ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically filed cost report Date: 11/23/2015 Time: 18:29 2. [X] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 WERE 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 certification 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

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		207,893	155,641	1		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-303,663				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		-95,770	155,641	1		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 resopnd 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.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence

not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1515 MAIN STREET	P.O. Box:		1
2	City: HIGHLAND	State: IL	ZIP Code: 62249	County: MADISON	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. JOSEPH'S HOSPITAL-HIGHLAND IL	14-1336	99914	1	06 / 01 / 2004	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	ST. JOSEPH'S HOSPITAL-SWING BED	14-Z336	99914		08 / 19 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or '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.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2			26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:	36

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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 reseived 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	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. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	34,237	185,250	224,989	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost 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 cetfified 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 cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
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 (see instructions)	Y	148005	140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES Contractor's Number: 00131		141
142	Street: 4936 LAVERNA ROAD	P.O. Box:		142
143	City: SPRINGFIELD	State: IL	ZIP Code: 62794	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
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. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2014	06 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

HOSPITAL AND HOSPITAL 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	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	Y			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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

Bad Debts		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		1	2	3	4	
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	11/12/2015	Y	11/12/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL 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 relifed for Medicare purposes? If yes, see instructions.	Y	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	Y	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	Y		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render servcies to other chain components? If yes, see instructions.	Y		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: COREY	Last name: HASTINGS	Title: DIRECTOR OF FINANCE	41
42	Employer: ST. JOSEPH'S HOSPITAL			42
43	Phone number: 618-651-2525	E-mail Address: COREY.HASTINGS@HSHS.ORG		43

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	70,658.00		1,930	80	3,036	1
2	HMO and other (see instructions)						439	83		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						2,309		2,888	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	70,658.00		4,239	80	5,924	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	70,658.00		4,239	80	5,924	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								371	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								13	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					481	28	808	1
2	HMO and other (see instructions)					98	26		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		205.10			481	28	808	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		205.10						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N	/ /	2

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.370794	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,440,733	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	10,762,597	6
7	Medicaid cost (line 1 times line 6)	3,990,706	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	549,973	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	549,973	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,296,525	5,413,195	6,709,720	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	480,744	2,007,180	2,487,924	21
22	Partial payment by patients approved for charity care	12,401	2,271,433	2,283,834	22
23	Cost of charity care (line 21 minus line 22)	468,343	-264,253	204,090	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)	2,076,126	26
27	Medicare bad debts for the entire hospital complex (see instructions)	129,481	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,946,645	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	721,804	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	925,894	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,475,867	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,489,766	1,489,766	3,336,606	4,826,372	60,548	4,886,920	1
1.01	00101	CAP REL COSTS-MAB BUILDING								1.01
2	00200	Cap Rel Costs-Mvble Equip		2,130,901	2,130,901	292,553	2,423,454		2,423,454	2
2.01	00201	CAP REL COSTS-MAB EQUIPMENT								2.01
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	128,834	4,052,159	4,180,993		4,180,993	-744,386	3,436,607	4
5.01	00540	COMMUNICATIONS		7,895	7,895	485	8,380		8,380	5.01
5.02	00550	INFORMATION SYSTEMS		10,061	10,061	-2,172	7,889	2,535,817	2,543,706	5.02
5.03	00560	PURCHASING/RECEIVENG/STORES	132,199	49,641	181,840	-17,593	164,247	-3,307	160,940	5.03
5.04	00570	ADMITTING	327,908	18,154	346,062	-2,247	343,815		343,815	5.04
5.05	00580	PATIENT ACCOUNTING	401,561	622,335	1,023,896	-2,528	1,021,368		1,021,368	5.05
5.06	00590	OTHER ADMIN & GENERAL	1,223,667	4,092,902	5,316,569	-888,973	4,427,596	-1,186,574	3,241,022	5.06
6	00600	Maintenance & Repairs	218,852	51,659	270,511	-4,281	266,230	-75,200	191,030	6
7	00700	Operation of Plant	151,461	462,056	613,517	3,108	616,625		616,625	7
7.01	00701	PLANT OPS-MAB BUILDING								7.01
8	00800	Laundry & Linen Service		119,324	119,324		119,324	-8,709	110,615	8
9	00900	Housekeeping	295,932	89,396	385,328	6,834	392,162	-28,127	364,035	9
10	01000	Dietary	293,134	182,761	475,895	-273,999	201,896	-153,094	48,802	10
11	01100	Cafeteria	94,032	62,646	156,678	273,969	430,647	-40,806	389,841	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	249,532	9,254	258,786	-43	258,743		258,743	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	234,272	117,568	351,840	-4,708	347,132	-6,106	341,026	16
17	01700	Social Service	175,546	101,487	277,033		277,033		277,033	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,649,882	199,958	1,849,840	-332,944	1,516,896		1,516,896	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,000,942	1,673,072	2,674,014	-1,454,107	1,219,907		1,219,907	50
53	05300	Anesthesiology		738,177	738,177	-23,376	714,801	-638,987	75,814	53
54	05400	Radiology-Diagnostic	755,363	562,103	1,317,466	-144,809	1,172,657		1,172,657	54
60	06000	Laboratory	598,357	925,012	1,523,369	-21,724	1,501,645	-23,961	1,477,684	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	263,331	60,702	324,033	-13,422	310,611		310,611	65
66	06600	Physical Therapy	586,503	23,307	609,810	-2,657	607,153	-68	607,085	66
67	06700	Occupational Therapy	115,263	2,003	117,266		117,266	-74,763	42,503	67
68	06800	Speech Pathology	21,771	701	22,472		22,472		22,472	68
68.01	03040	AUDIOLOGY	51,765	72,281	124,046	-34	124,012	-5	124,007	68.01
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients	63,838	53,041	116,879	833,506	950,385	-770	949,615	71
72	07200	Impl. Dev. Charged to Patients				512,132	512,132		512,132	72
73	07300	Drugs Charged to Patients	453,841	797,523	1,251,364	412,357	1,663,721		1,663,721	73
76.97	07697	CARDIAC REHABILITATION	234,123	14,216	248,339	-818	247,521		247,521	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	189,708	467,023	656,731	-17	656,714		656,714	76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	78,039	547	78,586		78,586		78,586	90
91	09100	Emergency	1,181,820	970,467	2,152,287	-22,217	2,130,070	-691,221	1,438,849	91
92	09200	Observation Beds (Non-Distinct Part)								92
93	04950	O/P GERIATRIC PSYCH CENTER	128	430,196	430,324	-927	429,397		429,397	93
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		2,454,240	2,454,240	-2,454,240				113
118		SUBTOTALS (sum of lines 1-117)	11,171,604	23,114,534	34,286,138	3,714	34,289,852	-1,079,719	33,210,133	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		38,072	38,072		38,072		38,072	190
192	19200	Physicians' Private Offices	7,029	2,721,164	2,728,193	-3,229	2,724,964	-2,725,896	-932	192
194	07950	TRANSPORTATION	23,714	8,179	31,893	-485	31,408		31,408	194

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194.01	07951	FUND DEVELOPMENT								194.01
200		TOTAL (sum of lines 118-199)	11,202,347	25,881,949	37,084,296		37,084,296	-3,805,615	33,278,681	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA EXPENSE	A	Cafeteria	11	192,517	81,482	1
500	Total reclassifications				192,517	81,482	500
	Code Letter - A						
1	RENTAL EXPENSE	B	Cap Rel Costs-Bldg & Fixt	1		852,889	1
2			Cap Rel Costs-Mvble Equip	2		292,553	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
500	Total reclassifications					1,145,442	500
	Code Letter - B						
1	TELEPHONE EXPENSE	C	COMMUNICATIONS	5.01		485	1
2							2
500	Total reclassifications					485	500
	Code Letter - C						
1	POSTAGE EXPENSE	D	OTHER ADMIN & GENERAL	5.06		11,777	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
500	Total reclassifications					11,777	500
	Code Letter - D						
1	INTEREST EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		2,454,240	1
500	Total reclassifications					2,454,240	500
	Code Letter - E						
1	MEDICAL SUPPLIES EXPENSE	F	Medical Supplies Charged to P	71		833,618	1
2			Impl. Dev. Charged to Patient	72		512,132	2
3							3
500	Total reclassifications					1,345,750	500
	Code Letter - F						
1	PHARMACY EXPENSE	G	Drugs Charged to Patients	73		138,849	1
500	Total reclassifications					138,849	500
	Code Letter - G						
1	PROPERTY INSURANCE	I	Cap Rel Costs-Bldg & Fixt	1		29,477	1
500	Total reclassifications					29,477	500
	Code Letter - I						

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	SURG PROCEDURES & DRUG ADMIN	J	Operating Room	50	44,208	18,696	1
2			Drugs Charged to Patients	73	228,394	45,129	2
3							3
4							4
5							5
500	Total reclassifications				272,602	63,825	500
	Code Letter - J						
1	SHARED DIRECTOR	L	Maintenance & Repairs	6	3,659		1
2			Operation of Plant	7	3,176		2
3			Housekeeping	9	6,834		3
500	Total reclassifications				13,669		500
	Code Letter - L						
	GRAND TOTAL (Increases)				478,788	5,271,327	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	CAFETERIA EXPENSE	A	Dietary	10	192,517	81,482		1
500	Total reclassifications				192,517	81,482		500
	Code letter - A							
1	RENTAL EXPENSE	B	INFORMATION SYSTEMS	5.02		2,027	10	1
2			PURCHASING/RECEIVENG/STORES	5.03		9,652	10	2
3			ADMITTING	5.04		2,247		3
4			PATIENT ACCOUNTING	5.05		2,514		4
5			OTHER ADMIN & GENERAL	5.06		857,152		5
6			Maintenance & Repairs	6		7,876		6
7			Medical Records & Library	16		4,585		7
8			Adults & Pediatrics	30		21,252		8
9			Operating Room	50		204,699		9
10			Anesthesiology	53		902		10
11			Radiology-Diagnostic	54		818		11
12			Laboratory	60		20,466		12
13			Respiratory Therapy	65		972		13
14			Physical Therapy	66		2,657		14
15			CARDIAC REHABILITATION	76.97		818		15
16			Emergency	91		2,649		16
17			O/P GERIATRIC PSYCH CENTER	93		927		17
18			Physicians' Private Offices	192		3,229		18
500	Total reclassifications					1,145,442		500
	Code letter - B							
1	TELEPHONE EXPENSE	C						1
2			TRANSPORTATION	194		485		2
500	Total reclassifications					485		500
	Code letter - C							
1	POSTAGE EXPENSE	D	Maintenance & Repairs	6		64		1
2			INFORMATION SYSTEMS	5.02		145		2
3			PURCHASING/RECEIVENG/STORES	5.03		7,941		3
4			PATIENT ACCOUNTING	5.05		14		4
5			OTHER ADMIN & GENERAL	5.06		452		5
6			Operation of Plant	7		68		6
7			Cafeteria	11		30		7
8			Nursing Administration	13		43		8
9			Medical Records & Library	16		123		9
10			Adults & Pediatrics	30		126		10
11			Operating Room	50		1,479		11
12			Anesthesiology	53		7		12
13			Radiology-Diagnostic	54		288		13
14			Laboratory	60		806		14
15			AUDIOLOGY	68.01		34		15
16			Medical Supplies Charged to P	71		112		16
17			Drugs Charged to Patients	73		15		17
18			HYPERBARIC OXYGEN THERAPY	76.98		17		18
19			Emergency	91		13		19
500	Total reclassifications					11,777		500
	Code letter - D							
1	INTEREST EXPENSE	E	Interest Expense	113		2,454,240	11	1
500	Total reclassifications					2,454,240		500
	Code letter - E							
1	MEDICAL SUPPLIES EXPENSE	F	Operating Room	50		1,310,833		1
2			Anesthesiology	53		22,467		2
3			Respiratory Therapy	65		12,450		3
500	Total reclassifications					1,345,750		500
	Code letter - F							
1	PHARMACY EXPENSE	G	Radiology-Diagnostic	54		138,849		1
500	Total reclassifications					138,849		500
	Code letter - G							
1	PROPERTY INSURANCE	I	OTHER ADMIN & GENERAL	5.06		29,477	12	1
500	Total reclassifications					29,477		500
	Code letter - I							

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	SURG PROCEDURES & DRUG ADMIN	J	Adults & Pediatrics	30	256,807	51,281		1
2			Adults & Pediatrics	30	3,317	161		2
3			Radiology-Diagnostic	54	1,804	3,050		3
4			Laboratory	60	174	278		4
5			Emergency	91	10,500	9,055		5
500	Total reclassifications				272,602	63,825		500
	Code letter - J							
1	SHARED DIRECTOR	L	OTHER ADMIN & GENERAL	5.06	13,669			1
2								2
3								3
500	Total reclassifications				13,669			500
	Code letter - L							
	GRAND TOTAL (Decreases)				478,788	5,271,327		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	3,759,039					3,759,039		1
2	Land Improvements								2
3	Buildings and Fixtures	37,745,696				2,163,710	35,581,986		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	12,570,604				1,700,004	10,870,600		6
7	HIT-designated Assets	10,000,000					10,000,000		7
8	Subtotal (sum of lines 1-7)	64,075,339				3,863,714	60,211,625		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	64,075,339				3,863,714	60,211,625		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,272,621					217,145	1,489,766	1
1.01	CAP REL COSTS-MAB BUILDING								1.01
2	Cap Rel Costs-Mvble Equip	1,709,467					421,434	2,130,901	2
2.01	CAP REL COSTS-MAB EQUIPMENT								2.01
3	Total (sum of lines 1-2)	2,982,088					638,579	3,620,667	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
1.01	CAP REL COSTS-MAB BUILD				0.000000					1.01
2	Cap Rel Costs-Mvble Equ				0.000000					2
2.01	CAP REL COSTS-MAB EQUIP				0.000000					2.01
3	Total (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,383,809	802,249	2,454,240	29,477		217,145	4,886,920	1
1.01	CAP REL COSTS-MAB BUILDING								1.01
2	Cap Rel Costs-Mvble Equip	1,709,467	292,553				421,434	2,423,454	2
2.01	CAP REL COSTS-MAB EQUIPMENT								2.01
3	Total (sum of lines 1-2)	3,093,276	1,094,802	2,454,240	29,477		638,579	7,310,374	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,
Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-50,640	Cap Rel Costs-Bldg & Fixt	1	10	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-765,984				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,848,034				12
13	Laundry and linen service	B	-8,709	Laundry & Linen Service	8		13
14	Cafeteria - employees and guests	B	-40,806	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-6,106	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34	EDUCATIONAL CLASSES	B	-503	OTHER ADMIN & GENERAL	5.06		34
35	SANITARY MACHINES	B	-28,127	Housekeeping	9		35
36							36
37							37
38							38
39							39
40	MISCELLANEOUS REVENUE	B	-15,528	Employee Benefits Department	4		40
40.02	MISCELLANEOUS REVENUE	B	-3,307	PURCHASING/RECEIVENG/STORES	5.03		40.02
40.04	MISCELLANEOUS REVENUE	B	-750	OTHER ADMIN & GENERAL	5.06		40.04
40.05	MISCELLANEOUS REVENUE	B	-75,200	Maintenance & Repairs	6		40.05
40.07	MISCELLANEOUS REVENUE	B	-153,094	Dietary	10		40.07
40.08	MISCELLANEOUS REVENUE	B	-23,961	Laboratory	60		40.08
40.09	MISCELLANEOUS REVENUE	B	-68	Physical Therapy	66		40.09
40.11	MISCELLANEOUS REVENUE	B	-5	AUDIOLOGY	68.01		40.11
40.12	MISCELLANEOUS REVENUE	B	-770	Medical Supplies Charged to Patients	71		40.12
41							41
41.01	HEALTH FAIR EXPENSE	A	-27,254	OTHER ADMIN & GENERAL	5.06		41.01
42	COMMUNITY REL SALARY EXPENSE	A	-105,276	OTHER ADMIN & GENERAL	5.06		42
42.01	COMMUNITY REL BENEFIT EXPENSE	A	-40,005	Employee Benefits Department	4		42.01
42.02	COMMUNITY REL OTHER EXPENSE	A	-179,943	OTHER ADMIN & GENERAL	5.06		42.02
43	CRNA PART B	A	-638,987	Anesthesiology	53		43
44	DEPRECIATION LAPSING SCHEDULE	A	-568	Cap Rel Costs-Bldg & Fixt	1	9	44
45	NON REIMBURSABLE EXPENSE	A	30,000	OTHER ADMIN & GENERAL	5.06		45
46	MEDICAID TAX ASSESSMENT	A	514,786	OTHER ADMIN & GENERAL	5.06		46

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
47	SELF-INSURANCE EXPENSE	A	-558,422	Employee Benefits Department	4		47
48	MEDICAL GROUP PURCHASE SVC EXPE	A	-2,725,896	Physicians' Private Offices	192		48
49	PENSION EXPENSE ADD-ON ADJUSTMENT	A	-100,666	Employee Benefits Department	4		49
49.02	MEANINGFUL USE DEPRECIATION	A	-759,616	OTHER ADMIN & GENERAL	5.06		49.02
49.03	USEFUL LIVES LAPSING SCHEDULE N	A	111,756	Cap Rel Costs-Bldg & Fixt	1	9	49.03
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,805,615				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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 CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	4	Employee Benefits Department	HEALTH & DENTAL PREMIUMS	2,185,319	2,215,084	-29,765		1
2	5.02	INFORMATION SYSTEMS	COMPUTER FEES	2,535,817		2,535,817		2
3	5.06	OTHER ADMIN & GENERAL	MANAGEMENT FEES	914,024	1,572,042	-658,018		3
3.01	5.06	OTHER ADMIN & GENERAL	ISC MANAGEMENT FEES	963	963			3.01
3.02	5.06	OTHER ADMIN & GENERAL	ISC MANAGEMENT FEES	35,100	35,100			3.02
3.03	17	Social Service	ISC MANAGEMENT FEES	10,730	10,730			3.03
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			5,681,953	3,833,919	1,848,034		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			HOSPITAL SISTERS HEALTH SYSTEM	100.00	CORPORATE OFFICE	6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	60	Laboratory VARIOUS	25,000		25,000					1
2	67	Occupational Therapy VARIOUS	74,763	74,763						2
3	69	Electrocardiology VARIOUS	33,839							3
4	70	Electroencephalograp VARIOUS	34,459							4
5	90	Clinic VARIOUS								5
6	91	Emergency VARUOUS	821,399	691,221	130,178					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
200		TOTAL	989,460	765,984	155,178					200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	60	Laboratory VARIOUS								1
2	67	Occupational Therapy VARIOUS							74,763	2
3	69	Electrocardiology VARIOUS								3
4	70	Electroencephalograp VARIOUS								4
5	90	Clinic VARIOUS								5
6	91	Emergency VARUOUS							691,221	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
200		TOTAL							765,984	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICAT	INFORMATIO TECHNOLOGY	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	4,886,920	4,886,920					1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip	2,423,454		2,423,454				2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department	3,436,607	6,159	1,405	3,444,171			4
5.01	COMMUNICATIONS	8,380	900	17,550		26,830		5.01
5.02	INFORMATION SYSTEMS	2,543,706	62,694	275,675		2,974	2,885,049	5.02
5.03	PURCHASING/RECEIVENG/STORES	160,940	198,530	3,421	41,118	434	47,326	5.03
5.04	ADMITTING	343,815	58,127	32,541	101,989	375	333,750	5.04
5.05	PATIENT ACCOUNTING	1,021,368	13,424	2,291	124,897	60	54,867	5.05
5.06	OTHER ADMIN & GENERAL	3,241,022	225,586	34,223	376,343	2,914	653,460	5.06
6	Maintenance & Repairs	191,030	45,671	3,083	69,207	60	30,164	6
7	Operation of Plant	616,625	373,878	13,999	48,096	60		7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service	110,615	30,240					8
9	Housekeeping	364,035	135,144	5,120	94,169	307	46,286	9
10	Dietary	48,802	190,157	5,241	31,295	494	35,494	10
11	Cafeteria	389,841	174,518	1,747	89,125	60	32,244	11
12	Maintenance of Personnel							12
13	Nursing Administration	258,743	7,335	1,067	77,611	60	4,291	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	341,026	24,635	4,203	72,865	1,303	446,734	16
17	Social Service	277,033	3,045	1	54,600	60		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,516,896	1,172,148	142,166	432,253	3,041	199,184	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,219,907	801,178	301,064	325,071	1,491	67,868	50
53	Anesthesiology	75,814		9,626				53
54	Radiology-Diagnostic	1,172,657	423,978	972,005	234,378	1,303	82,950	54
60	Laboratory	1,477,684	66,569	62,815	186,052	989	234,678	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	310,611	73,696	14,823	81,903	562	34,454	65
66	Physical Therapy	607,085	54,251	13,861	182,419	1,363	119,484	66
67	Occupational Therapy	42,503	6,435		35,850	60	1,040	67
68	Speech Pathology	22,472		390	6,771			68
68.01	AUDIOLOGY	124,007		1,952	16,100	60	35,494	68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	949,615	121,927	72,580	19,855	60	7,541	71
72	Impl. Dev. Charged to Patients	512,132						72
73	Drugs Charged to Patients	1,663,721	82,346	14,706	212,194	375	83,990	73
76.97	CARDIAC REHABILITATION	247,521		14,432	72,819	60	43,035	76.97
76.98	HYPERBARIC OXYGEN THERAPY	656,714		16,676	59,004	622	2,210	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	78,586			24,272	60	1,040	90
91	Emergency	1,438,849	472,140	58,486	364,313	1,423	205,685	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER	429,397		2,020	40	494		93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	33,210,133	4,824,711	2,099,169	3,434,609	21,124	2,803,269	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	38,072	48,992	963				190
192	Physicians' Private Offices	-932	8,581	323,322	2,186	5,706	81,780	192
194	TRANSPORTATION	31,408			7,376			194
194.01	FUND DEVELOPMENT		4,636					194.01
200	Cross Foot Adjustments							200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICAT	INFORMATIO TECHNOLOGY	
		0	1	2	4	5.01	5.02	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	33,278,681	4,886,920	2,423,454	3,444,171	26,830	2,885,049	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING STORES	ADMITTING	PATIENT ACCOUNTING	SUBTOTAL (cols.0-4)	OTHER ADMIN & GENERAL	MAIN-TENANCE + REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES	451,769						5.03
5.04	ADMITTING	79	870,676					5.04
5.05	PATIENT ACCOUNTING	18		1,216,925				5.05
5.06	OTHER ADMIN & GENERAL	209			4,533,757	4,533,757		5.06
6	Maintenance & Repairs	7			339,222	53,503	392,725	6
7	Operation of Plant				1,052,658	166,029		7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service				140,855	22,216	829	8
9	Housekeeping	278			645,339	101,785	18,510	9
10	Dietary	9			311,492	49,130	24,727	10
11	Cafeteria	4			687,539	108,441	1,381	11
12	Maintenance of Personnel							12
13	Nursing Administration	255			349,362	55,103	5,664	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	5			890,771	140,496	5,940	16
17	Social Service				334,739	52,796		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	25,423	131,600	51,540	3,674,251	579,514	60,642	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	254,496	61,464	109,032	3,141,571	495,501	36,468	50
53	Anesthesiology	4,362	51,481	52,469	193,752	30,559		53
54	Radiology-Diagnostic	22,756	92,401	339,706	3,342,134	527,135	18,925	54
60	Laboratory	80,841	150,182	256,531	2,516,341	396,887	27,628	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,417	35,567	26,238	580,271	91,523	5,526	65
66	Physical Therapy	818	37,105	43,634	1,060,020	167,191	14,504	66
67	Occupational Therapy	117	14,777	6,946	107,728	16,991		67
68	Speech Pathology		1,636	1,175	32,444	5,117		68
68.01	AUDIOLOGY	13,405		2,829	193,847	30,574	553	68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	7,297	71,823	45,460	1,296,158	204,435	3,868	71
72	Impl. Dev. Charged to Patients		46,043	23,233	581,408	91,702		72
73	Drugs Charged to Patients	1,628	140,689	102,842	2,302,491	363,158	3,868	73
76.97	CARDIAC REHABILITATION	732	5,811	18,943	403,353	63,618	8,565	76.97
76.98	HYPERBARIC OXYGEN THERAPY	19,281		26,111	780,618	123,122	8,150	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			8,164	112,122	17,684		90
91	Emergency	17,280	30,097	92,509	2,680,782	422,824	46,138	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER	30		9,563	441,544	69,642	6,492	93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	451,747	870,676	1,216,925	32,726,569	4,446,676	298,378	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	21			88,048	13,887		190
192	Physicians' Private Offices	1			420,644	66,346	92,551	192
194	TRANSPORTATION				38,784	6,117	1,796	194
194.01	FUND DEVELOPMENT				4,636	731		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	451,769	870,676	1,216,925	33,278,681	4,533,757	392,725	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B**
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING							5.04
5.05	PATIENT ACCOUNTING							5.05
5.06	OTHER ADMIN & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,218,687						7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service	9,445	173,345					8
9	Housekeeping	42,209		807,843				9
10	Dietary	59,391	2,430	269	447,439			10
11	Cafeteria	54,507	84	27,738		879,690		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,291		161		20,537	433,118	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	7,694		3,279		45,280		16
17	Social Service	951				17,259		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	366,095	77,171	280,339	359,807	213,289	184,931	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	250,230	25,077	69,130	17,833	105,840	100,449	50
53	Anesthesiology							53
54	Radiology-Diagnostic	132,420	17,271	49,509		73,117		54
60	Laboratory	20,791		40,424		84,932		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	23,017	1,638	8,225		34,703		65
66	Physical Therapy	16,944	11,139	19,621		58,827		66
67	Occupational Therapy	2,010				9,155		67
68	Speech Pathology					1,237		68
68.01	AUDIOLOGY			5,644		5,753		68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	38,081	258	9,407		11,753	34	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	25,719		4,838		27,341		73
76.97	CARDIAC REHABILITATION			9,085		18,248	27,336	76.97
76.98	HYPERBARIC OXYGEN THERAPY		4,288	25,211		21,403		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic					10,763	27,073	90
91	Emergency	147,462	32,730	106,920	12,911	114,129	93,295	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER		20	14,944	56,888	62		93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,199,257	172,106	674,744	447,439	873,628	433,118	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	15,302		215				190
192	Physicians' Private Offices	2,680	1,239	132,884				192
194	TRANSPORTATION					6,062		194
194.01	FUND DEVELOPMENT	1,448						194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,218,687	173,345	807,843	447,439	879,690	433,118	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING							5.04
5.05	PATIENT ACCOUNTING							5.05
5.06	OTHER ADMIN & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,093,460						16
17	Social Service		405,745					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	561,642	400,769	6,758,450		6,758,450		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	85,276		4,327,375		4,327,375		50
53	Anesthesiology			224,311		224,311		53
54	Radiology-Diagnostic	174,332		4,334,843		4,334,843		54
60	Laboratory	17,643		3,104,646		3,104,646		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			744,903		744,903		65
66	Physical Therapy	63,432		1,411,678		1,411,678		66
67	Occupational Therapy			135,884		135,884		67
68	Speech Pathology			38,798		38,798		68
68.01	AUDIOLOGY			236,371		236,371		68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients			1,563,994		1,563,994		71
72	Impl. Dev. Charged to Patients			673,110		673,110		72
73	Drugs Charged to Patients			2,727,415		2,727,415		73
76.97	CARDIAC REHABILITATION	13,022		543,227		543,227		76.97
76.98	HYPERBARIC OXYGEN THERAPY			962,792		962,792		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			167,642		167,642		90
91	Emergency	162,150	1,340	3,820,681		3,820,681		91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER	15,963		605,555		605,555		93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,093,460	402,109	32,381,675		32,381,675		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			117,452		117,452		190
192	Physicians' Private Offices		3,636	719,980		719,980		192
194	TRANSPORTATION			52,759		52,759		194
194.01	FUND DEVELOPMENT			6,815		6,815		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,093,460	405,745	33,278,681		33,278,681		202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICAT	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department		6,159	1,405	7,564	7,564		4
5.01	COMMUNICATIONS		900	17,550	18,450		18,450	5.01
5.02	INFORMATION SYSTEMS		62,694	275,675	338,369		2,045	5.02
5.03	PURCHASING/RECEIVENG/STORES		198,530	3,421	201,951	90	299	5.03
5.04	ADMITTING		58,127	32,541	90,668	224	258	5.04
5.05	PATIENT ACCOUNTING		13,424	2,291	15,715	274	41	5.05
5.06	OTHER ADMIN & GENERAL		225,586	34,223	259,809	826	2,004	5.06
6	Maintenance & Repairs		45,671	3,083	48,754	152	41	6
7	Operation of Plant		373,878	13,999	387,877	106	41	7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service		30,240		30,240			8
9	Housekeeping		135,144	5,120	140,264	207	211	9
10	Dietary		190,157	5,241	195,398	69	340	10
11	Cafeteria		174,518	1,747	176,265	196	41	11
12	Maintenance of Personnel							12
13	Nursing Administration		7,335	1,067	8,402	170	41	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		24,635	4,203	28,838	160	896	16
17	Social Service		3,045	1	3,046	120	41	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,172,148	142,166	1,314,314	948	2,091	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		801,178	301,064	1,102,242	714	1,025	50
53	Anesthesiology			9,626	9,626			53
54	Radiology-Diagnostic		423,978	972,005	1,395,983	515	896	54
60	Laboratory		66,569	62,815	129,384	409	680	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		73,696	14,823	88,519	180	386	65
66	Physical Therapy		54,251	13,861	68,112	401	937	66
67	Occupational Therapy		6,435		6,435	79	41	67
68	Speech Pathology			390	390	15		68
68.01	AUDIOLOGY			1,952	1,952	35	41	68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients		121,927	72,580	194,507	44	41	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		82,346	14,706	97,052	466	258	73
76.97	CARDIAC REHABILITATION			14,432	14,432	160	41	76.97
76.98	HYPERBARIC OXYGEN THERAPY			16,676	16,676	130	428	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic					53	41	90
91	Emergency		472,140	58,486	530,626	800	979	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER			2,020	2,020		340	93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		4,824,711	2,099,169	6,923,880	7,543	14,524	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		48,992	963	49,955			190
192	Physicians' Private Offices		8,581	323,322	331,903	5	3,926	192
194	TRANSPORTATION					16		194
194.01	FUND DEVELOPMENT		4,636		4,636			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICAT	
		0	1	2	2A	4	5.01	
202	TOTAL (sum of lines 118-201)		4,886,920	2,423,454	7,310,374	7,564	18,450	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	INFORMATIO TECHNOLOG Y	PURCHASING RECEIVING STORES	ADMITTING	PATIENT ACCOUNTING	OTHER ADMIN & GENERAL	MAIN-TENANCE + REPAIRS	
		5.02	5.03	5.04	5.05	5.06	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS	340,414						5.02
5.03	PURCHASING/RECEIVENG/STORES	5,584	207,924					5.03
5.04	ADMITTING	39,380	36	130,566				5.04
5.05	PATIENT ACCOUNTING	6,474	8		22,512			5.05
5.06	OTHER ADMIN & GENERAL	77,105	96			339,840		5.06
6	Maintenance & Repairs	3,559	3			4,011	56,520	6
7	Operation of Plant					12,446		7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service					1,665	119	8
9	Housekeeping	5,461	128			7,630	2,664	9
10	Dietary	4,188	4			3,683	3,559	10
11	Cafeteria	3,805	2			8,129	199	11
12	Maintenance of Personnel							12
13	Nursing Administration	506	117			4,131	815	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	52,711	2			10,532	855	16
17	Social Service					3,958		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	23,502	11,701	19,736	954	43,425	8,727	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,008	117,133	9,217	2,019	37,143	5,248	50
53	Anesthesiology		2,008	7,720	971	2,291		53
54	Radiology-Diagnostic	9,787	10,473	13,857	6,270	39,514	2,724	54
60	Laboratory	27,690	37,207	22,515	4,750	29,751	3,976	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,065	1,112	5,334	486	6,861	795	65
66	Physical Therapy	14,098	377	5,565	808	12,533	2,087	66
67	Occupational Therapy	123	54	2,216	129	1,274		67
68	Speech Pathology			245	22	384		68
68.01	AUDIOLOGY	4,188	6,169		52	2,292	80	68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	890	3,358	10,771	842	15,324	557	71
72	Impl. Dev. Charged to Patients			6,905	430	6,874		72
73	Drugs Charged to Patients	9,910	749	21,099	1,904	27,222	557	73
76.97	CARDIAC REHABILITATION	5,078	337	872	351	4,769	1,233	76.97
76.98	HYPERBARIC OXYGEN THERAPY	261	8,874		483	9,229	1,173	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	123			151	1,326		90
91	Emergency	24,269	7,953	4,514	1,713	31,695	6,640	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER		14		177	5,220	934	93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	330,765	207,915	130,566	22,512	333,312	42,942	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		9			1,041		190
192	Physicians' Private Offices	9,649				4,973	13,320	192
194	TRANSPORTATION					459	258	194
194.01	FUND DEVELOPMENT					55		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	INFORMATIO TECHNOLOG Y	PURCHASING RECEIVING STORES	ADMITTING	PATIENT ACCOUNTING	OTHER ADMIN & GENERAL	MAIN-TENANCE + REPAIRS	
		5.02	5.03	5.04	5.05	5.06	6	
202	TOTAL (sum of lines 118-201)	340,414	207,924	130,566	22,512	339,840	56,520	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING							5.04
5.05	PATIENT ACCOUNTING							5.05
5.06	OTHER ADMIN & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant	400,470						7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service	3,104	35,128					8
9	Housekeeping	13,870		170,435				9
10	Dietary	19,516	493	57	227,307			10
11	Cafeteria	17,911	17	5,852		212,417		11
12	Maintenance of Personnel							12
13	Nursing Administration	753		34		4,959	19,928	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	2,528		692		10,934		16
17	Social Service	312				4,167		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	120,304	15,638	59,142	182,788	51,503	8,507	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	82,227	5,082	14,585	9,060	25,557	4,622	50
53	Anesthesiology							53
54	Radiology-Diagnostic	43,514	3,500	10,445		17,655		54
60	Laboratory	6,832		8,529		20,508		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,564	332	1,735		8,380		65
66	Physical Therapy	5,568	2,257	4,140		14,205		66
67	Occupational Therapy	660				2,211		67
68	Speech Pathology					299		68
68.01	AUDIOLOGY			1,191		1,389		68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	12,514	52	1,985		2,838	2	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	8,451		1,021		6,602		73
76.97	CARDIAC REHABILITATION			1,917		4,406	1,258	76.97
76.98	HYPERBARIC OXYGEN THERAPY		869	5,319		5,168		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic					2,599	1,246	90
91	Emergency	48,457	6,633	22,558	6,559	27,558	4,293	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER		4	3,153	28,900	15		93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	394,085	34,877	142,355	227,307	210,953	19,928	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,028		45				190
192	Physicians' Private Offices	881	251	28,035				192
194	TRANSPORTATION					1,464		194
194.01	FUND DEVELOPMENT	476						194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	400,470	35,128	170,435	227,307	212,417	19,928	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING							5.04
5.05	PATIENT ACCOUNTING							5.05
5.06	OTHER ADMIN & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	108,148						16
17	Social Service		11,644					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	55,549	11,502	1,930,331		1,930,331		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,434		1,432,316		1,432,316		50
53	Anesthesiology			22,616		22,616		53
54	Radiology-Diagnostic	17,242		1,572,375		1,572,375		54
60	Laboratory	1,745		293,976		293,976		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			125,749		125,749		65
66	Physical Therapy	6,274		137,362		137,362		66
67	Occupational Therapy			13,222		13,222		67
68	Speech Pathology			1,355		1,355		68
68.01	AUDIOLOGY			17,389		17,389		68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients			243,725		243,725		71
72	Impl. Dev. Charged to Patients			14,209		14,209		72
73	Drugs Charged to Patients			175,291		175,291		73
76.97	CARDIAC REHABILITATION	1,288		36,142		36,142		76.97
76.98	HYPERBARIC OXYGEN THERAPY			48,610		48,610		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			5,539		5,539		90
91	Emergency	16,037	38	741,322		741,322		91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER	1,579		42,356		42,356		93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	108,148	11,540	6,853,885		6,853,885		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			56,078		56,078		190
192	Physicians' Private Offices		104	393,047		393,047		192
194	TRANSPORTATION			2,197		2,197		194
194.01	FUND DEVELOPMENT			5,167		5,167		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	108,148	11,644	7,310,374		7,310,374		202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	COMMUNICAT TELEPHONES	INFORMATIO TECHNOLOGY TIME SPENT	PURCHASING RECEIVING STORES SUPPLY EXPENSE	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	70,622						1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip		2,130,900					2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department	89	1,235	11,073,513				4
5.01	COMMUNICATIONS	13	15,431		3,582			5.01
5.02	INFORMATION SYSTEMS	906	242,396		397	22,190		5.02
5.03	PURCHASING/RECEIVENG/STORES	2,869	3,008	132,199	58	364	2,326,920	5.03
5.04	ADMITTING	840	28,613	327,908	50	2,567	406	5.04
5.05	PATIENT ACCOUNTING	194	2,014	401,561	8	422	94	5.05
5.06	OTHER ADMIN & GENERAL	3,260	30,092	1,209,998	389	5,026	1,079	5.06
6	Maintenance & Repairs	660	2,711	222,511	8	232	37	6
7	Operation of Plant	5,403	12,309	154,637	8			7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service	437						8
9	Housekeeping	1,953	4,502	302,766	41	356	1,433	9
10	Dietary	2,748	4,608	100,617	66	273	45	10
11	Cafeteria	2,522	1,536	286,549	8	248	20	11
12	Maintenance of Personnel							12
13	Nursing Administration	106	938	249,532	8	33	1,313	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	356	3,696	234,272	174	3,436	24	16
17	Social Service	44	1	175,546	8			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	16,939	125,004	1,389,758	406	1,532	130,947	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,578	264,720	1,045,150	199	522	1,310,833	50
53	Anesthesiology		8,464				22,467	53
54	Radiology-Diagnostic	6,127	854,667	753,559	174	638	117,207	54
60	Laboratory	962	55,232	598,183	132	1,805	416,386	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,065	13,034	263,331	75	265	12,450	65
66	Physical Therapy	784	12,188	586,503	182	919	4,215	66
67	Occupational Therapy	93		115,263	8	8	604	67
68	Speech Pathology		343	21,771				68
68.01	AUDIOLOGY		1,716	51,765	8	273	69,043	68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	1,762	63,818	63,838	8	58	37,583	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	1,190	12,931	682,235	50	646	8,384	73
76.97	CARDIAC REHABILITATION		12,690	234,123	8	331	3,769	76.97
76.98	HYPERBARIC OXYGEN THERAPY		14,663	189,708	83	17	99,311	76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			78,039	8	8		90
91	Emergency	6,823	51,426	1,171,320	190	1,582	89,006	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER		1,776	128	66		154	93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	69,723	1,845,762	11,042,770	2,820	21,561	2,326,810	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	708	847				106	190
192	Physicians' Private Offices	124	284,291	7,029	762	629	4	192
194	TRANSPORTATION			23,714				194
194.01	FUND DEVELOPMENT	67						194.01
200	Cross foot adjustments							200
201	Negative cost centers							201

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	COMMUNICAT TELEPHONES	INFORMATIO TECHNOLOGY TIME SPENT	PURCHASING RECEIVING STORES SUPPLY EXPENSE	
		1	2	4	5.01	5.02	5.03	
202	Cost to be allocated (Per Wkst. B, Part I)	4,886,920	2,423,454	3,444,171	26,830	2,885,049	451,769	202
203	Unit Cost Multiplier (Wkst. B, Part I)	69.198267	1.137291	0.311028	7.490229	130.015728	0.194149	203
204	Cost to be allocated (Per Wkst. B, Part II)			7,564	18,450	340,414	207,924	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000683	5.150754	15.340874	0.089356	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	PATIENT ACCOUNTING GROSS REVENUE	RECON-CILIATION	OTHER ADMIN & GENERAL ACCUM COST	MAIN-TENANCE + REPAIRS TIME SPENT	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	5A.06	5.06	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING	22,731,840						5.04
5.05	PATIENT ACCOUNTING		87,330,662					5.05
5.06	OTHER ADMIN & GENERAL			-4,533,757	28,744,924			5.06
6	Maintenance & Repairs				339,222	2,843		6
7	Operation of Plant				1,052,658		56,388	7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service				140,855	6	437	8
9	Housekeeping				645,339	134	1,953	9
10	Dietary				311,492	179	2,748	10
11	Cafeteria				687,539	10	2,522	11
12	Maintenance of Personnel							12
13	Nursing Administration				349,362	41	106	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library				890,771	43	356	16
17	Social Service				334,739		44	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,435,857	3,698,583		3,674,251	439	16,939	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,604,714	7,824,349		3,141,571	264	11,578	50
53	Anesthesiology	1,344,083	3,765,241		193,752			53
54	Radiology-Diagnostic	2,412,444	24,379,890		3,342,134	137	6,127	54
60	Laboratory	3,920,911	18,409,093		2,516,341	200	962	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	928,599	1,882,872		580,271	40	1,065	65
66	Physical Therapy	968,760	3,131,262		1,060,020	105	784	66
67	Occupational Therapy	385,799	498,487		107,728		93	67
68	Speech Pathology	42,716	84,305		32,444			68
68.01	AUDIOLOGY		203,001		193,847	4		68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	1,875,167	3,262,310		1,296,158	28	1,762	71
72	Impl. Dev. Charged to Patients	1,202,113	1,667,236		581,408			72
73	Drugs Charged to Patients	3,673,158	7,380,154		2,302,491	28	1,190	73
76.97	CARDIAC REHABILITATION	151,725	1,359,357		403,353	62		76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,873,788		780,618	59		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		585,832		112,122			90
91	Emergency	785,794	6,638,642		2,680,782	334	6,823	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER		686,260		441,544	47		93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	22,731,840	87,330,662	-4,533,757	28,192,812	2,160	55,489	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				88,048		708	190
192	Physicians' Private Offices				420,644	670	124	192
194	TRANSPORTATION				38,784	13		194
194.01	FUND DEVELOPMENT				4,636		67	194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	870,676	1,216,925		4,533,757	392,725	1,218,687	202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	PATIENT ACCOUNTING GROSS REVENUE	RECON-CILIATION	OTHER ADMIN & GENERAL ACCUM COST	MAIN-TENANCE + REPAIRS TIME SPENT	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	5A.06	5.06	6	7	
203	Unit Cost Multiplier (Wkst. B, Part I)	0.038302	0.013935		0.157724	138.137531	21.612524	203
204	Cost to be allocated (Per Wkst. B, Part II)	130,566	22,512		339,840	56,520	400,470	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.005744	0.000258		0.011823	19.880408	7.102043	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PLANT OPS MAB BUILDING SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS FTES	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		7.01	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING							5.04
5.05	PATIENT ACCOUNTING							5.05
5.06	OTHER ADMIN & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	PLANT OPS-MAB BUILDING	56,388						7.01
8	Laundry & Linen Service	437	164,547					8
9	Housekeeping	1,953		15,028				9
10	Dietary	2,748	2,307	5	25,090			10
11	Cafeteria	2,522	80	516		14,221		11
12	Maintenance of Personnel							12
13	Nursing Administration	106		3		332	88,806	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	356		61		732		16
17	Social Service	44				279		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	16,939	73,254	5,215	20,176	3,448	37,918	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,578	23,804	1,286	1,000	1,711	20,596	50
53	Anesthesiology							53
54	Radiology-Diagnostic	6,127	16,394	921		1,182		54
60	Laboratory	962		752		1,373		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,065	1,555	153		561		65
66	Physical Therapy	784	10,574	365		951		66
67	Occupational Therapy	93				148		67
68	Speech Pathology					20		68
68.01	AUDIOLOGY			105		93		68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	1,762	245	175		190	7	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	1,190		90		442		73
76.97	CARDIAC REHABILITATION			169		295	5,605	76.97
76.98	HYPERBARIC OXYGEN THERAPY		4,070	469		346		76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic					174	5,551	90
91	Emergency	6,823	31,069	1,989	724	1,845	19,129	91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER		19	278	3,190	1		93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	55,489	163,371	12,552	25,090	14,123	88,806	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	708		4				190
192	Physicians' Private Offices	124	1,176	2,472				192
194	TRANSPORTATION					98		194
194.01	FUND DEVELOPMENT	67						194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		173,345	807,843	447,439	879,690	433,118	202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PLANT OPS MAB BUILDING SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS FTES	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		7.01	8	9	10	11	13	
203	Unit Cost Multiplier (Wkst. B, Part I)		1.053468	53.755856	17.833360	61.858519	4.877125	203
204	Cost to be allocated (Per Wkst. B, Part II)		35,128	170,435	227,307	212,417	19,928	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.213483	11.341163	9.059665	14.936854	0.224399	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT					
		16	17					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING							5.04
5.05	PATIENT ACCOUNTING							5.05
5.06	OTHER ADMIN & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	2,603						16
17	Social Service		2,120					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,337	2,094					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	203						50
53	Anesthesiology							53
54	Radiology-Diagnostic	415						54
60	Laboratory	42						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy	151						66
67	Occupational Therapy							67
68	Speech Pathology							68
68.01	AUDIOLOGY							68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION	31						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	386	7					91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER	38						93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,603	2,101					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		19					192
194	TRANSPORTATION							194
194.01	FUND DEVELOPMENT							194.01
200	Cross foot adjustments							200

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT					
		16	17					
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,093,460	405,745					202
203	Unit Cost Multiplier (Wkst. B, Part I)	420.076834	191.389151					203
204	Cost to be allocated (Per Wkst. B, Part II)	108,148	11,644					204
205	Unit Cost Multiplier (Wkst. B, Part II)	41.547445	5.492453					205

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	6,758,450		6,758,450			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,327,375		4,327,375			50
53	Anesthesiology	224,311		224,311			53
54	Radiology-Diagnostic	4,334,843		4,334,843			54
60	Laboratory	3,104,646		3,104,646			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	744,903		744,903			65
66	Physical Therapy	1,411,678		1,411,678			66
67	Occupational Therapy	135,884		135,884			67
68	Speech Pathology	38,798		38,798			68
68.01	AUDIOLOGY	236,371		236,371			68.01
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients	1,563,994		1,563,994			71
72	Impl. Dev. Charged to Patients	673,110		673,110			72
73	Drugs Charged to Patients	2,727,415		2,727,415			73
76.97	CARDIAC REHABILITATION	543,227		543,227			76.97
76.98	HYPERBARIC OXYGEN THERAPY	962,792		962,792			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	167,642		167,642			90
91	Emergency	3,820,681		3,820,681			91
92	Observation Beds (Non-Distinct Part)	398,313		398,313			92
93	O/P GERIATRIC PSYCH CENTER	605,555		605,555			93
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	32,779,988		32,779,988			200
201	Less Observation Beds	398,313		398,313			201
202	Total (line 200 minus line 201)	32,381,675		32,381,675			202

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C**
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	3,435,857		3,435,857				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,604,714	6,219,635	7,824,349	0.553065			50
53	Anesthesiology	1,344,083	2,421,158	3,765,241	0.059574			53
54	Radiology-Diagnostic	2,412,444	21,967,446	24,379,890	0.177804			54
60	Laboratory	3,920,911	14,488,182	18,409,093	0.168647			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	928,599	954,273	1,882,872	0.395621			65
66	Physical Therapy	968,760	2,162,502	3,131,262	0.450834			66
67	Occupational Therapy	385,799	112,688	498,487	0.272593			67
68	Speech Pathology	42,716	41,589	84,305	0.460210			68
68.01	AUDIOLOGY		203,001	203,001	1.164383			68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients	1,875,167	1,387,143	3,262,310	0.479413			71
72	Impl. Dev. Charged to Patients	1,202,113	465,123	1,667,236	0.403728			72
73	Drugs Charged to Patients	3,673,158	3,706,996	7,380,154	0.369561			73
76.97	CARDIAC REHABILITATION	151,725	1,207,632	1,359,357	0.399621			76.97
76.98	HYPERBARIC OXYGEN THERAPY		1,873,788	1,873,788	0.513821			76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		585,832	585,832	0.286161			90
91	Emergency	785,794	5,852,848	6,638,642	0.575521			91
92	Observation Beds (Non-Distinct Part)		262,726	262,726	1.516078			92
93	O/P GERIATRIC PSYCH CENTER		686,260	686,260	0.882399			93
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	22,731,840	64,598,822	87,330,662				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	22,731,840	64,598,822	87,330,662				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1336** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.553065		2,492,636			1,378,590		50
53	Anesthesiology	0.059574		428,734			25,541		53
54	Radiology-Diagnostic	0.177804		7,947,599			1,413,115		54
60	Laboratory	0.168647		4,617,217	3,148		778,680	531	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.395621		615,494			243,502		65
66	Physical Therapy	0.450834		765,867			345,279		66
67	Occupational Therapy	0.272593		28,890			7,875		67
68	Speech Pathology	0.460210		11,323			5,211		68
68.01	AUDIOLOGY	1.164383		28,717			33,438		68.01
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat	0.479413		593,978			284,761		71
72	Impl. Dev. Charged to Patients	0.403728		207,503			83,775		72
73	Drugs Charged to Patients	0.369561		1,428,512	12,659		527,922	4,678	73
76.97	CARDIAC REHABILITATION	0.399621		190,619			76,175		76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.513821		917,493			471,427		76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.286161							90
91	Emergency	0.575521		2,182,844			1,256,273		91
92	Observation Beds (Non-Distinct	1.516078		188,866			286,336		92
93	O/P GERIATRIC PSYCH CENTER	0.882399		657,619			580,282		93
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			23,303,911	15,807		7,798,182	5,209	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			23,303,911	15,807		7,798,182	5,209	202

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z336** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P [ ] Hospital [ ] SUB (Other) [XX] Swing Bed SNF
[XX] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF
[ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.553065							50
53	Anesthesiology	0.059574							53
54	Radiology-Diagnostic	0.177804							54
60	Laboratory	0.168647							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.395621							65
66	Physical Therapy	0.450834							66
67	Occupational Therapy	0.272593							67
68	Speech Pathology	0.460210							68
68.01	AUDIOLOGY	1.164383							68.01
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat	0.479413							71
72	Impl. Dev. Charged to Patients	0.403728							72
73	Drugs Charged to Patients	0.369561							73
76.97	CARDIAC REHABILITATION	0.399621							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.513821							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.286161							90
91	Emergency	0.575521							91
92	Observation Beds (Non-Distinct	1.516078							92
93	O/P GERIATRIC PSYCH CENTER	0.882399							93
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,930,331	885,590	1,044,741	3,407	306.65	80	24,532	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,930,331		1,044,741	3,407		80	24,532	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1336** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Hospital** **[ ] SUB (Other)** **[ ] Title XVIII, Part A** **[ ] IPF** **[XX] Title XIX** **[ ] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,432,316	7,824,349	0.183059			50
53	Anesthesiology	22,616	3,765,241	0.006007			53
54	Radiology-Diagnostic	1,572,375	24,379,890	0.064495			54
60	Laboratory	293,976	18,409,093	0.015969			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	125,749	1,882,872	0.066786			65
66	Physical Therapy	137,362	3,131,262	0.043868			66
67	Occupational Therapy	13,222	498,487	0.026524			67
68	Speech Pathology	1,355	84,305	0.016073			68
68.01	AUDIOLOGY	17,389	203,001	0.085660			68.01
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Pat	243,725	3,262,310	0.074709			71
72	Impl. Dev. Charged to Patients	14,209	1,667,236	0.008522			72
73	Drugs Charged to Patients	175,291	7,380,154	0.023752			73
76.97	CARDIAC REHABILITATION	36,142	1,359,357	0.026588			76.97
76.98	HYPERBARIC OXYGEN THERAPY	48,610	1,873,788	0.025942			76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	5,539	585,832	0.009455			90
91	Emergency	741,322	6,638,642	0.111668			91
92	Observation Beds (Non-Distinct	210,200	262,726	0.800073			92
93	O/P GERIATRIC PSYCH CENTER	42,356	686,260	0.061720			93
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,133,754	83,894,805				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	3,407		80		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	3,407		80		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1336** **WORKSHEET D PART IV**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
68.01	AUDIOLOGY							68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
93	O/P GERIATRIC PSYCH CENTER							93
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1336** **WORKSHEET D PART IV**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	7,824,349							50
53	Anesthesiology	3,765,241							53
54	Radiology-Diagnostic	24,379,890							54
60	Laboratory	18,409,093							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,882,872							65
66	Physical Therapy	3,131,262							66
67	Occupational Therapy	498,487							67
68	Speech Pathology	84,305							68
68.01	AUDIOLOGY	203,001							68.01
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat	3,262,310							71
72	Impl. Dev. Charged to Patients	1,667,236							72
73	Drugs Charged to Patients	7,380,154							73
76.97	CARDIAC REHABILITATION	1,359,357							76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,873,788							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	585,832							90
91	Emergency	6,638,642							91
92	Observation Beds (Non-Distinct	262,726							92
93	O/P GERIATRIC PSYCH CENTER	686,260							93
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	83,894,805							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1336** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.553065							50
53	Anesthesiology	0.059574							53
54	Radiology-Diagnostic	0.177804							54
60	Laboratory	0.168647							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.395621							65
66	Physical Therapy	0.450834							66
67	Occupational Therapy	0.272593							67
68	Speech Pathology	0.460210							68
68.01	AUDIOLOGY	1.164383							68.01
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat	0.479413							71
72	Impl. Dev. Charged to Patients	0.403728							72
73	Drugs Charged to Patients	0.369561							73
76.97	CARDIAC REHABILITATION	0.399621							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.513821							76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.286161							90
91	Emergency	0.575521							91
92	Observation Beds (Non-Distinct	1.516078							92
93	O/P GERIATRIC PSYCH CENTER	0.882399							93
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1336** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,295	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,407	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,036	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,444	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)	1,444	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,930	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)	1,155	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)	1,154	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 XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.03	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20
21	Total general inpatient routine service cost (see instructions)	6,758,450	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)	3,100,615	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,657,835	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,657,835	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1336** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[ ] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,073.62	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,072,087	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					2,072,087	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,577,619	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					4,649,706	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						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 (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					1,240,031	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					1,238,957	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					2,478,988	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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					371	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,073.62	88
89	Observation bed cost (line 87 x line 88) (see instructions)					398,313	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,930,331	3,657,835	0.527725	398,313	210,200	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1336** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,295	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,407	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,036	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,444	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)	1,444	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	80	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 XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.03	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20
21	Total general inpatient routine service cost (see instructions)	6,758,450	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)	3,100,615	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,657,835	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,657,835	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1336** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Hospital** **[ ] SUB (Other)** **[ ] PPS**
[ ] Title XVIII, Part A **[ ] IPF** **[ ] TEFRA**
[XX] Title XIX - I/P **[ ] IRF** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,073.62	38
39	Program general inpatient routine service cost (line 9 x line 38)	85,890	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)	85,890	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	85,890	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	24,532	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 (sum of lines 50 and 51)	24,532	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 (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1336** **WORKSHEET D-1 PARTS III & IV**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					371	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	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1336** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[ ] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/IID**
[ ] PPS **[ ] TEFRA** **[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,529,065		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.553065	952,178	526,616	50
53	Anesthesiology	0.059574	450,714	26,851	53
54	Radiology-Diagnostic	0.177804	751,208	133,568	54
60	Laboratory	0.168647	1,502,066	253,319	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.395621	392,366	155,228	65
66	Physical Therapy	0.450834	254,966	114,947	66
67	Occupational Therapy	0.272593	67,418	18,378	67
68	Speech Pathology	0.460210	11,584	5,331	68
68.01	AUDIOLOGY	1.164383			68.01
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.479413	932,846	447,218	71
72	Impl. Dev. Charged to Patients	0.403728	870,053	351,265	72
73	Drugs Charged to Patients	0.369561	1,439,276	531,900	73
76.97	CARDIAC REHABILITATION	0.399621			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.513821			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.286161			90
91	Emergency	0.575521	22,585	12,998	91
92	Observation Beds (Non-Distinct Part)	1.516078			92
93	O/P GERIATRIC PSYCH CENTER	0.882399			93
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		7,647,260	2,577,619	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		7,647,260		202

(A) Worksheet A line numbers

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z336** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [XX] Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.553065	4,542	2,512	50
53	Anesthesiology	0.059574	801	48	53
54	Radiology-Diagnostic	0.177804	141,682	25,192	54
60	Laboratory	0.168647	660,137	111,330	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.395621	308,015	121,857	65
66	Physical Therapy	0.450834	531,827	239,766	66
67	Occupational Therapy	0.272593	248,793	67,819	67
68	Speech Pathology	0.460210	22,728	10,460	68
68.01	AUDIOLOGY	1.164383			68.01
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.479413	305,964	146,683	71
72	Impl. Dev. Charged to Patients	0.403728			72
73	Drugs Charged to Patients	0.369561	936,435	346,070	73
76.97	CARDIAC REHABILITATION	0.399621			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.513821			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.286161			90
91	Emergency	0.575521			91
92	Observation Beds (Non-Distinct Part)	1.516078			92
93	O/P GERIATRIC PSYCH CENTER	0.882399			93
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,160,924	1,071,737	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,160,924		202

(A) Worksheet A line numbers

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1336** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.553065			50
53	Anesthesiology	0.059574			53
54	Radiology-Diagnostic	0.177804			54
60	Laboratory	0.168647			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.395621			65
66	Physical Therapy	0.450834			66
67	Occupational Therapy	0.272593			67
68	Speech Pathology	0.460210			68
68.01	AUDIOLOGY	1.164383			68.01
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.479413			71
72	Impl. Dev. Charged to Patients	0.403728			72
73	Drugs Charged to Patients	0.369561			73
76.97	CARDIAC REHABILITATION	0.399621			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.513821			76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.286161			90
91	Emergency	0.575521			91
92	Observation Beds (Non-Distinct Part)	1.516078			92
93	O/P GERIATRIC PSYCH CENTER	0.882399			93
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1336** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	7,803,391			1
2	Medical and other services reimbursed under OPPS (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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	7,803,391			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, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable 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)	7,881,425			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	28,710			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,781,516			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,071,199			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)	4,071,199			30
31	Primary payer payments	1,294			31
32	Subtotal (line 30 minus line 31)	4,069,905			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)	142,751			34
35	Adjusted reimbursable bad debts (see instructions)	108,491			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	141,872			36
37	Subtotal (see instructions)	4,178,396			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,178,396			40
40.01	Sequestration adjustment (see instructions)	83,568			40.01
41	Interim payments	3,939,187			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	155,641			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1336** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				3,678,352		3,792,214	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	05/28/2015	162,688	05/28/2015	64,403	3.01
	amount based on subsequent revision of the interim		.02	02/12/2015	158,237	02/12/2015	82,570	3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		320,925		146,973	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				3,999,277		3,939,187	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		207,893		155,641	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				4,207,170		4,094,828	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [XX] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				3,411,664			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	05/28/2015	170,578			3.01
	amount based on subsequent revision of the interim		.02	02/12/2015	169,227			3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		339,805			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				3,751,469			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-303,663			6.02
7	Total Medicare program liability (see instructions)				3,447,806			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	808	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,930	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	439	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	3,036	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	87,330,662	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	6,709,720	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	1	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z336** **WORKSHEET E-2**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII** **[ ] Title XIX**
[XX] Swing Bed - SNF **[ ] Swing Bed - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	2,503,778		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	1,082,454		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	2,309		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3,586,232		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	3,586,232		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	3,586,232		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	68,063		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	3,518,169		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	3,518,169		19
19.01	Sequestration adjustment (see instructions)	70,363		19.01
20	Interim payments	3,751,469		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-303,663		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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

1	Inpatient services	4,649,706	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	4,649,706	4
5	Primary payer payments	8,784	5
6	Total cost (see instructions)	4,687,419	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	4,687,419	19
20	Deductibles (exclude professional component)	414,444	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	4,272,975	22
23	Coinsurance	934	23
24	Subtotal (line 22 minus line 23)	4,272,041	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,619	25
26	Adjusted reimbursable bad debts (see instructions)	20,990	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,619	27
28	Subtotal (sum of lines 24 and 26)	4,293,031	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	4,293,031	30
30.01	Sequestration adjustment (see instructions)	85,861	30.01
31	Interim payments	3,999,277	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	207,893	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	85,890		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	85,890		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	85,890		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 cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	85,890		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	Titles V or XIX (sum of lines 21 and 27)	85,890		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)	85,890		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)	85,890		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	85,890		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)	85,890		40
41	Interim payments	85,890		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	3,028,967				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,833,789				4
5	Other receivables	6,821,745				5
6	Allowances for uncollectible notes and accounts receivable	-1,190,049				6
7	Inventory	524,948				7
8	Prepaid expenses	1,116,329				8
9	Other current assets					9
10	Due from other funds	530,996				10
11	Total current assets (sum of lines 1-10)	18,666,725				11
	FIXED ASSETS					
12	Land	3,759,039				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	46,307,912				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	18,085,165				23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	68,152,116				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	86,818,841				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,806,323				37
38	Salaries, wages and fees payable	1,374,154				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	14,617,705				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	5,230,730				44
45	Total current liabilities (sum of lines 37 thru 44)	23,028,912				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	41,257,301				47
48	Unsecured loans					48
49	Other long term liabilities	5,297,745				49
50	Total long term liabilities (sum of lines 46 thru 49)	46,555,046				50
51	Total liabilities (sum of lines 45 and 50)	69,583,958				51
	CAPITAL ACCOUNTS					
52	General fund balance	17,234,883				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
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 thru 58)	17,234,883				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	86,818,841				60

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		17,435,723			1
2	Net income (loss) (from Worksheet G-3, line 29)		365,963			2
3	Total (sum of line 1 and line 2)		17,801,686			3
4	Additions (credit adjustments) (specify)	-566,803				4
5						5
6	INVESTMENT INCOME					6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		-566,803			10
11	Subtotal (line 3 plus line 10)		17,234,883			11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER TO AFFILIATES					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,234,883			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6	INVESTMENT INCOME					6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER TO AFFILIATES					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,478,440		3,478,440	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	3,478,440		3,478,440	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	3,478,440		3,478,440	17
18	Ancillary services	19,336,830		19,336,830	18
19	Outpatient services		65,672,676	65,672,676	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	22,815,270	65,672,676	88,487,946	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		37,084,296	29
30	PROVISION FOR BAD DEBT			30
31	ROUNDING			31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38		-1		38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-1	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		37,084,295	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	88,487,946	1
2	Less contractual allowances and discounts on patients' accounts	51,137,467	2
3	Net patient revenues (line 1 minus line 2)	37,350,479	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	37,084,295	4
5	Net income from service to patients (line 3 minus line 4)	266,184	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service	8,709	13
14	Revenue from meals sold to employees and guests	40,806	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	6,106	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (MISCELLANEOUS OPERATING REVENUE)		24
24.01	Other (HEALTH FAIR)	28,127	24.01
24.02	Other (EDUCATIONAL CLASSES)	503	24.02
24.03	Other (VAN SERVICE)		24.03
24.04	Other (MEALS ON WHEELS)		24.04
24.05	Other (MASSAGE REVENUE)		24.05
24.06	Other (EMPLOYEE FITNESS)		24.06
24.07	Other (BENEFIT INTEREST)	15,528	24.07
24.08	Other (GRANT REVENUE)		24.08
24.09	Other (LOSS ON INVESTMENTS)		24.09
25	Total other income (sum of lines 6-24)	99,779	25
26	Total (line 5 plus line 25)	365,963	26
29	Net income (or loss) for the period (line 26 minus line 28)	365,963	29

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES **WORKSHEET L-1**
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	CAP REL COSTS-MAB BUILDING							1.01
2	Cap Rel Costs-Mvble Equip							2
2.01	CAP REL COSTS-MAB EQUIPMENT							2.01
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.02	INFORMATION SYSTEMS							5.02
5.03	PURCHASING/RECEIVENG/STORES							5.03
5.04	ADMITTING							5.04
5.05	PATIENT ACCOUNTING							5.05
5.06	OTHER ADMIN & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	PLANT OPS-MAB BUILDING							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
68.01	AUDIOLOGY							68.01
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93	O/P GERIATRIC PSYCH CENTER							93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	TRANSPORTATION							194
194.01	FUND DEVELOPMENT							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

ST. JOSEPH'S HOSPITAL-HIGHLAND IL Provider CCN: 14-1336	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 18:29 Version: 2015.10 (11/17/2015)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
202	TOTAL (sum of lines 118-201)							202