS							8
9 HOME PROGRAM - CAPD							9
10 HOME PROGRAM - CCPD							10
11 TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)							11
12 TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))							12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

COMPONENT NO: -

WORKSHEET I-5

DESCRIPTION

1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11)(SEE INSTRUCTIONS)	1	2	2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11)(SEE INSTRUCTIONS)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11)(SEE INSTRUCTIONS)			2.02
2.03	TOTAL PAYMENT DUE (SEE INSTRUCTIONS)			2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.03
4	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4
4.01	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (SUM OF LINE 5 THROUGH LINE 5.04)			5.05
6	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			8
9	PROGRAM PAYMENT (SEE INSTRUCTIONS)			9
10	UNRECOVERED FROM MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (TRANSFER TO WKST E, PART B, LINE 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

12	TOTAL ALLOWABLE EXPENSES (SEE INSTRUCTIONS)			12
13	TOTAL COMPOSITE COSTS (FROM WKST I-4, COL. 2, LINE 11)			13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (LINE 13 DIVIDED BY LINE 12)			14

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
1.01 CAP REL COSTS-MAB BUILDING					1.01
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 CAP REL COSTS-MAB EQUIPMENT					2.01
4 EMPLOYEE BENEFITS DEPARTMENT					4
5.01 COMMUNICATIONS					5.01
5.02 INFORMATION SYSTEMS					5.02
5.03 PURCHASING/RECEIVENG/STORES					5.03
5.04 ADMITTING					5.04
5.05 PATIENT ACCOUNTING					5.05
5.06 OTHER ADMIN & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
7.01 PLANT OPS-MAB BUILDING					7.01
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
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
68.01 AUDIOLOGY					68.01
71 MEDICAL SUPPLIES CHARGED TO PA					71
72 IMPL. DEV. CHARGED TO PATIENTS					72
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					
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT					92
93 O/P GERIATRIC PSYCH CENTER					93
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 TRANSPORTATION					194
194.01 FUND 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