

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: _____ TIME: _____
 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 PROVENA ST. JOSEPH MEDICAL CENTER (14-0007) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1	HOSPITAL					1
2	SUBPROVIDER - IPF	-1,393,580	504,960			2
3	SUBPROVIDER - IRF	78,161				3
4	SUBPROVIDER (OTHER)	-39,208				4
5	SWING BED - SNF					5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	-1,354,627	504,960			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.

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/30/2012 15:30

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 333 NORTH MADISON STREET
 2 CITY: JOLIET

STATE: IL

P.O. BOX:
 ZIP CODE: 60435

COUNTY: CHAMPAIGN

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	PROVENA ST. JOSEPH MEDICAL CE	14-0007	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF	SJMC PSYCH UNIT	14-S007	16974	4	09/01/1984	N	P	O	4
5	SUBPROVIDER - IRF	SJMC PHYSICAL MED & REHAB	14-T007	16974	5	09/07/1987	N	P	O	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 01/01/2011 TO: 12/31/2011									20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	1	2
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	Y	N
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N

24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	24
		24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	13,326	1,771	68	15	
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	125	15			6		
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	56
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			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)	Y			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
	ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.3+COL.4) 5
	PROGRAM NAME	PROGRAM CODE	1	2	3
	1	2	3	4	5
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
					66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
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.			Y 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.			N N 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.			Y 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.			N N 76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V XIX 1 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	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.	N		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: PAID LOSSES: 1,081,242 AND/OR SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN 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? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148003	140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.				
141	NAME: PROVENA HEALTH CONTRACTOR'S NAME: NGS CONTRACTOR'S NUMBER: 00131			141
142	STREET: 19065 HICKORY CREEK DRIVE, S P.O. BOX: 2952			142
143	CITY: MOKENA STATE: IL ZIP CODE: 60448			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B.
 SEE 42 CFR §413.13)

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

MULTICAMPUS

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

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

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

		Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES				
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	Y		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		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
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.		Y	15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
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	05/21/2012	Y	05/21/2012
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

LINE	DESCRIPTION	WKST A NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
1		2	3	4	5	6		
SALARIES								
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	130,765,232	-3,836,908	126,928,324	4,290,305.00	29.58	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A		353,039		353,039	2,080.00	169.73	4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		6,688,415	44,225	6,732,640	119,355.00	56.41	10
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (SEE INSTRUCTIONS)		428,777		428,777	6,724.00	63.77	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A		1,395,921		1,395,921	6,783.00	205.80	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		17,300,080		17,300,080	301,155.00	57.45	14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
WAGE-RELATED COSTS								
17	WAGE-RELATED COSTS (CORE)		37,436,768		37,436,768			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		1,117,155		1,117,155			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A		94,380		94,380			22
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS		1,422,615	-841,224	581,391	6,203.00	93.73	26
27	ADMINISTRATIVE & GENERAL		14,601,411	-3,075,976	11,525,435	430,485.00	26.77	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		3,674,976		3,674,976	22,588.00	162.70	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		3,105,589		3,105,589	125,093.00	24.83	30
31	LAUNDRY & LINEN SERVICE		167,470		167,470	12,171.00	13.76	31
32	HOUSEKEEPING		2,693,023		2,693,023	205,693.00	13.09	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		3,128,516	-1,919,039	1,209,477	90,602.00	13.35	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		465,130		465,130	10,428.00	44.60	35
36	CAFETERIA			1,919,039	1,919,039	123,320.00	15.56	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		4,730,721		4,730,721	111,931.00	42.26	38
39	CENTRAL SERVICES AND SUPPLY		1,501,068		1,501,068	85,226.00	17.61	39
40	PHARMACY		3,887,065	-106,326	3,780,739	97,836.00	38.64	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		3,376,586		3,376,586	156,473.00	21.58	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)		134,905,338	-3,836,908	131,068,430	4,323,321.0	30.32	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		6,688,415	44,225	6,732,640	119,355.00	56.41	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)		128,216,923	-3,881,133	124,335,790	4,203,966.0	29.58	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)		19,124,778		19,124,778	314,662.00	60.78	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)		37,531,148		37,531,148		30.19%	5
6	TOTAL (SUM OF LINES 3 THRU 5)		184,872,849	-3,881,133	180,991,716	4,518,628.0	40.05	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)		42,754,170	-4,023,526	38,730,644	1,478,049.0	26.20	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	6,095,324	3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	17,155,536	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	950,505	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	234,631	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	295,010	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	2,717,426	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	9,047,116	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	188,872	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION	128,244	21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	624,198	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	37,436,862	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/30/2012 15:30

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL	3,029,918	2
3	SUBPROVIDER - IPF	3,029,918	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.220954	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				29,067,275	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				197,157,627	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				43,562,766	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				14,495,491	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				14,495,491	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	40,251,365	2,624,787	42,876,152		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	8,893,700	579,957	9,473,657		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	282,828	14,197	297,025		22
23	COST OF CHARITY CARE	8,610,872	565,760	9,176,632		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)			33,076,860		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			1,532,312		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			31,544,548		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			6,969,894		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			16,146,526		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			30,642,017		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		21,173,118	21,173,118	1,291,537	1
2	00200				10,320,714	2
3	00300					3
4	00400	1,422,615	39,239,765	40,662,380	-2,769	4
5	00500	14,601,411	94,447,385	109,048,796	-332,476	5
6	00600					6
7	00700	3,105,589	9,272,700	12,378,289	-4,423	7
8	00800	167,470	1,192,149	1,359,619	-1	8
9	00900	2,693,023	1,353,471	4,046,494	-5,347	9
10	01000	3,128,516	2,806,498	5,935,014	-3,665,544	10
11	01100				3,648,382	11
12	01200					12
13	01300		352,243	5,082,964	-2,122	13
14	01400	4,730,721	3,434,299	4,935,367	-2,570,535	14
15	01500	1,501,068	16,093,552	19,980,617	-861,984	15
16	01600	3,887,065	1,560,175	4,936,761	-797	16
17	01700	3,376,586				17
19	01900					19
20	02000					20
21	02100					21
22	02200				80,292	22
23	02300	44,426	7,204	51,630	106,326	23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	35,049,140	3,435,016	38,484,156	-4,563,043	30
31	03100	5,694,819	1,276,697	6,971,516	-328,903	31
34	03400	3,997,028	1,099,856	5,096,884	-234,014	34
35	02060					35
40	04000	2,966,719	439,546	3,406,265	-75,455	40
41	04100	2,435,961	186,906	2,622,867	-65,379	41
43	04300	1,708,748	73,318	1,782,066	-47,435	43
ANCILLARY SERVICE COST CENTERS						
50	05000	9,154,844	27,433,006	36,587,850	-23,219,035	50
54	05400	9,418,555	4,421,553	13,840,108	-1,343,832	54
60	06000	20,923	14,233,308	14,254,231	-2,422,214	60
62.30	06250					62.30
65	06500	2,287,168	644,082	2,931,250	-242,484	65
66	06600	6,466,014	2,108,770	8,574,784	-249,612	66
69	06900	3,354,027	7,388,690	10,742,717	-7,121,577	69
70	07000	363,034	60,444	423,478	-19,110	70
71	07100				16,249,236	71
72	07200				24,254,042	72
73	07300					73
74	07400					74
76	03140	636,629	93,542	730,171	3,195,009	76
76.10	03551	124,322	6	124,328	74,705	76.10
76.97	07697	492,553	11,604	504,157	-5,068	76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	6,694,949	1,794,636	8,489,585	-565,929	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
113	11300		11,174,926	11,174,926	-11,174,926	113
118		129,523,923	266,808,465	396,332,388	96,229	118
NONREIMBURSABLE COST CENTERS						
192.01	19201	1,241,309	1,691,856	2,933,165	-96,229	192.01
194	07950					194
194.01	07951					194.01
194.02	07952					194.02
194.04	07953					194.04
194.05	07954					194.05
194.06	07955					194.06
200		130,765,232	268,500,321	399,265,553		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	22,464,655	-4,591,090	17,873,565	1
2	00200	CAP REL COSTS-MVBLE EQUIP	10,320,714	4,762,294	15,083,008	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	40,659,611	8,876,889	49,536,500	4
5	00500	ADMINISTRATIVE & GENERAL	108,716,320	-46,190,750	62,525,570	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	12,373,866	-51,807	12,322,059	7
8	00800	LAUNDRY & LINEN SERVICE	1,359,618		1,359,618	8
9	00900	HOUSEKEEPING	4,041,147		4,041,147	9
10	01000	DIETARY	2,269,470	-85,931	2,183,539	10
11	01100	CAFETERIA	3,648,382	-1,900,130	1,748,252	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	5,080,842	-131,146	4,949,696	13
14	01400	CENTRAL SERVICES & SUPPLY	2,364,832		2,364,832	14
15	01500	PHARMACY	19,118,633	-126,517	18,992,116	15
16	01600	MEDICAL RECORDS & LIBRARY	4,935,964	-7,723	4,928,241	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	80,292		80,292	22
23	02300	PARAMED ED PRGM-(SPECIFY)	157,956		157,956	23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	33,921,113	-697,302	33,223,811	30
31	03100	INTENSIVE CARE UNIT	6,642,613	-332,199	6,310,414	31
34	03400	SURGICAL INTENSIVE CARE UNIT	4,862,870	-273,925	4,588,945	34
35	02060	NEO NATAL INTENSIVE CARE				35
40	04000	SUBPROVIDER - IPF	3,330,810	-33,123	3,297,687	40
41	04100	SUBPROVIDER - IRF	2,557,488	-70,000	2,487,488	41
43	04300	NURSERY	1,734,631		1,734,631	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	13,368,815	-733,092	12,635,723	50
54	05400	RADIOLOGY-DIAGNOSTIC	12,496,276	-757,841	11,738,435	54
60	06000	LABORATORY	11,832,017	-143,697	11,688,320	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	2,688,766	-6,572	2,682,194	65
66	06600	PHYSICAL THERAPY	8,325,172	-187,255	8,137,917	66
69	06900	ELECTROCARDIOLOGY	3,621,140	-188,395	3,432,745	69
70	07000	ELECTROENCEPHALOGRAPHY	404,368	-33,750	370,618	70
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	16,249,236		16,249,236	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	24,254,042		24,254,042	72
73	07300	DRUGS CHARGED TO PATIENTS				73
74	07400	RENAL DIALYSIS				74
76	03140	OTHER	3,925,180		3,925,180	76
76.10	03551	OP PSYCH	199,033		199,033	76.10
76.97	07697	CARDIAC REHABILITATION	499,089	-1,315	497,774	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	EMERGENCY	7,923,656	-16,247	7,907,409	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
94	09400	HOME PROGRAM DIALYSIS				94
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	396,428,617	-42,920,624	353,507,993	118
NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	2,836,936		2,836,936	192.01
194	07950	OTHER NON-REIMBURSABLE				194
194.01	07951	SHARED SERVICES				194.01
194.02	07952	CASE MANAGEMENT				194.02
194.04	07953	OUTPATIENT PHARMACY				194.04
194.05	07954	PRIMARY CARE PHYSICIAN				194.05
194.06	07955	PATIENT SITTERS				194.06
200		TOTAL (SUM OF LINES 118-199)	399,265,553	-42,920,624	356,344,929	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
	1	2	3	4	5		
1 CAFETERIA	A	CAFETERIA	11		1,919,039	1,729,343	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					1,919,039	1,729,343	500
1 CAPITAL INSURANCE	B	CAP REL COSTS-BLDG & FIXT	1			301,056	1
2 CAPITAL INSURANCE	B	CAP REL COSTS-MVBLE EQUIP	2			45,372	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B						346,428	500
1 INTEREST	C	CAP REL COSTS-BLDG & FIXT	1			11,174,926	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C						11,174,926	500
1 MEDICAL SUPPLIES AND IMPLANTS	D	MEDICAL SUPPLIES CHRGED TO PA	71			16,249,236	1
2 MEDICAL SUPPLIES AND IMPLANTS	D	IMPL. DEV. CHARGED TO PATIENT	72			24,254,042	2
3 MEDICAL SUPPLIES AND IMPLANTS	D	ADMINISTRATIVE & GENERAL	5			94,244	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
500 TOTAL RECLASSIFICATIONS CODE LETTER - D						40,597,522	500
1 ALLOCATED SALARY TO OTHER	E	ADMINISTRATIVE & GENERAL	5			2,995,684	1
2		EMPLOYEE BENEFITS	4			841,224	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - E						3,836,908	500
1 MME	F	CAP REL COSTS-MVBLE EQUIP	2			10,275,342	1
2		CAP REL COSTS-BLDG & FIXT	1			90,897	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F						10,366,239	500
1 IV THERAPY	G	OTHER	76		2,910,220	295,206	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					2,910,220	295,206	500
1 OP PSYCH	H	OP PSYCH	76.10		62,101	12,604	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					62,101	12,604	500
1 PHARMACIST TEACHING TIME	I	PARAMED ED PRGM-(SPECIFY)	23		106,326		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					106,326		500
1 INTERN AND RESIDENT COST	J	I&R SRVCES-OTHER PRGM COSTS A	22		80,292		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - J					80,292		500
GRAND TOTAL (INCREASES)					5,077,978	68,359,176	

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	A	DIETARY	10	1,919,039	1,729,343	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				1,919,039	1,729,343	500
1 CAPITAL INSURANCE	B	ADMINISTRATIVE & GENERAL	5		301,056	9 1
2 CAPITAL INSURANCE	B	ADMINISTRATIVE & GENERAL	5		45,372	9 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					346,428	500
1 INTEREST	C	INTEREST EXPENSE	113		11,174,926	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					11,174,926	500
1 MEDICAL SUPPLIES AND IMPLANTS	D	EMPLOYEE BENEFITS	4		2,769	1
2 MEDICAL SUPPLIES AND IMPLANTS	D	OPERATION OF PLANT	7		4,423	2
3 MEDICAL SUPPLIES AND IMPLANTS	D	LAUNDRY & LINEN SERVICE	8		1	3
4		HOUSEKEEPING	9		5,347	4
5		DIETARY	10		17,162	5
6		NURSING ADMINISTRATION	13		2,122	6
7		CENTRAL SERVICES & SUPPLY	14		2,570,535	7
8		PHARMACY	15		755,658	8
9		MEDICAL RECORDS & LIBRARY	16		797	9
10		ADULTS & PEDIATRICS	30		1,357,617	10
11		INTENSIVE CARE UNIT	31		328,903	11
12		SURGICAL INTENSIVE CARE UNIT	34		234,014	12
13		SUBPROVIDER - IRF	41		65,379	13
14		SUBPROVIDER - IPF	40		750	14
15		NURSERY	43		47,435	15
16		OPERATING ROOM	50		23,219,035	16
17		RADIOLOGY-DIAGNOSTIC	54		1,343,832	17
18		LABORATORY	60		2,422,214	18
19		RESPIRATORY THERAPY	65		242,484	19
20		PHYSICAL THERAPY	66		249,612	20
21		ELECTROCARDIOLOGY	69		7,121,577	21
22		ELECTROENCEPHALOGRAPHY	70		19,110	22
23		OTHER	76		10,417	23
24		CARDIAC REHABILITATION	76.97		5,068	24
25		EMERGENCY	91		565,929	25
26		OTHER NRCC	192.01		5,332	26
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					40,597,522	500
1 ALLOCATED SALARY TO OTHER	E	ADMINISTRATIVE & GENERAL	5	2,995,684		1
2		EMPLOYEE BENEFITS	4	841,224		2
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				3,836,908		500
1 MME	F	CAP REL COSTS-BLDG & FIXT	1		10,275,342	9 1
2		OTHER NRCC	192.01		90,897	9 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					10,366,239	500
1 IV THERAPY	G	ADULTS & PEDIATRICS	30	2,910,220	295,206	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G				2,910,220	295,206	500
1 OP PSYCH	H	SUBPROVIDER - IPF	40	62,101	12,604	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - H				62,101	12,604	500
1 PHARMACIST TEACHING TIME	I	PHARMACY	15	106,326		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - I				106,326		500
1 INTERN AND RESIDENT COST	J	ADMINISTRATIVE & GENERAL	5	80,292		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				80,292		500
GRAND TOTAL (DECREASES)				8,914,886	64,522,268	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION		AND		BALANCE
	1	2	3	4	5	6	7
1 LAND	1,884,595					1,884,595	
2 LAND IMPROVEMENTS	3,208,539					3,208,539	3,148,289
3 BUILDINGS AND FIXTURES	326,265,338	10,419,247		10,419,247	14,289,299	322,395,286	32,323,821
4 BUILDING IMPROVEMENTS	1,439,521					1,439,521	
5 FIXED EQUIPMENT							
6 MOVABLE EQUIPMENT	138,546,600	15,836,023		15,836,023	32,809,595	121,573,028	41,362,390
7 HIT DESIGNATED ASSETS							
8 SUBTOTAL (SUM OF LINES 1-7)	471,344,593	26,255,270		26,255,270	47,098,894	450,500,969	76,834,500
9 RECONCILING ITEMS							
10 TOTAL (LINE 7 MINUS LINE 9)	471,344,593	26,255,270		26,255,270	47,098,894	450,500,969	76,834,500

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(1)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	21,173,118						21,173,118
2 CAP REL COSTS-MVBLE EQUIP							
3 TOTAL (SUM OF LINES 1-2)	21,173,118						21,173,118

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	RATIOS		INSURANCE	TAXES	OTHER	TOTAL
			FOR RATIO (COL. 1 - COL. 2)	RATIO (SEE INSTR.)			CAPITAL- RELATED COSTS	(SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	328,927,941		328,927,941	0.730138				
2 CAP REL COSTS-MVBLE EQUIP	121,573,028		121,573,028	0.269862				
3 TOTAL (SUM OF LINES 1-2)	450,500,969		450,500,969	1.000000				

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(2)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	11,146,600		6,726,965				17,873,565
2 CAP REL COSTS-MVBLE EQUIP	15,083,008						15,083,008
3 TOTAL	26,229,608		6,726,965				32,956,573

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	-40,000	CAP REL COSTS-BLDG & FIXT	1	9 6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-7,342,751			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-1,447,318			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-1,877,170	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	B	-103,491	PHARMACY	15	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-22,960	CAFETERIA	11	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 MISC INCOME	B	-2,004	EMPLOYEE BENEFITS	4	33
34 MISC INCOME	B	-239,294	ADMINISTRATIVE & GENERAL	5	34
35 MISC INCOME	B	-1,760	NURSING ADMINISTRATION	13	35
36 MISC INCOME	B	-7,723	MEDICAL RECORDS & LIBRARY	16	36
37 MISC INCOME	B	-1,905	SUBPROVIDER - IPF	40	37
38 MISC INCOME	B	-35,754	RADIOLOGY-DIAGNOSTIC	54	38
39 MISC INCOME	B	-4,816	LABORATORY	60	39
40 MISC INCOME	B	-37,885	PHYSICAL THERAPY	66	40
41 MISC INCOME	B	-1,315	CARDIAC REHABILITATION	76.97	41
42 RENTAL INCOME	B	-6,832	CAP REL COSTS-BLDG & FIXT	1	9 42
42.01 RENTAL INCOME	B	-5,400	CAP REL COSTS-BLDG & FIXT	1	9 42.01
42.02 MISC INCOME	B	-20,955	ADULTS & PEDIATRICS	30	42.02
42.03 MISC INCOME	B	-1,629	OPERATING ROOM	50	42.03
43 MAINTENANCE REVENUE	B	-10,800	OPERATION OF PLANT	7	43
44 GIFT SHOP	B	-230,277	ADMINISTRATIVE & GENERAL	5	44
45 AUXILIARY	B	-56,192	ADMINISTRATIVE & GENERAL	5	45
45.01 PLANT OP	B	-41,007	OPERATION OF PLANT	7	45.01
45.02 FOOD OTHER	B	-85,931	DIETARY	10	45.02
45.03 SEMINAR REVENUE	B	-4,240	NURSING ADMINISTRATION	13	45.03
45.04 SEMINAR REVENUE	B	-12,595	ADULTS & PEDIATRICS	30	45.04
45.05 SEMINAR REVENUE	B	-1,845	INTENSIVE CARE UNIT	31	45.05
45.06 SILVER RECOVERY	B	-135,529	RADIOLOGY-DIAGNOSTIC	54	45.06
45.08 UBIT REVENUE	B	-25,036	LABORATORY	60	45.08
45.09 EMT REVENUE	B	-6,950	EMERGENCY	91	45.09
45.10 NONALLOWABLE EXP	A	-34,578	ADMINISTRATIVE & GENERAL	5	45.10
45.11 MARKETING OFFSET	A	-664,526	ADMINISTRATIVE & GENERAL	5	45.11
45.12 DUES LOBBYING PORTION	A	-43,077	ADMINISTRATIVE & GENERAL	5	45.12
45.13 NRCC DEPR EXP	A	-90,897	CAP REL COSTS-BLDG & FIXT	1	9 45.13
45.14 PATIENT TRANSPORTATION	A	-149,370	PHYSICAL THERAPY	66	45.14

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/30/2012 15:30

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
			COST CENTER 3	LINE NO. 4	
45.15 NONALLOWABLE EXP	A	-146	NURSING ADMINISTRATION	13	45.15
45.16 NONALLOWABLE EXP	A	-93	EMPLOYEE BENEFITS	4	45.16
46 CASH FUNDING OF PENSION	A	10,157,052	EMPLOYEE BENEFITS	4	46
47 REMOVE BAD DEBT EXPENSE	A	-40,283,625	ADMINISTRATIVE & GENERAL	5	47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-42,920,624			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	5,099,128	6,371,194	-1,272,066	1
2	5	ADMINISTRATIVE & GENERAL	27,467,696	27,455,371	12,325	2
3	31	INTENSIVE CARE UNIT	542,171	816,096	-273,925	3
4	34	SURGICAL INTENSIVE CARE UNIT	542,171	816,096	-273,925	4
4.01	54	RADIOLOGY-DIAGNOSTIC	1,259,321	1,299,540	-40,219	4.01
4.02	1	CAP REL COSTS-BLDG & FIXT	6,804,948	11,252,909	-4,447,961	11 4.02
4.03	2	CAP REL COSTS-MVBLE EQUIP	4,762,294	4,762,294		9 4.03
4.04	60	LABORATORY	11,304,817	11,218,658	86,159	4.04
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.	57,782,546	59,229,864	-1,447,318	5

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 2	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----		TYPE OF BUSINESS 6
		PERCENT OF OWNERSHIP 3	NAME 4	
6	B PROVENA HEALTH		PROVENA HEALTH	
7				
8				
9				
10				

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	4 EMPLOYEE BENEFITS A	6,000	6,000		177,200	1	85	4	1
2	5 ADMINISTRATIVE & GENERAL A	4,698,788	4,636,208	62,580	177,200	555	47,282	2,364	2
3	13 NURSING ADMINISTRATION A	125,000	125,000		177,200	1	85	4	3
4	15 PHARMACY A	23,026	23,026		177,200	1	85	4	4
5	30 ADULTS & PEDIATRICS A	993,898	466,354	527,544	138,700	4,951	330,146	16,507	5
6	31 INTENSIVE CARE UNIT A	56,429	56,429		208,000	1	100	5	6
7	40 SUBPROVIDER - IPF A	31,440	31,107	333	154,100	3	222	11	7
8	41 SUBPROVIDER - IRF A	70,000	70,000		138,700	1	67	3	8
9	50 OPERATING ROOM A	764,163	698,863	65,300	208,000	327	32,700	1,635	9
10	54 RADIOLOGY-DIAGNOSTIC A	546,339	546,339		225,300	1	108	5	10
11	60 LABORATORY A	200,004	200,004		215,700	1	104	5	11
12	65 RESPIRATORY THERAPY A	30,000	2,500	27,500	177,200	275	23,428	1,171	12
13	69 ELECTROCARDIOLOGY A	212,917	182,117	30,800	165,600	308	24,522	1,226	13
14	70 ELECTROENCEPHALOGRAPHY A	33,750	33,750		165,600	1	80	4	14
15	91 EMERGENCY A	45,697	166	45,531	208,000	364	36,400	1,820	15
200	TOTAL	7,837,451	7,077,863	759,588		6,791	495,414	24,768	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
10	11	12	13	14	15	16	17	18	
1	4	EMPLOYEE BENEFITS	A			85		6,000	1
2	5	ADMINISTRATIVE & GENERAL	A			47,282	15,298	4,651,506	2
3	13	NURSING ADMINISTRATION	A			85		125,000	3
4	15	PHARMACY	A			85		23,026	4
5	30	ADULTS & PEDIATRICS	A			330,146	197,398	663,752	5
6	31	INTENSIVE CARE UNIT	A			100		56,429	6
7	40	SUBPROVIDER - IPF	A			222	111	31,218	7
8	41	SUBPROVIDER - IRF	A			67		70,000	8
9	50	OPERATING ROOM	A			32,700	32,600	731,463	9
10	54	RADIOLOGY-DIAGNOSTIC	A			108		546,339	10
11	60	LABORATORY	A			104		200,004	11
12	65	RESPIRATORY THERAPY	A			23,428	4,072	6,572	12
13	69	ELECTROCARDIOLOGY	A			24,522	6,278	188,395	13
14	70	ELECTROENCEPHALOGRAPHY	A			80		33,750	14
15	91	EMERGENCY	A			36,400	9,131	9,297	15
200		TOTAL				495,414	264,888	7,342,751	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	17,873,565	17,873,565				1
2 CAP REL COSTS-MVBLE EQUIP	15,083,008		15,083,008			2
4 EMPLOYEE BENEFITS	49,536,500	82,884	14,453	49,633,837		4
5 ADMINISTRATIVE & GENERAL	62,525,570	4,445,341	1,245,362	4,527,629	72,743,902	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	12,322,059	2,612,006	1,595,711	1,219,993	17,749,769	7
8 LAUNDRY & LINEN SERVICE	1,359,618	116,597	1,946	65,789	1,543,950	8
9 HOUSEKEEPING	4,041,147	218,536	166,180	1,057,922	5,483,785	9
10 DIETARY	2,183,539	177,920	60,670	475,129	2,897,258	10
11 CAFETERIA	1,748,252	242,186	82,579	753,871	2,826,888	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4,949,696	70,205	87,069	1,858,407	6,965,377	13
14 CENTRAL SERVICES & SUPPLY	2,364,832	351,245	354,994	589,677	3,660,748	14
15 PHARMACY	18,992,116	53,440	28,224	1,485,218	20,558,998	15
16 MEDICAL RECORDS & LIBRARY	4,928,241	144,135	33,161	1,326,451	6,431,988	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	80,292			31,542	111,834	22
23 PARAMED ED PRGM-(SPECIFY)	157,956	4,359		59,221	221,536	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	33,223,811	4,540,997	1,071,816	12,625,350	51,461,974	30
31 INTENSIVE CARE UNIT	6,310,414	497,360	354,350	2,237,141	9,399,265	31
34 SURGICAL INTENSIVE CARE UNIT	4,588,945	394,640	250,227	1,570,184	6,803,996	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	3,297,687	298,078	43,998	1,141,044	4,780,807	40
41 SUBPROVIDER - IRF	2,487,488	310,539	13,034	956,938	3,767,999	41
43 NURSERY	1,734,631	156,595	65,669	671,261	2,628,156	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,635,723	716,241	3,189,958	3,596,371	20,138,293	50
54 RADIOLOGY-DIAGNOSTIC	11,738,435	804,756	4,243,543	3,699,966	20,486,700	54
60 LABORATORY	11,688,320	412,423	1,356	8,219	12,110,318	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,682,194	39,925	90,893	898,487	3,711,499	65
66 PHYSICAL THERAPY	8,137,917	21,198	153,236	2,540,096	10,852,447	66
69 ELECTROCARDIOLOGY	3,432,745	331,464	1,552,964	1,317,589	6,634,762	69
70 ELECTROENCEPHALOGRAPHY	370,618	74,529	34,624	142,614	622,385	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	16,249,236				16,249,236	71
72 IMPL. DEV. CHARGED TO PATIENT	24,254,042				24,254,042	72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 OTHER	3,925,180		42,813	1,393,337	5,361,330	76
76.10 OP PSYCH	199,033		6,078	73,234	278,345	76.10
76.97 CARDIAC REHABILITATION	497,774	107,515	16,023	193,494	814,806	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	7,907,409	589,435	213,838	2,630,030	11,340,712	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	353,507,993	17,814,549	15,014,769	49,146,204	352,893,105	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC	2,836,936	59,016	68,239	487,633	3,451,824	192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	356,344,929	17,873,565	15,083,008	49,633,837	356,344,929	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	72,743,902					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4,552,833	22,302,602				7
8 LAUNDRY & LINEN SERVICE	396,025	242,276	2,182,251			8
9 HOUSEKEEPING	1,406,596	454,092		7,344,473		9
10 DIETARY	743,150	369,698		359,241	4,369,347	10
11 CAFETERIA	725,100	503,234		93,496	10,975	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,786,626	145,879		51,782		13
14 CENTRAL SERVICES & SUPPLY	938,986	729,846		26,610		14
15 PHARMACY	5,273,404	111,041		10,788		15
16 MEDICAL RECORDS & LIBRARY	1,649,811	299,495		17,980		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	28,686					22
23 PARAMED ED PRGM-(SPECIFY)	56,824	9,058				23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,200,000	9,435,651	1,738,519	3,686,620	3,339,138	30
31 INTENSIVE CARE UNIT	2,410,921	1,033,455	142,580	539,760	89,868	31
34 SURGICAL INTENSIVE CARE UNIT	1,745,232	820,015	60,046	189,869	75,696	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	1,226,282	619,371	15,394	44,950	361,076	40
41 SUBPROVIDER - IRF	966,496	645,263	113,552	307,099	305,387	41
43 NURSERY	674,125	325,387	111,285	47,108	185,526	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,165,492	1,488,264		758,037		50
54 RADIOLOGY-DIAGNOSTIC	5,254,859	1,672,188		290,197		54
60 LABORATORY	3,106,309	856,966		145,998		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	952,003	82,960		25,172		65
66 PHYSICAL THERAPY	2,783,664	44,047		182,317		66
69 ELECTROCARDIOLOGY	1,701,823	688,744		152,111		69
70 ELECTROENCEPHALOGRAPHY	159,642	154,862		12,586		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	4,167,945					71
72 IMPL. DEV. CHARGED TO PATIENT	6,221,186					72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 OTHER	1,375,187					76
76.10 OP PSYCH	71,396					76.10
76.97 CARDIAC REHABILITATION	208,999	223,404				76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,908,904	1,224,777	875	402,752	1,681	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	71,858,506	22,179,973	2,182,251	7,344,473	4,369,347	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC	885,396	122,629				192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	72,743,902	22,302,602	2,182,251	7,344,473	4,369,347	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	4,159,693					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	141,223	9,090,887				13
14 CENTRAL SERVICES & SUPPLY	107,525		5,463,715			14
15 PHARMACY	123,455			26,077,686		15
16 MEDICAL RECORDS & LIBRARY	197,439				8,596,713	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)	4,882					23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,526,215	5,155,719			763,464	30
31 INTENSIVE CARE UNIT	189,487	640,110			166,414	31
34 SURGICAL INTENSIVE CARE UNIT	148,099	500,296			120,686	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	84,088	284,060			59,117	40
41 SUBPROVIDER - IRF	100,544	339,648			56,053	41
43 NURSERY	54,379	183,699			28,780	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	292,971	989,688			730,214	50
54 RADIOLOGY-DIAGNOSTIC	364,960				1,721,559	54
60 LABORATORY	1,417				1,208,242	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	99,494				154,939	65
66 PHYSICAL THERAPY	230,219				236,497	66
69 ELECTROCARDIOLOGY	122,799				514,942	69
70 ELECTROENCEPHALOGRAPHY	17,269				28,955	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			5,463,715		684,559	71
72 IMPL. DEV. CHARGED TO PATIENT					469,623	72
73 DRUGS CHARGED TO PATIENTS				26,077,686	838,431	73
74 RENAL DIALYSIS						74
76 OTHER	16,980	57,362			103,715	76
76.10 OP PSYCH	4,960	16,756			7,539	76.10
76.97 CARDIAC REHABILITATION	19,710				10,392	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	273,392	923,549			692,592	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	4,121,507	9,090,887	5,463,715	26,077,686	8,596,713	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC	38,186					192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,159,693	9,090,887	5,463,715	26,077,686	8,596,713	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	140,520					22
23 PARAMED ED PRGM-(SPECIFY)		292,300				23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	70,260		90,377,560	-70,260	90,307,300	30
31 INTENSIVE CARE UNIT			14,611,860		14,611,860	31
34 SURGICAL INTENSIVE CARE UNIT			10,463,935		10,463,935	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF			7,475,145		7,475,145	40
41 SUBPROVIDER - IRF			6,602,041		6,602,041	41
43 NURSERY			4,238,445		4,238,445	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	70,260		29,633,219	-70,260	29,562,959	50
54 RADIOLOGY-DIAGNOSTIC			29,790,463		29,790,463	54
60 LABORATORY			17,429,250		17,429,250	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			5,026,067		5,026,067	65
66 PHYSICAL THERAPY			14,329,191		14,329,191	66
69 ELECTROCARDIOLOGY			9,815,181		9,815,181	69
70 ELECTROENCEPHALOGRAPHY			995,699		995,699	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			26,565,455		26,565,455	71
72 IMPL. DEV. CHARGED TO PATIENT			30,944,851		30,944,851	72
73 DRUGS CHARGED TO PATIENTS		292,300	27,208,417		27,208,417	73
74 RENAL DIALYSIS						74
76 OTHER			6,914,574		6,914,574	76
76.10 OP PSYCH			378,996		378,996	76.10
76.97 CARDIAC REHABILITATION			1,277,311		1,277,311	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY			17,769,234		17,769,234	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	140,520	292,300	351,846,894	-140,520	351,706,374	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC			4,498,035		4,498,035	192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	140,520	292,300	356,344,929	-140,520	356,204,409	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS
	0	1	2	2A	4
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS		82,884	14,453	97,337	97,337
5 ADMINISTRATIVE & GENERAL	66,460	4,445,341	1,245,362	5,757,163	8,875
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	49,615	2,612,006	1,595,711	4,257,332	2,391
8 LAUNDRY & LINEN SERVICE		116,597	1,946	118,543	129
9 HOUSEKEEPING		218,536	166,180	384,716	2,074
10 DIETARY	4,315	177,920	60,670	242,905	931
11 CAFETERIA		242,186	82,579	324,765	1,478
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION		70,205	87,069	157,274	3,643
14 CENTRAL SERVICES & SUPPLY	158,354	351,245	354,994	864,593	1,156
15 PHARMACY	917,872	53,440	28,224	999,536	2,911
16 MEDICAL RECORDS & LIBRARY		144,135	33,161	177,296	2,600
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					62
23 PARAMED ED PRGM-(SPECIFY)		4,359		4,359	116
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	2,255	4,540,997	1,071,816	5,615,068	24,794
31 INTENSIVE CARE UNIT		497,360	354,350	851,710	4,385
34 SURGICAL INTENSIVE CARE UNIT		394,640	250,227	644,867	3,078
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF		298,078	43,998	342,076	2,237
41 SUBPROVIDER - IRF		310,539	13,034	323,573	1,876
43 NURSERY		156,595	65,669	222,264	1,316
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	418,756	716,241	3,189,958	4,324,955	7,049
54 RADIOLOGY-DIAGNOSTIC	661,064	804,756	4,243,543	5,709,363	7,252
60 LABORATORY	12,544	412,423	1,356	426,323	16
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	6,130	39,925	90,893	136,948	1,761
66 PHYSICAL THERAPY	748,750	21,198	153,236	923,184	4,979
69 ELECTROCARDIOLOGY	76,188	331,464	1,552,964	1,960,616	2,583
70 ELECTROENCEPHALOGRAPHY		74,529	34,624	109,153	280
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76 OTHER			42,813	42,813	2,731
76.10 OP PSYCH			6,078	6,078	144
76.97 CARDIAC REHABILITATION		107,515	16,023	123,538	379
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY		589,435	213,838	803,273	5,155
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	3,122,303	17,814,549	15,014,769	35,951,621	96,381
NONREIMBURSABLE COST CENTERS					
192.01 OTHER NRCC	470,696	59,016	68,239	597,951	956
194 OTHER NON-REIMBURSABLE					194
194.01 SHARED SERVICES					194.01
194.02 CASE MANAGEMENT					194.02
194.04 OUTPATIENT PHARMACY					194.04
194.05 PRIMARY CARE PHYSICIAN					194.05
194.06 PATIENT SITTERS					194.06
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	3,592,999	17,873,565	15,083,008	36,549,572	97,337

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	5,766,038					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	360,888	4,620,611				7
8 LAUNDRY & LINEN SERVICE	31,392	50,194	200,258			8
9 HOUSEKEEPING	111,496	94,078		592,364		9
10 DIETARY	58,907	76,593		28,974	408,310	10
11 CAFETERIA	57,476	104,259		7,541	1,026	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	141,620	30,223		4,176		13
14 CENTRAL SERVICES & SUPPLY	74,430	151,208		2,146		14
15 PHARMACY	418,006	23,005		870		15
16 MEDICAL RECORDS & LIBRARY	130,775	62,049		1,450		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	2,274					22
23 PARAMED ED PRGM-(SPECIFY)	4,504	1,877				23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,046,188	1,954,860	159,539	297,344	312,038	30
31 INTENSIVE CARE UNIT	191,106	214,109	13,084	43,534	8,398	31
34 SURGICAL INTENSIVE CARE UNIT	138,339	169,889	5,510	15,314	7,074	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	97,203	128,320	1,413	3,625	33,742	40
41 SUBPROVIDER - IRF	76,611	133,684	10,420	24,769	28,538	41
43 NURSERY	53,436	67,413	10,212	3,799	17,337	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	409,452	308,336		61,139		50
54 RADIOLOGY-DIAGNOSTIC	416,536	346,441		23,406		54
60 LABORATORY	246,227	177,545		11,775		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	75,462	17,188		2,030		65
66 PHYSICAL THERAPY	220,652	9,126		14,705		66
69 ELECTROCARDIOLOGY	134,898	142,693		12,268		69
70 ELECTROENCEPHALOGRAPHY	12,654	32,084		1,015		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	330,379					71
72 IMPL. DEV. CHARGED TO PATIENT	493,133					72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 OTHER	109,007					76
76.10 OP PSYCH	5,659					76.10
76.97 CARDIAC REHABILITATION	16,567	46,284				76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	230,579	253,747	80	32,484	157	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	5,695,856	4,595,205	200,258	592,364	408,310	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC	70,182	25,406				192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	5,766,038	4,620,611	200,258	592,364	408,310	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	496,545					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	16,858	353,794				13
14 CENTRAL SERVICES & SUPPLY	12,835		1,106,368			14
15 PHARMACY	14,737			1,459,065		15
16 MEDICAL RECORDS & LIBRARY	23,568				397,738	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)	583					23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	182,186	200,649			35,290	30
31 INTENSIVE CARE UNIT	22,619	24,911			7,692	31
34 SURGICAL INTENSIVE CARE UNIT	17,679	19,470			5,579	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	10,038	11,055			2,733	40
41 SUBPROVIDER - IRF	12,002	13,218			2,591	41
43 NURSERY	6,491	7,149			1,330	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	34,972	38,516			33,753	50
54 RADIOLOGY-DIAGNOSTIC	43,565				79,942	54
60 LABORATORY	169				55,850	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	11,877				7,162	65
66 PHYSICAL THERAPY	27,481				10,932	66
69 ELECTROCARDIOLOGY	14,659				23,803	69
70 ELECTROENCEPHALOGRAPHY	2,061				1,338	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,106,368		31,643	71
72 IMPL. DEV. CHARGED TO PATIENT					21,708	72
73 DRUGS CHARGED TO PATIENTS				1,459,065	38,756	73
74 RENAL DIALYSIS						74
76 OTHER	2,027	2,232			4,794	76
76.10 OP PSYCH	592	652			348	76.10
76.97 CARDIAC REHABILITATION	2,353				480	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	32,635	35,942			32,014	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	491,987	353,794	1,106,368	1,459,065	397,738	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC	4,558					192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	496,545	353,794	1,106,368	1,459,065	397,738	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	2,336					22
23 PARAMED ED PRGM-(SPECIFY)		11,439				23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS			9,827,956		9,827,956	30
31 INTENSIVE CARE UNIT			1,381,548		1,381,548	31
34 SURGICAL INTENSIVE CARE UNIT			1,026,799		1,026,799	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF			632,442		632,442	40
41 SUBPROVIDER - IRF			627,282		627,282	41
43 NURSERY			390,747		390,747	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			5,218,172		5,218,172	50
54 RADIOLOGY-DIAGNOSTIC			6,626,505		6,626,505	54
60 LABORATORY			917,905		917,905	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			252,428		252,428	65
66 PHYSICAL THERAPY			1,211,059		1,211,059	66
69 ELECTROCARDIOLOGY			2,291,520		2,291,520	69
70 ELECTROENCEPHALOGRAPHY			158,585		158,585	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,468,390		1,468,390	71
72 IMPL. DEV. CHARGED TO PATIENT			514,841		514,841	72
73 DRUGS CHARGED TO PATIENTS			1,497,821		1,497,821	73
74 RENAL DIALYSIS						74
76 OTHER			163,604		163,604	76
76.10 OP PSYCH			13,473		13,473	76.10
76.97 CARDIAC REHABILITATION			189,601		189,601	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY			1,426,066		1,426,066	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)			35,836,744		35,836,744	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC			699,053		699,053	192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06
200 CROSS FOOT ADJUSTMENTS	2,336	11,439	13,775		13,775	200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,336	11,439	36,549,572		36,549,572	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	983,988					1
2 CAP REL COSTS-MVBLE EQUIP		9,229,599				2
4 EMPLOYEE BENEFITS	4,563	8,844	126,346,933			4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	244,728	762,062	11,525,435	-72,743,902	283,601,027	5
7 OPERATION OF PLANT	143,798	976,448	3,105,589		17,749,769	7
8 LAUNDRY & LINEN SERVICE	6,419	1,191	167,470		1,543,950	8
9 HOUSEKEEPING	12,031	101,689	2,693,023		5,483,785	9
10 DIETARY	9,795	37,125	1,209,477		2,897,258	10
11 CAFETERIA	13,333	50,532	1,919,039		2,826,888	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,865	53,279	4,730,721		6,965,377	13
14 CENTRAL SERVICES & SUPPLY	19,337	217,228	1,501,068		3,660,748	14
15 PHARMACY	2,942	17,271	3,780,739		20,558,998	15
16 MEDICAL RECORDS & LIBRARY	7,935	20,292	3,376,586		6,431,988	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			80,292		111,834	22
23 PARAMED ED PRGM-(SPECIFY)	240		150,752		221,536	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	249,994	655,866	32,138,920		51,461,974	30
31 INTENSIVE CARE UNIT	27,381	216,834	5,694,819		9,399,265	31
34 SURGICAL INTENSIVE CARE UNIT	21,726	153,119	3,997,028		6,803,996	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	16,410	26,923	2,904,618		4,780,807	40
41 SUBPROVIDER - IRF	17,096	7,976	2,435,961		3,767,999	41
43 NURSERY	8,621	40,184	1,708,748		2,628,156	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	39,431	1,952,000	9,154,844		20,138,293	50
54 RADIOLOGY-DIAGNOSTIC	44,304	2,596,711	9,418,555		20,486,700	54
60 LABORATORY	22,705	830	20,923		12,110,318	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,198	55,619	2,287,168		3,711,499	65
66 PHYSICAL THERAPY	1,167	93,768	6,466,014		10,852,447	66
69 ELECTROCARDIOLOGY	18,248	950,290	3,354,027		6,634,762	69
70 ELECTROENCEPHALOGRAPHY	4,103	21,187	363,034		622,385	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					16,249,236	71
72 IMPL. DEV. CHARGED TO PATIENT					24,254,042	72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 OTHER		26,198	3,546,849		5,361,330	76
76.10 OP PSYCH		3,719	186,423		278,345	76.10
76.97 CARDIAC REHABILITATION	5,919	9,805	492,553		814,806	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	32,450	130,852	6,694,949		11,340,712	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	980,739	9,187,842	125,105,624	-72,743,902	280,149,203	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC	3,249	41,757	1,241,309		3,451,824	192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTEES						194.06

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	17,873,565	15,083,008	49,633,837		72,743,902	202
203	UNIT COST MULT-WS B PT I	18.164414	1.634200	0.392838		0.256501	203
204	COST TO BE ALLOC PER B PT II			97,337		5,766,038	204
205	UNIT COST MULT-WS B PT II			0.000770		0.020332	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET	POUNDS OF LAUNDRY	PATIENT DAYS	MEALS SERVED	FTE'S	
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	590,899					7
8 LAUNDRY & LINEN SERVICE	6,419	2,477,930				8
9 HOUSEKEEPING	12,031		20,424			9
10 DIETARY	9,795		999	397,708		10
11 CAFETERIA	13,333		260	999	158,496	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,865		144		5,381	13
14 CENTRAL SERVICES & SUPPLY	19,337		74		4,097	14
15 PHARMACY	2,942		30		4,704	15
16 MEDICAL RECORDS & LIBRARY	7,935		50		7,523	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)	240				186	23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	249,994	1,974,076	10,252	303,936	58,153	30
31 INTENSIVE CARE UNIT	27,381	161,899	1,501	8,180	7,220	31
34 SURGICAL INTENSIVE CARE UNIT	21,726	68,182	528	6,890	5,643	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	16,410	17,480	125	32,866	3,204	40
41 SUBPROVIDER - IRF	17,096	128,937	854	27,797	3,831	41
43 NURSERY	8,621	126,363	131	16,887	2,072	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	39,431		2,108		11,163	50
54 RADIOLOGY-DIAGNOSTIC	44,304		807		13,906	54
60 LABORATORY	22,705		406		54	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,198		70		3,791	65
66 PHYSICAL THERAPY	1,167		507		8,772	66
69 ELECTROCARDIOLOGY	18,248		423		4,679	69
70 ELECTROENCEPHALOGRAPHY	4,103		35		658	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 OTHER					647	76
76.10 OP PSYCH					189	76.10
76.97 CARDIAC REHABILITATION	5,919				751	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	32,450	993	1,120	153	10,417	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	587,650	2,477,930	20,424	397,708	157,041	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC	3,249				1,455	192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06

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COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA
	SQUARE FEET	POUNDS OF LAUNDRY	PATIENT DAYS	MEALS SERVED	FTE'S
	7	8	9	10	11
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	22,302,602	2,182,251	7,344,473	4,369,347	4,159,693
203 UNIT COST MULT-WS B PT I	37.743509	0.880675	359.600127	10.986319	26.244782
204 COST TO BE ALLOC PER B PT II	4,620,611	200,258	592,364	408,310	496,545
205 UNIT COST MULT-WS B PT II	7.819629	0.080817	29.003329	1.026658	3.132855

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION FTE'S	CENTRAL SERVICES & SUPPLY SUPPLIES	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R PROGRAM COSTS ASSIGNED TIME	
	13	14	15	16	22	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	102,539					13
14 CENTRAL SERVICES & SUPPLY		39,358,539				14
15 PHARMACY			12,633,135			15
16 MEDICAL RECORDS & LIBRARY				1,635,364,849		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					100	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	58,153			145,228,085	50	30
31 INTENSIVE CARE UNIT	7,220			31,655,723		31
34 SURGICAL INTENSIVE CARE UNIT	5,643			22,957,134		34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	3,204			11,245,308		40
41 SUBPROVIDER - IRF	3,831			10,662,550		41
43 NURSERY	2,072			5,474,634		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,163			138,903,262	50	50
54 RADIOLOGY-DIAGNOSTIC				327,555,980		54
60 LABORATORY				229,834,927		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY				29,472,820		65
66 PHYSICAL THERAPY				44,987,027		66
69 ELECTROCARDIOLOGY				97,953,592		69
70 ELECTROENCEPHALOGRAPHY				5,507,872		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		39,358,539		130,218,506		71
72 IMPL. DEV. CHARGED TO PATIENT				89,332,823		72
73 DRUGS CHARGED TO PATIENTS			12,633,135	159,488,435		73
74 RENAL DIALYSIS						74
76 OTHER	647			19,728,865		76
76.10 OP PSYCH	189			1,434,001		76.10
76.97 CARDIAC REHABILITATION				1,976,725		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	10,417			131,746,580		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	102,539	39,358,539	12,633,135	1,635,364,849	100	118
NONREIMBURSABLE COST CENTERS						
192.01 OTHER NRCC						192.01
194 OTHER NON-REIMBURSABLE						194
194.01 SHARED SERVICES						194.01
194.02 CASE MANAGEMENT						194.02
194.04 OUTPATIENT PHARMACY						194.04
194.05 PRIMARY CARE PHYSICIAN						194.05
194.06 PATIENT SITTERS						194.06

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COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION FTE'S	CENTRAL SERVICES & SUPPLY SUPPLIES	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R PROGRAM COSTS ASSIGNED TIME	
	13	14	15	16	22	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	9,090,887	5,463,715	26,077,686	8,596,713	140,520	202
203 UNIT COST MULT-WS B PT I	88.657847	0.138819	2.064229	0.005257	1,405.200000	203
204 COST TO BE ALLOC PER B PT II	353,794	1,106,368	1,459,065	397,738	2,336	204
205 UNIT COST MULT-WS B PT II	3.450336	0.028110	0.115495	0.000243	23.360000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PARAMED EDUCATION	ASSIGNED TIME	
		23	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)	100		23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS			30
31 INTENSIVE CARE UNIT			31
34 SURGICAL INTENSIVE CARE UNIT			34
35 NEO NATAL INTENSIVE CARE			35
40 SUBPROVIDER - IPF			40
41 SUBPROVIDER - IRF			41
43 NURSERY			43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
54 RADIOLOGY-DIAGNOSTIC			54
60 LABORATORY			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
69 ELECTROCARDIOLOGY			69
70 ELECTROENCEPHALOGRAPHY			70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS	100		73
74 RENAL DIALYSIS			74
76 OTHER			76
76.10 OP PSYCH			76.10
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
91 EMERGENCY			91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	100		118
NONREIMBURSABLE COST CENTERS			
192.01 OTHER NRCC			192.01
194 OTHER NON-REIMBURSABLE			194
194.01 SHARED SERVICES			194.01
194.02 CASE MANAGEMENT			194.02
194.04 OUTPATIENT PHARMACY			194.04
194.05 PRIMARY CARE PHYSICIAN			194.05
194.06 PATIENT SITTERS			194.06

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		PARAMED EDUCATION	
		ASSIGNED TIME	
		23	
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	292,300	202
203	UNIT COST MULT-WS B PT I	2,923.000000	203
204	COST TO BE ALLOC PER B PT II	11,439	204
205	UNIT COST MULT-WS B PT II	114.390000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	90,307,300		90,307,300	197,398	90,504,698	30
31 INTENSIVE CARE UNIT	14,611,860		14,611,860		14,611,860	31
34 SURGICAL INTENSIVE CARE UNI	10,463,935		10,463,935		10,463,935	34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	7,475,145		7,475,145	111	7,475,256	40
41 SUBPROVIDER - IRF	6,602,041		6,602,041		6,602,041	41
43 NURSERY	4,238,445		4,238,445		4,238,445	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	29,562,959		29,562,959	32,600	29,595,559	50
54 RADIOLOGY-DIAGNOSTIC	29,790,463		29,790,463		29,790,463	54
60 LABORATORY	17,429,250		17,429,250		17,429,250	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	5,026,067		5,026,067	4,072	5,030,139	65
66 PHYSICAL THERAPY	14,329,191		14,329,191		14,329,191	66
69 ELECTROCARDIOLOGY	9,815,181		9,815,181	6,278	9,821,459	69
70 ELECTROENCEPHALOGRAPHY	995,699		995,699		995,699	70
71 MEDICAL SUPPLIES CHRGED TO	26,565,455		26,565,455		26,565,455	71
72 IMPL. DEV. CHARGED TO PATIE	30,944,851		30,944,851		30,944,851	72
73 DRUGS CHARGED TO PATIENTS	27,208,417		27,208,417		27,208,417	73
74 RENAL DIALYSIS						74
76 OTHER	6,914,574		6,914,574		6,914,574	76
76.10 OP PSYCH	378,996		378,996		378,996	76.10
76.97 CARDIAC REHABILITATION	1,277,311		1,277,311		1,277,311	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	17,769,234		17,769,234	9,131	17,778,365	91
92 OBSERVATION BEDS	9,633,896		9,633,896		9,633,896	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	361,340,270		361,340,270	249,590	361,589,860	200
201 LESS OBSERVATION BEDS	9,633,896		9,633,896		9,633,896	201
202 TOTAL (SEE INSTRUCTIONS)	351,706,374		351,706,374		351,955,964	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	127,112,325		127,112,325			30
31 INTENSIVE CARE UNIT	31,655,723		31,655,723			31
34 SURGICAL INTENSIVE CARE UNI	22,957,134		22,957,134			34
35 NEO NATAL INTENSIVE CARE						35
40 SUBPROVIDER - IPF	11,245,308		11,245,308			40
41 SUBPROVIDER - IRF	10,662,550		10,662,550			41
43 NURSERY	5,474,634		5,474,634			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	65,489,171	73,414,091	138,903,262	0.212831	0.212831	0.213066 50
54 RADIOLOGY-DIAGNOSTIC	116,122,204	211,433,776	327,555,980	0.090948	0.090948	0.090948 54
60 LABORATORY	125,660,599	104,174,328	229,834,927	0.075834	0.075834	0.075834 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	26,943,617	2,529,203	29,472,820	0.170532	0.170532	0.170670 65
66 PHYSICAL THERAPY	22,281,594	22,705,433	44,987,027	0.318518	0.318518	0.318518 66
69 ELECTROCARDIOLOGY	52,884,332	45,069,260	97,953,592	0.100202	0.100202	0.100266 69
70 ELECTROENCEPHALOGRAPHY	2,305,086	3,202,786	5,507,872	0.180777	0.180777	0.180777 70
71 MEDICAL SUPPLIES CHRGED TO	91,396,164	38,822,342	130,218,506	0.204007	0.204007	0.204007 71
72 IMPL. DEV. CHARGED TO PATIE	66,404,612	22,928,211	89,332,823	0.346400	0.346400	0.346400 72
73 DRUGS CHARGED TO PATIENTS	119,376,524	40,111,911	159,488,435	0.170598	0.170598	0.170598 73
74 RENAL DIALYSIS						74
76 OTHER	56,696	19,672,169	19,728,865	0.350480	0.350480	0.350480 76
76.10 OP PSYCH	634,813	799,188	1,434,001	0.264293	0.264293	0.264293 76.10
76.97 CARDIAC REHABILITATION	13,932	1,962,793	1,976,725	0.646175	0.646175	0.646175 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	46,936,927	84,809,653	131,746,580	0.134874	0.134874	0.134944 91
92 OBSERVATION BEDS		18,115,760	18,115,760	0.531796	0.531796	0.531796 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	945,613,945	689,750,904	1,635,364,849			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	945,613,945	689,750,904	1,635,364,849			202

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3		5		7	
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	9,827,956		9,827,956	87,678	112.09	47,035	5,272,153	30
32 INTENSIVE CARE UNIT	1,381,548		1,381,548	7,006	197.19	3,736	736,702	31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT	1,026,799		1,026,799	5,608	183.10	2,939	538,131	34
40 NEO NATAL INTENSIVE CARE								35
41 SUBPROVIDER - IPF	632,442		632,442	8,944	70.71	185	13,081	40
42 SUBPROVIDER - IRF	627,282		627,282	8,024	78.18	6,222	486,436	41
43 SUBPROVIDER I								42
44 NURSERY	390,747		390,747	4,841	80.72			43
45 SKILLED NURSING FACILITY								44
200 NURSING FACILITY								45
TOTAL (LINES 30-199)	13,886,774		13,886,774	122,101		60,117	7,046,503	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL	
	(FROM WKST B, PT. II, COL. 26) 1	(FROM WKST C, PT. I, COL. 8) 2	(COL.1 + COL.2) 3	4	(COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,218,172	138,903,262	0.037567	30,348,168	1,140,090	50
54 RADIOLOGY-DIAGNOSTIC	6,626,505	327,555,980	0.020230	65,886,705	1,332,888	54
60 LABORATORY	917,905	229,834,927	0.003994	71,568,890	285,846	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	252,428	29,472,820	0.008565	16,674,717	142,819	65
66 PHYSICAL THERAPY	1,211,059	44,987,027	0.026920	9,021,731	242,865	66
69 ELECTROCARDIOLOGY	2,291,520	97,953,592	0.023394	33,559,838	785,099	69
70 ELECTROENCEPHALOGRAPHY	158,585	5,507,872	0.028792	1,375,822	39,613	70
71 MEDICAL SUPPLIES CHRGED TO PA	1,468,390	130,218,506	0.011276	46,721,537	526,832	71
72 IMPL. DEV. CHARGED TO PATIENT	514,841	89,332,823	0.005763	31,772,183	183,103	72
73 DRUGS CHARGED TO PATIENTS	1,497,821	159,488,435	0.009391	66,426,541	623,812	73
74 RENAL DIALYSIS						74
76 OTHER	163,604	19,728,865	0.008293	54,412	451	76
76.10 OP PSYCH	13,473	1,434,001	0.009395	140,187	1,317	76.10
76.97 CARDIAC REHABILITATION	189,601	1,976,725	0.095917	7,861	754	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,426,066	131,746,580	0.010824	26,371,264	285,443	91
92 OBSERVATION BEDS	1,046,154	18,115,760	0.057748			92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	22,996,124	1,426,257,175	1,426,257,175	399,929,856	5,590,932	200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 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 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	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	
30 INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	87,678		47,035		30
31 INTENSIVE CARE UNIT	7,006		3,736		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT	5,608		2,939		34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF	8,944		185		40
41 SUBPROVIDER - IRF	8,024		6,222		41
42 SUBPROVIDER I					42
43 NURSERY	4,841				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	122,101		60,117		200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS. 1-4) 5	TOTAL O/P COST (SUM OF COLS. 2-4) 6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
54 RADIOLOGY-DIAGNOSTIC							54
60 LABORATORY							60
62.30 BLOOD CLOTTING FOR HEMOPHILIA							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
70 ELECTROENCEPHALOGRAPHY							70
71 MEDICAL SUPPLIES CHRGED TO PA							71
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
74 RENAL DIALYSIS							74
76 OTHER							76
76.10 OP PSYCH							76.10
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY							91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 ÷ COL. 7)	(COL. 6 ÷ COL. 7)	PGM COL. 10	COL. 8 x COL. 10	COL. 12	COL. 9 x COL. 12
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	138,903,262			30,348,168		18,649,308	50
54 RADIOLOGY-DIAGNOSTIC	327,555,980			65,886,705		52,871,086	54
60 LABORATORY	229,834,927			71,568,890		8,242,936	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	29,472,820			16,674,717		622,903	65
66 PHYSICAL THERAPY	44,987,027			9,021,731		2,334,115	66
69 ELECTROCARDIOLOGY	97,953,592			33,559,838		16,056,536	69
70 ELECTROENCEPHALOGRAPHY	5,507,872			1,375,822		890,680	70
71 MEDICAL SUPPLIES CHRGD TO P	130,218,506			46,721,537		10,767,116	71
72 IMPL. DEV. CHARGED TO PATIEN	89,332,823			31,772,183		7,595,081	72
73 DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833	66,426,541	121,760	12,752,180	23,375 73
74 RENAL DIALYSIS							74
76 OTHER	19,728,865			54,412		5,142,766	76
76.10 OP PSYCH	1,434,001			140,187			76.10
76.97 CARDIAC REHABILITATION	1,976,725			7,861		966,185	76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	131,746,580			26,371,264		12,353,688	91
92 OBSERVATION BEDS	18,115,760					5,953,361	92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	1,426,257,175			399,929,856	121,760	155,197,941	23,375 200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST		
	FROM WKST C, PT I, COL. 9 1	REIMBURSED SERVICES 2	SUBJECT TO DED & COINS 3	SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	SUBJECT TO DED & COINS 6	SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.212831	18,649,308			3,969,151			50
54 RADIOLOGY-DIAGNOSTIC	0.090948	52,871,086			4,808,520			54
60 LABORATORY	0.075834	8,242,936			625,095			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.170532	622,903			106,225			65
66 PHYSICAL THERAPY	0.318518	2,334,115			743,458			66
69 ELECTROCARDIOLOGY	0.100202	16,056,536			1,608,897			69
70 ELECTROENCEPHALOGRAPHY	0.180777	890,680			161,014			70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007	10,767,116		64,265	2,196,567		13,111	71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400	7,595,081			2,630,936			72
73 DRUGS CHARGED TO PATIENTS	0.170598	12,752,180		9,607	2,175,496		1,639	73
74 RENAL DIALYSIS								74
76 OTHER	0.350480	5,142,766			1,802,437			76
76.10 OP PSYCH	0.264293							76.10
76.97 CARDIAC REHABILITATION	0.646175	966,185			624,325			76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.134874	12,353,688			1,666,191			91
92 OBSERVATION BEDS	0.531796	5,953,361			3,165,974			92
OTHER REIMBURSABLE COST CENTERS								
94 HOME PROGRAM DIALYSIS								94
200 SUBTOTAL (SEE INSTRUCTIONS)		155,197,941		73,872	26,284,286		14,750	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		155,197,941		73,872	26,284,286		14,750	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[] HOSPITAL [XX] IPF (14-S007) [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA				
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5			
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	5,218,172	138,903,262	0.037567				50
54	RADIOLOGY-DIAGNOSTIC	6,626,505	327,555,980	0.020230	19,844	401		54
60	LABORATORY	917,905	229,834,927	0.003994	56,615	226		60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	252,428	29,472,820	0.008565	1,010	9		65
66	PHYSICAL THERAPY	1,211,059	44,987,027	0.026920	2,427	65		66
69	ELECTROCARDIOLOGY	2,291,520	97,953,592	0.023394	2,788	65		69
70	ELECTROENCEPHALOGRAPHY	158,585	5,507,872	0.028792	882	25		70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,390	130,218,506	0.011276	2,772	31		71
72	IMPL. DEV. CHARGED TO PATIENT	514,841	89,332,823	0.005763				72
73	DRUGS CHARGED TO PATIENTS	1,497,821	159,488,435	0.009391	43,830	412		73
74	RENAL DIALYSIS							74
76	OTHER	163,604	19,728,865	0.008293				76
76.10	OP PSYCH	13,473	1,434,001	0.009395	12,179	114		76.10
76.97	CARDIAC REHABILITATION	189,601	1,976,725	0.095917				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	1,426,066	131,746,580	0.010824	39,892	432		91
92	OBSERVATION BEDS	1,046,154	18,115,760	0.057748				92
OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)	22,996,124	1,426,257,175	1,426,257,175	182,239	1,780		200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
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KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S007) [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS			292,300		292,300	73
74 RENAL DIALYSIS						74
76 OTHER						76
76.10 OP PSYCH						76.10
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S007) [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 ÷ COL. 7)	(COL. 6 ÷ COL. 7)	PGM COL. 10	(COL. 8 x COL. 10)	COL. 12	(COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	138,903,262						50
54 RADIOLOGY-DIAGNOSTIC	327,555,980			19,844			54
60 LABORATORY	229,834,927			56,615			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	29,472,820			1,010			65
66 PHYSICAL THERAPY	44,987,027			2,427			66
69 ELECTROCARDIOLOGY	97,953,592			2,788			69
70 ELECTROENCEPHALOGRAPHY	5,507,872			882			70
71 MEDICAL SUPPLIES CHRGED TO P	130,218,506			2,772			71
72 IMPL. DEV. CHARGED TO PATIEN	89,332,823						72
73 DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833	43,830	80		73
74 RENAL DIALYSIS							74
76 OTHER	19,728,865						76
76.10 OP PSYCH	1,434,001			12,179			76.10
76.97 CARDIAC REHABILITATION	1,976,725						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	131,746,580			39,892			91
92 OBSERVATION BEDS	18,115,760						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	1,426,257,175			182,239	80		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [XX] IPF (14-S007) [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9 1	REIMBURSED SERVICES 2	SUBJECT TO DED & COINS 3	SUBJECT TO DED & COINS 4	PPS SERVICES 5	SUBJECT TO DED & COINS 6	SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.212831						50
54 RADIOLOGY-DIAGNOSTIC	0.090948						54
60 LABORATORY	0.075834						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.170532						65
66 PHYSICAL THERAPY	0.318518						66
69 ELECTROCARDIOLOGY	0.100202						69
70 ELECTROENCEPHALOGRAPHY	0.180777						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007						71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400						72
73 DRUGS CHARGED TO PATIENTS	0.170598						73
74 RENAL DIALYSIS							74
76 OTHER	0.350480						76
76.10 OP PSYCH	0.264293						76.10
76.97 CARDIAC REHABILITATION	0.646175						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.134874						91
92 OBSERVATION BEDS	0.531796						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[] HOSPITAL [] IPF [XX] IRF (14-T007)	[] SUB (OTHER)	[XX] PPS [] TEFRA			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,218,172	138,903,262	0.037567	37,518	1,409	50
54	RADIOLOGY-DIAGNOSTIC	6,626,505	327,555,980	0.020230	788,496	15,951	54
60	LABORATORY	917,905	229,834,927	0.003994	2,539,258	10,142	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	252,428	29,472,820	0.008565	500,117	4,284	65
66	PHYSICAL THERAPY	1,211,059	44,987,027	0.026920	7,838,022	211,000	66
69	ELECTROCARDIOLOGY	2,291,520	97,953,592	0.023394	339,411	7,940	69
70	ELECTROENCEPHALOGRAPHY	158,585	5,507,872	0.028792			70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,390	130,218,506	0.011276	1,178,669	13,291	71
72	IMPL. DEV. CHARGED TO PATIENT	514,841	89,332,823	0.005763	246,699	1,422	72
73	DRUGS CHARGED TO PATIENTS	1,497,821	159,488,435	0.009391	2,514,934	23,618	73
74	RENAL DIALYSIS						74
76	OTHER	163,604	19,728,865	0.008293			76
76.10	OP PSYCH	13,473	1,434,001	0.009395			76.10
76.97	CARDIAC REHABILITATION	189,601	1,976,725	0.095917			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,426,066	131,746,580	0.010824			91
92	OBSERVATION BEDS	1,046,154	18,115,760	0.057748			92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	22,996,124	1,426,257,175	1,426,257,175	15,983,124	289,057	200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [XX] IRF (14-T007) [] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS. 1-4) 5	TOTAL O/P COST (SUM OF COLS. 2-4) 6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
54 RADIOLOGY-DIAGNOSTIC							54
60 LABORATORY							60
62.30 BLOOD CLOTTING FOR HEMOPHILIA							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
70 ELECTROENCEPHALOGRAPHY							70
71 MEDICAL SUPPLIES CHRGED TO PA							71
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
74 RENAL DIALYSIS							74
76 OTHER							76
76.10 OP PSYCH							76.10
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY							91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [XX] IRF (14-T007) [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 ÷ COL. 7)	(COL. 6 ÷ COL. 7)	PGM COL. 10	(COL. 8 x COL. 10)	COL. 12	(COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	138,903,262			37,518			50
54 RADIOLOGY-DIAGNOSTIC	327,555,980			788,496			54
60 LABORATORY	229,834,927			2,539,258			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	29,472,820			500,117			65
66 PHYSICAL THERAPY	44,987,027			7,838,022			66
69 ELECTROCARDIOLOGY	97,953,592			339,411			69
70 ELECTROENCEPHALOGRAPHY	5,507,872						70
71 MEDICAL SUPPLIES CHRGED TO P	130,218,506			1,178,669			71
72 IMPL. DEV. CHARGED TO PATIEN	89,332,823			246,699			72
73 DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833	2,514,934	4,610		73
74 RENAL DIALYSIS							74
76 OTHER	19,728,865						76
76.10 OP PSYCH	1,434,001						76.10
76.97 CARDIAC REHABILITATION	1,976,725						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	131,746,580						91
92 OBSERVATION BEDS	18,115,760						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	1,426,257,175			15,983,124	4,610		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [XX] IRF (14-T007) [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SERVICES DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.212831						50
54 RADIOLOGY-DIAGNOSTIC	0.090948						54
60 LABORATORY	0.075834						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.170532						65
66 PHYSICAL THERAPY	0.318518						66
69 ELECTROCARDIOLOGY	0.100202						69
70 ELECTROENCEPHALOGRAPHY	0.180777						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007						71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400						72
73 DRUGS CHARGED TO PATIENTS	0.170598						73
74 RENAL DIALYSIS							74
76 OTHER	0.350480						76
76.10 OP PSYCH	0.264293						76.10
76.97 CARDIAC REHABILITATION	0.646175						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.134874						91
92 OBSERVATION BEDS	0.531796						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	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	(COL.1 MINUS COL.2)					
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	9,827,956		9,827,956	87,678	112.09	12,242	1,372,206	30
32 INTENSIVE CARE UNIT	1,381,548		1,381,548	7,006	197.19	139	27,409	31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT	1,026,799		1,026,799	5,608	183.10	183	33,507	34
40 NEO NATAL INTENSIVE CARE								35
41 SUBPROVIDER - IPF	632,442		632,442	8,944	70.71	185	13,081	40
42 SUBPROVIDER - IRF	627,282		627,282	8,024	78.18	140	10,945	41
43 SUBPROVIDER I								42
44 NURSERY	390,747		390,747	4,841	80.72	2,337	188,643	43
45 SKILLED NURSING FACILITY								44
200 NURSING FACILITY								45
TOTAL (LINES 30-199)	13,886,774		13,886,774	122,101		15,226	1,645,791	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0007) [] IPF [] IRF	[] SUB (OTHER)	[] PPS [] TEFRA [XX] OTHER				
		CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,218,172	138,903,262	0.037567				50
54	RADIOLOGY-DIAGNOSTIC	6,626,505	327,555,980	0.020230				54
60	LABORATORY	917,905	229,834,927	0.003994				60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	252,428	29,472,820	0.008565				65
66	PHYSICAL THERAPY	1,211,059	44,987,027	0.026920				66
69	ELECTROCARDIOLOGY	2,291,520	97,953,592	0.023394				69
70	ELECTROENCEPHALOGRAPHY	158,585	5,507,872	0.028792				70
71	MEDICAL SUPPLIES CHRGD TO PA	1,468,390	130,218,506	0.011276				71
72	IMPL. DEV. CHARGED TO PATIENT	514,841	89,332,823	0.005763				72
73	DRUGS CHARGED TO PATIENTS	1,497,821	159,488,435	0.009391				73
74	RENAL DIALYSIS							74
76	OTHER	163,604	19,728,865	0.008293				76
76.10	OP PSYCH	13,473	1,434,001	0.009395				76.10
76.97	CARDIAC REHABILITATION	189,601	1,976,725	0.095917				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,426,066	131,746,580	0.010824				91
92	OBSERVATION BEDS	1,046,154	18,115,760	0.057748				92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)	22,996,124	1,426,257,175	1,426,257,175				200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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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 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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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	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	
30 INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	87,678		12,242		30
31 INTENSIVE CARE UNIT	7,006		139		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT	5,608		183		34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF	8,944		185		40
41 SUBPROVIDER - IRF	8,024		140		41
42 SUBPROVIDER I					42
43 NURSERY	4,841		2,337		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	122,101		15,226		200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
54 RADIOLOGY-DIAGNOSTIC							54
60 LABORATORY							60
62.30 BLOOD CLOTTING FOR HEMOPHILIA							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
70 ELECTROENCEPHALOGRAPHY							70
71 MEDICAL SUPPLIES CHRGED TO PA							71
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
74 RENAL DIALYSIS							74
76 OTHER							76
76.10 OP PSYCH							76.10
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY							91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] 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 CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	138,903,262						50
54 RADIOLOGY-DIAGNOSTIC	327,555,980						54
60 LABORATORY	229,834,927						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	29,472,820						65
66 PHYSICAL THERAPY	44,987,027						66
69 ELECTROCARDIOLOGY	97,953,592						69
70 ELECTROENCEPHALOGRAPHY	5,507,872						70
71 MEDICAL SUPPLIES CHRGED TO P	130,218,506						71
72 IMPL. DEV. CHARGED TO PATIEN	89,332,823						72
73 DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833				73
74 RENAL DIALYSIS							74
76 OTHER	19,728,865						76
76.10 OP PSYCH	1,434,001						76.10
76.97 CARDIAC REHABILITATION	1,976,725						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	131,746,580						91
92 OBSERVATION BEDS	18,115,760						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	1,426,257,175						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	COST REIMB.	COST REIMB.	COST	COST		
	CHARGE RATIO	PPS	SVCES NOT	SVCES	SVCES NOT		
FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO	
PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.212831						50
54 RADIOLOGY-DIAGNOSTIC	0.090948						54
60 LABORATORY	0.075834						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.170532						65
66 PHYSICAL THERAPY	0.318518						66
69 ELECTROCARDIOLOGY	0.100202						69
70 ELECTROENCEPHALOGRAPHY	0.180777						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007						71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400						72
73 DRUGS CHARGED TO PATIENTS	0.170598						73
74 RENAL DIALYSIS							74
76 OTHER	0.350480						76
76.10 OP PSYCH	0.264293						76.10
76.97 CARDIAC REHABILITATION	0.646175						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.134874						91
92 OBSERVATION BEDS	0.531796						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[] HOSPITAL [XX] IPF (14-S007) [] IRF	[] SUB (OTHER)	[] PPS [] TEFRA [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	5,218,172	138,903,262	0.037567	50
54	RADIOLOGY-DIAGNOSTIC	6,626,505	327,555,980	0.020230	54
60	LABORATORY	917,905	229,834,927	0.003994	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
65	RESPIRATORY THERAPY	252,428	29,472,820	0.008565	65
66	PHYSICAL THERAPY	1,211,059	44,987,027	0.026920	66
69	ELECTROCARDIOLOGY	2,291,520	97,953,592	0.023394	69
70	ELECTROENCEPHALOGRAPHY	158,585	5,507,872	0.028792	70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,390	130,218,506	0.011276	71
72	IMPL. DEV. CHARGED TO PATIENT	514,841	89,332,823	0.005763	72
73	DRUGS CHARGED TO PATIENTS	1,497,821	159,488,435	0.009391	73
74	RENAL DIALYSIS				74
76	OTHER	163,604	19,728,865	0.008293	76
76.10	OP PSYCH	13,473	1,434,001	0.009395	76.10
76.97	CARDIAC REHABILITATION	189,601	1,976,725	0.095917	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY	1,426,066	131,746,580	0.010824	91
92	OBSERVATION BEDS	1,046,154	18,115,760	0.057748	92
OTHER REIMBURSABLE COST CENTERS					
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-199)	22,996,124	1,426,257,175	1,426,257,175	200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[] HOSPITAL [XX] IPF (14-S007) [] IRF	[] SUB (OTHER) [] SNF [] NF	[] ICF/MR	[] PPS [] TEFRA [XX] OTHER	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS. 1-4) 5	TOTAL O/P COST (SUM OF COLS. 2-4) 6	
ANCILLARY SERVICE COST CENTERS													
50						OPERATING ROOM							50
54						RADIOLOGY-DIAGNOSTIC							54
60						LABORATORY							60
62.30						BLOOD CLOTTING FOR HEMOPHILIA							62.30
65						RESPIRATORY THERAPY							65
66						PHYSICAL THERAPY							66
69						ELECTROCARDIOLOGY							69
70						ELECTROENCEPHALOGRAPHY							70
71						MEDICAL SUPPLIES CHRGED TO PA							71
72						IMPL. DEV. CHARGED TO PATIENT							72
73						DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
74						RENAL DIALYSIS							74
76						OTHER							76
76.10						OP PSYCH							76.10
76.97						CARDIAC REHABILITATION							76.97
76.98						HYPERBARIC OXYGEN THERAPY							76.98
76.99						LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS													
91						EMERGENCY							91
92						OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS													
94						HOME PROGRAM DIALYSIS							94
200						TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S007) [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	138,903,262						50
54 RADIOLOGY-DIAGNOSTIC	327,555,980						54
60 LABORATORY	229,834,927						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	29,472,820						65
66 PHYSICAL THERAPY	44,987,027						66
69 ELECTROCARDIOLOGY	97,953,592						69
70 ELECTROENCEPHALOGRAPHY	5,507,872						70
71 MEDICAL SUPPLIES CHRGED TO P	130,218,506						71
72 IMPL. DEV. CHARGED TO PATIEN	89,332,823						72
73 DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833				73
74 RENAL DIALYSIS							74
76 OTHER	19,728,865						76
76.10 OP PSYCH	1,434,001						76.10
76.97 CARDIAC REHABILITATION	1,976,725						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	131,746,580						91
92 OBSERVATION BEDS	18,115,760						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	1,426,257,175						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [XX] IPF (14-S007) [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.212831						50
54 RADIOLOGY-DIAGNOSTIC	0.090948						54
60 LABORATORY	0.075834						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.170532						65
66 PHYSICAL THERAPY	0.318518						66
69 ELECTROCARDIOLOGY	0.100202						69
70 ELECTROENCEPHALOGRAPHY	0.180777						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007						71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400						72
73 DRUGS CHARGED TO PATIENTS	0.170598						73
74 RENAL DIALYSIS							74
76 OTHER	0.350480						76
76.10 OP PSYCH	0.264293						76.10
76.97 CARDIAC REHABILITATION	0.646175						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.134874						91
92 OBSERVATION BEDS	0.531796						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[] HOSPITAL [] IPF [XX] IRF (14-T007)	[] SUB (OTHER)	[] PPS [] TEFRA [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	5,218,172	138,903,262	0.037567	50
54	RADIOLOGY-DIAGNOSTIC	6,626,505	327,555,980	0.020230	54
60	LABORATORY	917,905	229,834,927	0.003994	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
65	RESPIRATORY THERAPY	252,428	29,472,820	0.008565	65
66	PHYSICAL THERAPY	1,211,059	44,987,027	0.026920	66
69	ELECTROCARDIOLOGY	2,291,520	97,953,592	0.023394	69
70	ELECTROENCEPHALOGRAPHY	158,585	5,507,872	0.028792	70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,390	130,218,506	0.011276	71
72	IMPL. DEV. CHARGED TO PATIENT	514,841	89,332,823	0.005763	72
73	DRUGS CHARGED TO PATIENTS	1,497,821	159,488,435	0.009391	73
74	RENAL DIALYSIS				74
76	OTHER	163,604	19,728,865	0.008293	76
76.10	OP PSYCH	13,473	1,434,001	0.009395	76.10
76.97	CARDIAC REHABILITATION	189,601	1,976,725	0.095917	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY	1,426,066	131,746,580	0.010824	91
92	OBSERVATION BEDS	1,046,154	18,115,760	0.057748	92
OTHER REIMBURSABLE COST CENTERS					
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-199)	22,996,124	1,426,257,175	1,426,257,175	200

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[] HOSPITAL [] IPF [XX] IRF (14-T007)	[] SUB (OTHER) [] SNF [] NF	[] ICF/MR	[] PPS [] TEFRA [XX] OTHER				
COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM								50
54	RADIOLOGY-DIAGNOSTIC								54
60	LABORATORY								60
62.30	BLOOD CLOTTING FOR HEMOPHILIA								62.30
65	RESPIRATORY THERAPY								65
66	PHYSICAL THERAPY								66
69	ELECTROCARDIOLOGY								69
70	ELECTROENCEPHALOGRAPHY								70
71	MEDICAL SUPPLIES CHRGD TO PA								71
72	IMPL. DEV. CHARGED TO PATIENT								72
73	DRUGS CHARGED TO PATIENTS			292,300	292,300	292,300			73
74	RENAL DIALYSIS								74
76	OTHER								76
76.10	OP PSYCH								76.10
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
91	EMERGENCY								91
92	OBSERVATION BEDS								92
OTHER REIMBURSABLE COST CENTERS									
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)			292,300	292,300	292,300			200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [XX] IRF (14-T007) [] NF [XX] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	138,903,262						50
54 RADIOLOGY-DIAGNOSTIC	327,555,980						54
60 LABORATORY	229,834,927						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	29,472,820						65
66 PHYSICAL THERAPY	44,987,027						66
69 ELECTROCARDIOLOGY	97,953,592						69
70 ELECTROENCEPHALOGRAPHY	5,507,872						70
71 MEDICAL SUPPLIES CHRGED TO P	130,218,506						71
72 IMPL. DEV. CHARGED TO PATIEN	89,332,823						72
73 DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833				73
74 RENAL DIALYSIS							74
76 OTHER	19,728,865						76
76.10 OP PSYCH	1,434,001						76.10
76.97 CARDIAC REHABILITATION	1,976,725						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	131,746,580						91
92 OBSERVATION BEDS	18,115,760						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	1,426,257,175						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [XX] IRF (14-T007) [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.212831						50
54 RADIOLOGY-DIAGNOSTIC	0.090948						54
60 LABORATORY	0.075834						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.170532						65
66 PHYSICAL THERAPY	0.318518						66
69 ELECTROCARDIOLOGY	0.100202						69
70 ELECTROENCEPHALOGRAPHY	0.180777						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007						71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400						72
73 DRUGS CHARGED TO PATIENTS	0.170598						73
74 RENAL DIALYSIS							74
76 OTHER	0.350480						76
76.10 OP PSYCH	0.264293						76.10
76.97 CARDIAC REHABILITATION	0.646175						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.134874						91
92 OBSERVATION BEDS	0.531796						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	87,678	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	87,678	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	87,678	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	47,035	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	90,504,698	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	90,504,698	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.641289	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,609.63	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)	90,504,698	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0007) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,032.24 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 48,551,408 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) 48,551,408 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	14,611,860	7,006	2,085.62	3,736	7,791,876	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT	10,463,935	5,608	1,865.89	2,939	5,483,851	46
47 NEO NATAL INTENSIVE CARE						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					62,708,352	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					124,535,487	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 6,546,986 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 5,712,692 51
 52 TOTAL PROGRAM EXCLUDABLE COST 12,259,678 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 112,275,809 53

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

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (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) 9,333 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,032.24 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 9,633,896 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	9,827,956	90,504,698	0.108591	9,633,896	1,046,154	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 [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S007) [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,944	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,944	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,944	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	185	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	7,475,256	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,475,256	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.890978	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)	938.05	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)	7,475,256	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S007) [] TEFRA
BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	835.78 38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	154,619 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)	154,619 41
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	24,127 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	178,746 49
PASS-THROUGH COST ADJUSTMENTS	
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	13,081 50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	1,860 51
52 TOTAL PROGRAM EXCLUDABLE COST	14,941 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	163,805 53
TARGET AMOUNT AND LIMIT COMPUTATION	
54 PROGRAM DISCHARGES	54
55 TARGET AMOUNT PER DISCHARGE	55
56 TARGET AMOUNT (LINE 54 x LINE 55)	56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58 BONUS PAYMENT (SEE INSTRUCTIONS)	58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET	59
60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E	61
62 RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST	
64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)	64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (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

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [XX] IRF (14-T007) [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,024	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,024	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,024	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	6,222	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,602,041	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,602,041	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.619180	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,328.83	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)	6,602,041	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[]	HOSPITAL	[]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF			[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[XX]	IRF (14-T007)			[]	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)	822.79 38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	5,119,399 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)	5,119,399 41
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	3,643,162 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	8,762,561 49
PASS-THROUGH COST ADJUSTMENTS	
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	486,436 50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	293,667 51
52 TOTAL PROGRAM EXCLUDABLE COST	780,103 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	7,982,458 53
TARGET AMOUNT AND LIMIT COMPUTATION	
54 PROGRAM DISCHARGES	54
55 TARGET AMOUNT PER DISCHARGE	55
56 TARGET AMOUNT (LINE 54 x LINE 55)	56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58 BONUS PAYMENT (SEE INSTRUCTIONS)	58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET	59
60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E	61
62 RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST	
64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)	64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (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

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0007) [] 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)	87,678	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	87,678	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	87,678	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	12,242	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)	4,841	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	2,337	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	90,307,300	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	90,307,300	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.639891	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,609.63	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)	90,307,300	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,029.99 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 12,609,138 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) 12,609,138 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)	4,238,445	4,841	875.53	2,337	2,046,114	42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	14,611,860	7,006	2,085.62	139	289,901	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT	10,463,935	5,608	1,865.89	183	341,458	46
47 NEO NATAL INTENSIVE CARE						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					15,286,611	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 1,621,765 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 1,621,765 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

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

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 9,333 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S007) [] 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)	8,944 1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,944 2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3 3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,944 4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	5 5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	6 6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	7 7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	8 8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	185 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 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 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 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 13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	14 14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	15 15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	16 16
SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17 17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18 18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	19 19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	20 20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	7,475,145 21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	22 22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	23 23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	24 24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	25 25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	26 26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,475,145 27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944 28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	29 29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944 30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.890965 31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	32 32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	938.05 33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	34 34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	35 35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	36 36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	7,475,145 37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] PPS
APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S007) [] 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)	835.77 38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	154,617 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)	154,617 41
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	154,617 49
PASS-THROUGH COST ADJUSTMENTS	
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	13,081 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	13,081 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	53
TARGET AMOUNT AND LIMIT COMPUTATION	
54 PROGRAM DISCHARGES	54
55 TARGET AMOUNT PER DISCHARGE	55
56 TARGET AMOUNT (LINE 54 x LINE 55)	56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58 BONUS PAYMENT (SEE INSTRUCTIONS)	58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET	59
60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E	61
62 RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST	
64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)	64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (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

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF (14-T007) NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,024	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,024	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,024	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	140	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,602,041	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,602,041	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.619180	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,328.83	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)	6,602,041	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] PPS
APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
BOXES [XX] TITLE XIX-INPT [XX] IRF (14-T007) [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)	822.79 38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	115,191 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)	115,191 41
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	115,191 49
PASS-THROUGH COST ADJUSTMENTS	
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	10,945 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	10,945 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	53
TARGET AMOUNT AND LIMIT COMPUTATION	
54 PROGRAM DISCHARGES	54
55 TARGET AMOUNT PER DISCHARGE	55
56 TARGET AMOUNT (LINE 54 x LINE 55)	56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58 BONUS PAYMENT (SEE INSTRUCTIONS)	58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET	59
60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E	61
62 RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST	
64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)	64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		65,617,638			30
31 INTENSIVE CARE UNIT		16,916,992			31
34 SURGICAL INTENSIVE CARE UNIT		12,597,424			34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.213066	30,348,168	6,466,163		50
54 RADIOLOGY-DIAGNOSTIC	0.090948	65,886,705	5,992,264		54
60 LABORATORY	0.075834	71,568,890	5,427,355		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.170670	16,674,717	2,845,874		65
66 PHYSICAL THERAPY	0.318518	9,021,731	2,873,584		66
69 ELECTROCARDIOLOGY	0.100266	33,559,838	3,364,911		69
70 ELECTROENCEPHALOGRAPHY	0.180777	1,375,822	248,717		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007	46,721,537	9,531,521		71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400	31,772,183	11,005,884		72
73 DRUGS CHARGED TO PATIENTS	0.170598	66,426,541	11,332,235		73
74 RENAL DIALYSIS					74
76 OTHER	0.350480	54,412	19,070		76
76.10 OP PSYCH	0.264293	140,187	37,050		76.10
76.97 CARDIAC REHABILITATION	0.646175	7,861	5,080		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.134944	26,371,264	3,558,644		91
92 OBSERVATION BEDS	0.531796				92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		399,929,856	62,708,352		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		399,929,856			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S007) [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
34 SURGICAL INTENSIVE CARE UNIT					34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF		223,776			40
41 SUBPROVIDER - IRF					41
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.213066				50
54 RADIOLOGY-DIAGNOSTIC	0.090948	19,844	1,805		54
60 LABORATORY	0.075834	56,615	4,293		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.170670	1,010	172		65
66 PHYSICAL THERAPY	0.318518	2,427	773		66
69 ELECTROCARDIOLOGY	0.100266	2,788	280		69
70 ELECTROENCEPHALOGRAPHY	0.180777	882	159		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007	2,772	566		71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400				72
73 DRUGS CHARGED TO PATIENTS	0.170598	43,830	7,477		73
74 RENAL DIALYSIS					74
76 OTHER	0.350480				76
76.10 OP PSYCH	0.264293	12,179	3,219		76.10
76.97 CARDIAC REHABILITATION	0.646175				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.134944	39,892	5,383		91
92 OBSERVATION BEDS	0.531796				92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		182,239	24,127		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		182,239			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [XX] IRF (14-T007) [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
34 SURGICAL INTENSIVE CARE UNIT					34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF		7,744,283			41
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.213066	37,518	7,994		50
54 RADIOLOGY-DIAGNOSTIC	0.090948	788,496	71,712		54
60 LABORATORY	0.075834	2,539,258	192,562		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.170670	500,117	85,355		65
66 PHYSICAL THERAPY	0.318518	7,838,022	2,496,551		66
69 ELECTROCARDIOLOGY	0.100266	339,411	34,031		69
70 ELECTROENCEPHALOGRAPHY	0.180777				70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007	1,178,669	240,457		71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400	246,699	85,457		72
73 DRUGS CHARGED TO PATIENTS	0.170598	2,514,934	429,043		73
74 RENAL DIALYSIS					74
76 OTHER	0.350480				76
76.10 OP PSYCH	0.264293				76.10
76.97 CARDIAC REHABILITATION	0.646175				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.134944				91
92 OBSERVATION BEDS	0.531796				92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		15,983,124	3,643,162		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		15,983,124			202

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/30/2012 15:30

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
34 SURGICAL INTENSIVE CARE UNIT					34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.212831				50
54 RADIOLOGY-DIAGNOSTIC	0.090948				54
60 LABORATORY	0.075834				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.170532				65
66 PHYSICAL THERAPY	0.318518				66
69 ELECTROCARDIOLOGY	0.100202				69
70 ELECTROENCEPHALOGRAPHY	0.180777				70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007				71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400				72
73 DRUGS CHARGED TO PATIENTS	0.170598				73
74 RENAL DIALYSIS					74
76 OTHER	0.350480				76
76.10 OP PSYCH	0.264293				76.10
76.97 CARDIAC REHABILITATION	0.646175				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.134874				91
92 OBSERVATION BEDS	0.531796				92
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

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2011.10
 05/30/2012 15:30

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S007) [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
			COL.1	COL.2	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
34 SURGICAL INTENSIVE CARE UNIT					34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.212831				50
54 RADIOLOGY-DIAGNOSTIC	0.090948				54
60 LABORATORY	0.075834				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.170532				65
66 PHYSICAL THERAPY	0.318518				66
69 ELECTROCARDIOLOGY	0.100202				69
70 ELECTROENCEPHALOGRAPHY	0.180777				70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007				71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400				72
73 DRUGS CHARGED TO PATIENTS	0.170598				73
74 RENAL DIALYSIS					74
76 OTHER	0.350480				76
76.10 OP PSYCH	0.264293				76.10
76.97 CARDIAC REHABILITATION	0.646175				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.134874				91
92 OBSERVATION BEDS	0.531796				92
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

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [XX] IRF (14-T007) [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
			COL.1	COL.2	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
34 SURGICAL INTENSIVE CARE UNIT					34
35 NEO NATAL INTENSIVE CARE					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.212831				50
54 RADIOLOGY-DIAGNOSTIC	0.090948				54
60 LABORATORY	0.075834				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.170532				65
66 PHYSICAL THERAPY	0.318518				66
69 ELECTROCARDIOLOGY	0.100202				69
70 ELECTROENCEPHALOGRAPHY	0.180777				70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204007				71
72 IMPL. DEV. CHARGED TO PATIENT	0.346400				72
73 DRUGS CHARGED TO PATIENTS	0.170598				73
74 RENAL DIALYSIS					74
76 OTHER	0.350480				76
76.10 OP PSYCH	0.264293				76.10
76.97 CARDIAC REHABILITATION	0.646175				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.134874				91
92 OBSERVATION BEDS	0.531796				92
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 A

CHECK [XX] HOSPITAL (14-0007)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	83,439,094	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	2,765,506	2
3	MANAGED CARE SIMULATED PAYMENTS	5,256,052	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	351.43	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)	9.00	6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.	5.85	7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)	3.15	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	1.04	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	1.04	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	1.08	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	0.68	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	0.93	15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	0.93	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.002646	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.023290	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.002646	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	128,253	22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)	-2.11	24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)	128,253	29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0275	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1649	31
32	SUM OF LINES 30 AND 31	0.1924	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0439	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	3,662,976	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	89,995,829	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	89,995,829	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	7,581,891	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0007)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)	47,540	52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)	121,760	58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	97,747,020	59
60	PRIMARY PAYER PAYMENTS	55,053	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	97,691,967	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,709,596	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	675,500	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	1,310,529	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	917,370	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	955,078	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	90,224,241	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	90,224,241	71
72	INTERIM PAYMENTS	91,617,821	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-1,393,580	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	870,555	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL (14-0007) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	14,750	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)	26,260,911	2
3	PPS PAYMENTS	23,104,020	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	102,419	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	23,375	9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	14,750	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	73,872	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)	73,872	14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	73,872	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	59,122	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)	14,750	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)	23,229,814	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	5,119,493	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	18,125,071	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)	9,368	28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	18,134,439	30
31	PRIMARY PAYER PAYMENTS	7,664	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	18,126,775	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)	754,978	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	528,485	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	570,495	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	18,655,260	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-195	38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	18,655,455	40
41	INTERIM PAYMENTS	18,150,495	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	504,960	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [XX] IPF (14-S007) [] IRF
 [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		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)		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)	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)		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
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		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)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		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)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF (14-T007)
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		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)		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)	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)		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
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		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)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		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)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0007) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		91,088,622		18,096,589	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 07/22/2011	529,199	07/22/2011	53,906	3.01
PROGRAM .02					3.02
TO .03					3.03
PROVIDER .04					3.04
TO .05					3.05
PROGRAM .06					3.06
TO .07					3.07
PROVIDER .08					3.08
TO .09					3.09
PROGRAM .50		NONE		NONE	3.50
TO .51					3.51
PROVIDER .52					3.52
TO .53					3.53
PROGRAM .54					3.54
TO .55					3.55
PROGRAM .56					3.56
TO .57					3.57
PROGRAM .58					3.58
TO .59					3.59
PROGRAM .99		529,199		53,906	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		529,199		53,906	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		91,617,821		18,150,495	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
TO .04					5.04
PROGRAM .05					5.05
TO .06					5.06
PROVIDER .07					5.07
TO .08					5.08
PROGRAM .09					5.09
TO .50					5.50
PROVIDER .51		NONE		NONE	5.51
TO .52					5.52
PROGRAM .53					5.53
TO .54					5.54
PROGRAM .55					5.55
TO .56					5.56
PROGRAM .57					5.57
TO .58					5.58
PROGRAM .59					5.59
TO .99					5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			504,960	6.01
TO .02					6.02
PROVIDER .03					6.03
TO .04					6.04
PROGRAM .05					6.05
TO .06					6.06
PROGRAM .07					6.07
TO .08					6.08
PROGRAM .09					6.09
TO .50					6.50
PROVIDER .51		-1,393,580			6.51
TO .52					6.52
PROGRAM .53					6.53
TO .54					6.54
PROGRAM .55					6.55
TO .56					6.56
PROGRAM .57					6.57
TO .58					6.58
PROGRAM .59					6.59
TO .99					6.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		90,224,241		18,655,455	7
8 NAME OF CONTRACTOR:	CONTRACTOR NUMBER:		DATE:		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [XX] IPF (14-S007) [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		131,265		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		3.01
PROGRAM .01				3.02
TO .02				3.03
PROVIDER .03				3.04
TO .04				3.05
PROVIDER .05				3.06
TO .06				3.07
PROVIDER .07				3.08
TO .08				3.09
PROVIDER .09				3.50
TO .50		NONE		NONE
PROVIDER .51				3.51
TO .52				3.52
PROVIDER .53				3.53
TO .54				3.54
PROVIDER .55				3.55
TO .56				3.56
PROVIDER .57				3.57
TO .58				3.58
PROVIDER .59				3.59
TO .99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		131,265		4
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		5.01
PROGRAM .01				5.02
TO .02				5.03
PROVIDER .03				5.04
TO .04				5.05
PROVIDER .05				5.06
TO .06				5.07
PROVIDER .07				5.08
TO .08				5.09
PROVIDER .09				5.50
TO .50		NONE		NONE
PROVIDER .51				5.51
TO .52				5.52
PROVIDER .53				5.53
TO .54				5.54
PROVIDER .55				5.55
TO .56				5.56
PROVIDER .57				5.57
TO .58				5.58
PROVIDER .59				5.59
TO .99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		78,161		6.01
PROGRAM .01				6.02
TO .02				6.02
PROVIDER .03				6.02
TO .04				6.02
PROVIDER .05				6.02
TO .06				6.02
PROVIDER .07				6.02
TO .08				6.02
PROVIDER .09				6.02
TO .01				6.02
PROVIDER .02				6.02
TO .03				6.02
PROVIDER .04				6.02
TO .05				6.02
PROVIDER .06				6.02
TO .07				6.02
PROVIDER .08				6.02
TO .09				6.02
PROVIDER .10				6.02
TO .01				6.02
PROVIDER .02				6.02
TO .03				6.02
PROVIDER .04				6.02
TO .05				6.02
PROVIDER .06				6.02
TO .07				6.02
PROVIDER .08				6.02
TO .09				6.02
PROVIDER .10				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		209,426		7

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [XX] IRF (14-T007) [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		7,970,033		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		3.01
PROGRAM .01				3.02
TO .02				3.03
PROVIDER .03				3.04
TO .04				3.05
PROVIDER .05				3.06
TO .06				3.07
PROVIDER .07				3.08
TO .08				3.09
PROVIDER .09				3.50
TO .50	07/22/2011	5,319		3.51
PROVIDER .51				3.52
TO .52				3.53
PROVIDER .53				3.54
TO .54				3.55
PROVIDER .55				3.56
TO .56				3.57
PROVIDER .57				3.58
TO .58				3.59
PROVIDER .59				3.99
TO .99				
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-5,319		
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		7,964,714		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		5.01
PROGRAM .01				5.02
TO .02				5.03
PROVIDER .03				5.04
TO .04				5.05
PROVIDER .05				5.06
TO .06				5.07
PROVIDER .07				5.08
TO .08				5.09
PROVIDER .09				5.50
TO .50				5.51
PROVIDER .51		NONE		5.52
TO .52				5.53
PROVIDER .53				5.54
TO .54				5.55
PROVIDER .55				5.56
TO .56				5.57
PROVIDER .57				5.58
TO .58				5.59
PROVIDER .59				5.99
TO .99				
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT				6.01
PROGRAM .01				6.02
TO .02				
PROVIDER .03				
TO .04				
PROVIDER .05				
TO .06				
PROVIDER .07				
TO .08				
PROVIDER .09				
TO .50				
PROVIDER .51				
TO .52				
PROVIDER .53				
TO .54				
PROVIDER .55				
TO .56				
PROVIDER .57				
TO .58				
PROVIDER .59				
TO .99				
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		7,925,506		7

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

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/30/2012 15:30

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL (14-0007) CAH
APPLICABLE BOX

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	24,005 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	53,710 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3,177 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	90,959 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,635,364,849 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	42,876,152 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

CHECK [] HOSPITAL
APPLICABLE BOX: [XX] IPF (14-S007)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	148,856	1
2	NET IPF PPS OUTLIER PAYMENT	221	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	24.504110	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8}/\text{LINE 9})) \text{ RAISED TO THE POWER OF } .5150 - 1\}$		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	149,077	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	149,077	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	149,077	18
19	DEDUCTIBLES	11,288	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	137,789	20
21	COINSURANCE	6,525	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	131,264	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	111,545	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	78,082	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	100,000	25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	209,346	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	80	28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	209,426	31
32	INTERIM PAYMENTS	131,265	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	78,161	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART III

CHECK [] HOSPITAL
APPLICABLE BOX: [XX] IRF (14-T007)

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	7,702,569	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.010900	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	102,583	3
4	OUTLIER PAYMENTS	171,790	4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		5
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		9
10	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	21.983562	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 9}/\text{LINE 10})) \text{ RAISED TO THE POWER OF } .6876 - 1\}$		11
12	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 11)		12
13	TOTAL PPS PAYMENT (SUM OF LINES 1, 3, 4 AND 12)	7,976,942	13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		14
15	ORGAN ACQUISITION		15
16	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SEE INSTRUCTIONS)	7,976,942	17
18	PRIMARY PAYER PAYMENTS	2,540	18
19	SUBTOTAL LINE 17b LESS LINE 18)	7,974,402	19
20	DEDUCTIBLES	25,940	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	7,948,462	21
22	COINSURANCE	35,941	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	7,912,521	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	11,964	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	8,375	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	7,920,896	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		28
29	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	4,610	29
30	OUTLIER PAYMENTS RECONCILIATION		30
31	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	7,925,506	32
33	INTERIM PAYMENTS	7,964,714	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	-39,208	35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0007) [] 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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	15,286,611 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	15,286,611 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	15,286,611 7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 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))	15,286,611 18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

CHECK [] TITLE V [] HOSPITAL [] SNF [] PPS
APPLICABLE [XX] TITLE XIX [XX] IPF (14-S007) [] 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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	154,617 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	154,617 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	154,617 7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 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))	154,617 18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

CHECK [] TITLE V [] HOSPITAL [] SNF [] PPS
APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
BOXES: [XX] IRF (14-T007) [] ICF/MR [XX] OTHER
[] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	115,191 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	115,191 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	115,191 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 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))	115,191 18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII
 BOX: [] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)		9.00	2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		5.85	3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)		3.15	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)		1.04	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6		1.04	7
		PRIMARY CARE 1	OTHER 2	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.96		0.96 8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.96		0.96 9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT	0.96		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	0.92		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	0.79		13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	0.89		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.89		17
18	PER RESIDENT AMOUNT	109,455.95	95,706.96	18
19	APPROVED AMOUNT FOR RESIDENT COSTS	97,416		19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			97,416 25
COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS	60,117	3,413	26
27	TOTAL INPATIENT DAYS	107,927	107,927	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.557015	0.031623	28
29	PROGRAM DIRECT GME AMOUNT	54,262	3,081	29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		435	30
31	NET PROGRAM DIRECT GME AMOUNT			56,908 31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)		133,476,794	37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		57,593	40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)		133,419,201	41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)		26,299,036	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		7,664	43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)		26,291,372	44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)		159,710,573	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)		0.835381	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)		0.164619	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)		56,908	48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)		47,540	49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)		9,368	50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII
 BOX: [XX] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
		PRIMARY CARE	OTHER	TOTAL
		1	2	3
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)			12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)			14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT			17
18	PER RESIDENT AMOUNT			18
19	APPROVED AMOUNT FOR RESIDENT COSTS			19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT	MANAGED	
26	INPATIENT DAYS	PART A	CARE	
27	TOTAL INPATIENT DAYS	12,889	712	26
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	107,927	107,927	27
29	PROGRAM DIRECT GME AMOUNT	0.119423	0.006597	28
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			29
31	NET PROGRAM DIRECT GME AMOUNT			30
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			50

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	16,503,359			1
2 TEMPORARY INVESTMENTS	1,209,454			2
3 NOTES RECEIVABLE	161,048			3
4 ACCOUNTS RECEIVABLE	61,031,027			4
5 OTHER RECEIVABLES	1,805,162			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	6,756,279			7
8 PREPAID EXPENSES				8
9 OTHER CURRENT ASSETS	7,175,255			9
10 DUE FROM OTHER FUNDS	360,998			10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	95,002,582			11
FIXED ASSETS				
12 LAND	1,884,595			12
13 LAND IMPROVEMENTS	3,208,539			13
14 ACCUMULATED DEPRECIATION	-3,194,775			14
15 BUILDINGS	322,395,286			15
16 ACCUMULATED DEPRECIATION	-118,763,967			16
17 LEASEHOLD IMPROVEMENTS	1,439,521			17
18 ACCUMULATED AMORTIZATION	-884,441			18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	121,573,028			23
24 ACCUMULATED DEPRECIATION	-76,822,481			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)	250,835,305			30
OTHER ASSETS				
31 INVESTMENTS				31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	5,050,795			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	5,050,795			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	350,888,682			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	26,770,829			37
38 SALARIES, WAGES & FEES PAYABLE				38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	891,087			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS	46,680,661			43
44 OTHER CURRENT LIABILITIES	7,121,338			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	81,463,915			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	2,692,549			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	2,883,031			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	5,575,580			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	87,039,495			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	263,849,187			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)	263,849,187			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	350,888,682			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		270,703,000							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		13,194,549							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		283,897,549							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 TRANSFERS FROM CORPORATE									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		283,897,549							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 ASSETS RELEASED FROM OPERATI	20,048,361								13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		20,048,361							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		263,849,188							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	189,134,515		189,134,515	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	189,134,515		189,134,515	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 NEO NATAL INTENSIVE CARE				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	189,134,515		189,134,515	18
19 ANCILLARY SERVICES	767,664,304		767,664,304	19
20 OUTPATIENT SERVICES		697,421,579	697,421,579	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	956,798,819	697,421,579	1,654,220,398	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		399,265,553	29
30 ADD (SPECIFY)			30
31 ROUNDING	3		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		3	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		399,265,556	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	1,654,220,398	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	1,245,596,380	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	408,624,018	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	399,265,556	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	9,358,462	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	406,400	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (ASSETS RELEASED FROM RESTRICTIONS)	295,489	24
24.01	OTHER (UNRESTRICTED CONTRIBUTIONS)	247,066	24.01
24.02	OTHER (OTHER OPERATING REVENUE)	3,574,679	24.02
24.03	OTHER (MISC)	-108,311	24.03
24.04	OTHER (MISC)	237,952	24.04
24.05	OTHER (IMPAIRMENTS)	-817,188	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,836,087	25
26	TOTAL (LINE 5 PLUS LINE 25)	13,194,549	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	13,194,549	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-000) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	6,774,751	1
2	CAPITAL DRG OUTLIER PAYMENTS	530,730	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	249.20	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	0.93	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0011	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	7,452	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0275	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.1649	8
9	SUM OF LINES 7 AND 8	0.1924	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0397	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	268,958	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	7,581,891	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL	I&R COST &	TOTAL
	NARY CAP- REL COSTS 0	(COLS.0-4) 2A	POST STEP- DOWN ADJS 25	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES AP				21
22 I&R SRVCES-OTHER PRGM COSTS AP				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
34 SURGICAL INTENSIVE CARE UNIT				34
35 NEO NATAL INTENSIVE CARE				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF				41
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM				50
54 RADIOLOGY-DIAGNOSTIC				54
60 LABORATORY				60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC				62.30
65 RESPIRATORY THERAPY				65
66 PHYSICAL THERAPY				66
69 ELECTROCARDIOLOGY				69
70 ELECTROENCEPHALOGRAPHY				70
71 MEDICAL SUPPLIES CHRGD TO PAT				71
72 IMPL. DEV. CHARGED TO PATIENT				72
73 DRUGS CHARGED TO PATIENTS				73
74 RENAL DIALYSIS				74
76 OTHER				76
76.10 OP PSYCH				76.10
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY				91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)				118
NONREIMBURSABLE COST CENTERS				
192.01 OTHER NRCC				192.01
194 OTHER NON-REIMBURSABLE				194
194.01 SHARED SERVICES				194.01
194.02 CASE MANAGEMENT				194.02
194.04 OUTPATIENT PHARMACY				194.04
194.05 PRIMARY CARE PHYSICIAN				194.05
194.06 PATIENT SITTERS				194.06
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

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	53.65		13.96				67.61 30
31 INTENSIVE CARE UNIT	53.33		1.98				55.31 31
34 SURGICAL INTENSIVE CARE UNIT	52.41		3.26				55.67 34
43 NURSERY			48.28				48.28 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	21.85	13.43					35.28 50
54 RADIOLOGY-DIAGNOSTIC	20.11	16.14					36.25 54
60 LABORATORY	31.14	3.59					34.73 60
65 RESPIRATORY THERAPY	56.58	2.11					58.69 65
66 PHYSICAL THERAPY	20.05	5.19					25.24 66
69 ELECTROCARDIOLOGY	34.26	16.39					50.65 69
70 ELECTROENCEPHALOGRAPHY	24.98	16.17					41.15 70
71 MEDICAL SUPPLIES CHRGD TO PATI	35.88	8.32					44.20 71
72 IMPL. DEV. CHARGED TO PATIENT	35.57	8.50					44.07 72
73 DRUGS CHARGED TO PATIENTS	41.65	8.00					49.65 73
76 OTHER	0.28	26.07					26.35 76
76.10 OP PSYCH	9.78						9.78 76.10
76.97 CARDIAC REHABILITATION	0.40	48.88					49.28 76.97
91 EMERGENCY	20.02	9.38					29.40 91
92 OBSERVATION BEDS		32.86					32.86 92
200 TOTAL CHARGES	28.04	10.89					38.93 200

***** REPORT 97 ***** UTILIZATION STATISTICS *****

SUBPROVIDER-IPF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
40 SUBPROVIDER - IPF	2.07		2.07				4.14 40
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.01						0.01 54
60 LABORATORY	0.02						0.02 60
66 PHYSICAL THERAPY	0.01						0.01 66
70 ELECTROENCEPHALOGRAPHY	0.02						0.02 70
73 DRUGS CHARGED TO PATIENTS	0.03						0.03 73
76.10 OP PSYCH	0.85						0.85 76.10
91 EMERGENCY	0.03						0.03 91
200 TOTAL CHARGES	0.01						0.01 200

***** REPORT 97 ***** UTILIZATION STATISTICS *****

SUBPROVIDER-IRF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
41 SUBPROVIDER - IRF	77.54		1.74				79.28 41
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	0.03						0.03 50
54 RADIOLOGY-DIAGNOSTIC	0.24						0.24 54
60 LABORATORY	1.10						1.10 60
65 RESPIRATORY THERAPY	1.70						1.70 65
66 PHYSICAL THERAPY	17.42						17.42 66
69 ELECTROCARDIOLOGY	0.35						0.35 69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.91						0.91 71
72 IMPL. DEV. CHARGED TO PATIENT	0.28						0.28 72
73 DRUGS CHARGED TO PATIENTS	1.58						1.58 73
200 TOTAL CHARGES	1.12						1.12 200

COST CENTER	---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	17,873,565	5.02	-17,873,565	-9.02		1
2	CAP REL COSTS-MVBLE EQUIP	15,083,008	4.23	-15,083,008	-7.61		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	49,536,500	13.90	-49,536,500	-25.00		4
5	ADMINISTRATIVE & GENERAL	62,525,570	17.55	-62,525,570	-31.56		5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	12,322,059	3.46	-12,322,059	-6.22		7
8	LAUNDRY & LINEN SERVICE	1,359,618	0.38	-1,359,618	-0.69		8
9	HOUSEKEEPING	4,041,147	1.13	-4,041,147	-2.04		9
10	DIETARY	2,183,539	0.61	-2,183,539	-1.10		10
11	CAFETERIA	1,748,252	0.49	-1,748,252	-0.88		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	4,949,696	1.39	-4,949,696	-2.50		13
14	CENTRAL SERVICES & SUPPLY	2,364,832	0.66	-2,364,832	-1.19		14
15	PHARMACY	18,992,116	5.33	-18,992,116	-9.58		15
16	MEDICAL RECORDS & LIBRARY	4,928,241	1.38	-4,928,241	-2.49		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APP						21
22	I&R SRVCES-OTHER PRGM COSTS APP	80,292	0.02	-80,292	-0.04		22
23	PARAMED ED PRGM-(SPECIFY)	157,956	0.04	-157,956	-0.08		23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	33,223,811	9.32	57,153,749	28.84	90,377,560	25.36
31	INTENSIVE CARE UNIT	6,310,414	1.77	8,301,446	4.19	14,611,860	4.10
34	SURGICAL INTENSIVE CARE UNIT	4,588,945	1.29	5,874,990	2.96	10,463,935	2.94
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	3,297,687	0.93	4,177,458	2.11	7,475,145	2.10
41	SUBPROVIDER - IRF	2,487,488	0.70	4,114,553	2.08	6,602,041	1.85
43	NURSERY	1,734,631	0.49	2,503,814	1.26	4,238,445	1.19
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	12,635,723	3.55	16,997,496	8.58	29,633,219	8.32
54	RADIOLOGY-DIAGNOSTIC	11,738,435	3.29	18,052,028	9.11	29,790,463	8.36
60	LABORATORY	11,688,320	3.28	5,740,930	2.90	17,429,250	4.89
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,682,194	0.75	2,343,873	1.18	5,026,067	1.41
66	PHYSICAL THERAPY	8,137,917	2.28	6,191,274	3.12	14,329,191	4.02
69	ELECTROCARDIOLOGY	3,432,745	0.96	6,382,436	3.22	9,815,181	2.75
70	ELECTROENCEPHALOGRAPHY	370,618	0.10	625,081	0.32	995,699	0.28
71	MEDICAL SUPPLIES CHRGD TO PATI	16,249,236	4.56	10,316,219	5.21	26,565,455	7.45
72	IMPL. DEV. CHARGED TO PATIENT	24,254,042	6.81	6,690,809	3.38	30,944,851	8.68
73	DRUGS CHARGED TO PATIENTS			27,208,417	13.73	27,208,417	7.64
74	RENAL DIALYSIS						74
76	OTHER	3,925,180	1.10	2,989,394	1.51	6,914,574	1.94
76.10	OP PSYCH	199,033	0.06	179,963	0.09	378,996	0.11
76.97	CARDIAC REHABILITATION	497,774	0.14	779,537	0.39	1,277,311	0.36
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
91	EMERGENCY	7,907,409	2.22	9,861,825	4.98	17,769,234	4.99
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
OUTPATIENT SERVICE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	2,836,936	0.80	1,661,099	0.84	4,498,035	1.26
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	356,344,929	100.00			356,344,929	100.00

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,218,172	138,903,262	0.037567	30,348,168	1,140,090	50
54 RADIOLOGY-DIAGNOSTIC	6,626,505	327,555,980	0.020230	65,886,705	1,332,888	54
60 LABORATORY	917,905	229,834,927	0.003994	71,568,890	285,846	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	252,428	29,472,820	0.008565	16,674,717	142,819	65
66 PHYSICAL THERAPY	1,211,059	44,987,027	0.026920	9,021,731	242,865	66
69 ELECTROCARDIOLOGY	2,291,520	97,953,592	0.023394	33,559,838	785,099	69
70 ELECTROENCEPHALOGRAPHY	158,585	5,507,872	0.028792	1,375,822	39,613	70
71 MEDICAL SUPPLIES CHRGD TO PATI	1,468,390	130,218,506	0.011276	46,721,537	526,832	71
72 IMPL. DEV. CHARGED TO PATIENT	514,841	89,332,823	0.005763	31,772,183	183,103	72
73 DRUGS CHARGED TO PATIENTS	1,497,821	159,488,435	0.009391	66,426,541	623,812	73
74 RENAL DIALYSIS						74
76 OTHER	163,604	19,728,865	0.008293	54,412	451	76
76.10 OP PSYCH	13,473	1,434,001	0.009395	140,187	1,317	76.10
76.97 CARDIAC REHABILITATION	189,601	1,976,725	0.095917	7,861	754	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,426,066	131,746,580	0.010824	26,371,264	285,443	91
92 OBSERVATION BEDS	1,046,154	18,115,760	0.057748			92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL	22,996,124	1,426,257,175		399,929,856	5,590,932	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	SWING-BED	REDUCED	TOTAL	PER	INPATIENT	MEDICARE	
	RELATED	ADJUSTMENT	CAPITAL	PATIENT				
	COSTS	AMOUNT	RELATED	DAYS	DIEM	PROGRAM	INPATIENT	
	1	2	COST	4	5	DAYS	PPS CAPITAL	
			3			6	COSTS	
							7	
INPATIENT ROUTINE SERVICE COST CENTERS								
30 ADULTS & PEDIATRICS	9,827,956		9,827,956	87,678	112.09	47,035	5,272,153	30
31 INTENSIVE CARE UNIT	1,381,548		1,381,548	7,006	197.19	3,736	736,702	31
34 SURGICAL INTENSIVE CARE UNIT	1,026,799		1,026,799	5,608	183.10	2,939	538,131	34
35 NEO NATAL INTENSIVE CARE								35
200 TOTAL	12,236,303		12,236,303	100,292		53,710	6,546,986	200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							6,546,986	
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							5,590,932	
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							12,137,918	
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)							10,792	
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)							53,710	
PER DISCHARGE CAPITAL COSTS							1,124.71	
PER DIEM CAPITAL COSTS							225.99	

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	112,275,809
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	495,061,910
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.227

COST TO CHARGE RATIO FOR REHAB SUBPROVIDER

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINE 41 + WKST D PART IV COL 11 LINE 200))	8,757,951
2. TOTAL MEDICARE CHARGES [(WKST D-1 PART II LINE 41 DIVIDED BY (WKST C PART I LINE 41 COLUMN 3 DIVIDED BY COLUMN 6)] PLUS WKST D-3 COLUMN 2 LINE 202	24,251,154
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.361

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINE 41 + WKST D PART IV COL 11 LINE 200))	178,666
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	406,015
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.440

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	12,137,918
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.025

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01 & 2.02 x (WKST B, PART I, COLUMN 26 - COLUMNS 20 & 23 / WKST C, PART I, COLUMN 8) LESS LINES 61, 66-68, 74, 94, 95 & 96) (SEE CR 5999)	25,517,454
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	152,863,826
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.167