

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
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
- DATE: _____ TIME: _____
- CONTRACTOR USE ONLY
5. COST REPORT STATUS
 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.
- 1 - AS SUBMITTED
 - 2 - SETTLED WITHOUT AUDIT
 - 3 - SETTLED WITH AUDIT
 - 4 - REOPENED
 - 5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. MARY'S HOSPITAL (14-0026) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		25,653	-434,982		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY			-256		7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY			-1		9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		25,653	-435,239		200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 111 E. SPRING ST.
 2 CITY: STREATOR

STATE: IL

P.O.BOX:
 ZIP CODE: 61364

COUNTY: LASALLE

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-0026	99914	1	05/23/1966	N	P	P	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	14-5594	99914		08/23/1988	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA	14-7173	99914		12/03/1979	N	P	N	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: 07/01/2010			TO: 06/30/2011				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

		IN-STATE		OUT-OF-STATE		MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
		MEDICAID PAID DAYS 1	MEDICAID ELIGIBLE DAYS 2	MEDICAID PAID DAYS 3	MEDICAID ELIGIBLE DAYS 4			
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.							1 N 2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							3 N 23
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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 '1' FOR URBAN AND '2' FOR RURAL.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.				1			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING: 07/01/2010	ENDING: 06/30/2011		38

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME		PROGRAM CODE			
1		2			
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

			1	2
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.		N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.		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
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	1,000,000	3,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		N	Y 120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

141	NAME: HOSPITAL SISTERS HEALTH SYSTEM CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET: 4936 LAVERNA RD. P.O. BOX: 19456		142
143	CITY: STSPRINGFIELD STATE: IL	ZIP CODE: 62794	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y 144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N 145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N 146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N 147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N 148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N 149

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

SEE 42 CFR §413.13)		PART A	PART B
155 HOSPITAL		1	2
156 SUBPROVIDER - IPF		N	N 155
157 SUBPROVIDER - IRF		N	N 156
158 SUBPROVIDER - (OTHER)		N	N 157
159 SNF		N	N 158
160 HHA		N	N 159
161 CMHC		N	N 160

MULTICAMPUS

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

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

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

		Y/N	Y/N
APPROVED EDUCATIONAL ACTIVITIES			
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2 6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N	7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N	8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N	9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N	11
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y/N Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N 14

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

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 Y	2 11/30/2011	3 Y	4 11/30/2011
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 REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

Y/N DATE
1 2

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	20,825,671		20,825,671	910,726.00	22.87
2	NON-PHYSICIAN ANESTHETIST PART A						
3	NON-PHYSICIAN ANESTHETIST PART B						
4	PHYSICIAN-PART A						
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B						
6	NON-PHYSICIAN-PART B						
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						
9	SNF	44	1,173,149		1,173,149	48,617.00	24.13
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		961,781	-103,740	858,041	33,443.00	25.66
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		433,947		433,947	7,111.00	61.02
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						
13	CONTRACT LABOR: PHYSICIAN-PART A		534,048		534,048	4,096.00	130.38
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,060,709		1,060,709	13,798.00	76.87
15	HOME OFFICE: PHYSICIAN-PART A						
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		6,915,446		6,915,446		
18	WAGE-RELATED COSTS (OTHER)						
19	EXCLUDED AREAS		712,099		712,099		
20	NON-PHYSICIAN ANESTHETIST PART A						
21	NON-PHYSICIAN ANESTHETIST PART B						
22	PHYSICIAN PART A						
23	PHYSICIAN PART B						
24	WAGE-RELATED COSTS (RHC/FQHC)						
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		203,554		203,554	8,610.00	23.64
27	ADMINISTRATIVE & GENERAL		3,799,870	28,942	3,828,812	152,749.00	25.07
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		172,476		172,476	1,219.00	141.49
29	MAINTENANCE & REPAIRS		592,503		592,503	24,645.00	24.04
30	OPERATION OF PLANT		126,618		126,618	9,263.00	13.67
31	LAUNDRY & LINEN SERVICE		26,559		26,559	2,966.00	8.95
32	HOUSEKEEPING		651,775		651,775	53,514.00	12.18
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						
34	DIETARY		472,491		472,491	31,572.00	14.97
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						
36	CAFETERIA		64,694		64,694	6,170.00	10.49
37	MAINTENANCE OF PERSONNEL						
38	NURSING ADMINISTRATION		709,363		709,363	24,396.00	29.08
39	CENTRAL SERVICES AND SUPPLY		129,552		129,552	8,609.00	15.05
40	PHARMACY		564,490		564,490	15,086.00	37.42
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		491,844		491,844	30,756.00	15.99
42	SOCIAL SERVICE			14,605	14,605	660.00	22.13
43	OTHER GENERAL SERVICE						

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	20,998,147			20,998,147	911,945.00	23.03
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2,134,930	-103,740		2,031,190	82,060.00	24.75
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	18,863,217	103,740		18,966,957	829,885.00	22.85
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	2,028,704			2,028,704	25,005.00	81.13
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	6,915,446			6,915,446		36.46%
6	TOTAL (SUM OF LINES 3 THRU 5)	27,807,367	103,740		27,911,107	854,890.00	32.65
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	8,005,789	43,547		8,049,336	370,215.00	21.74

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	1,210,764 3
4 PRIOR YEAR PENSION SERVICE COST	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	14,000 7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	4,086,770 8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	127,933 10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	23,042 11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	33,566 13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	65,699 14
15 WORKERS' COMPENSATION INSURANCE	431,679 15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	1,177,630 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	334,734 18
19 UNEMPLOYMENT INSURANCE	64,802 19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	56,926 23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	7,627,545 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/24/2012 09:19

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL	433,947	2
3	SUBPROVIDER - IPF	433,947	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7173

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: LASALLE

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		535			535	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		291.00		76.00	367.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL 3	
	STAFF 1	CONTRACT 2			
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)					3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			1.00	1.00	4
5 OTHER ADMINISTRATIVE PERSONNEL			2.69	2.69	5
6 DIRECT NURSING SERVICE			4.74	4.74	6
7 NURSING SUPERVISOR			1.57	1.57	7
8 PHYSICAL THERAPY SERVICE			0.86	0.86	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE			0.05	0.05	10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE			0.01	0.01	12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE			0.32	0.32	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE			0.26	0.26	16
17 HOME HEALTH AIDE SUPERVISOR					17
18 OTHER (SPECIFY)					18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.		2	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).		37900	20
20.01		99914	20.01

PPS ACTIVITY

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2				
21 SKILLED NURSING VISITS	2,568	32	83	12	2,695	21
22 SKILLED NURSING VISIT CHARGES	475,080	5,920	15,355	2,220	498,575	22
23 PHYSICAL THERAPY VISITS	707		5	8	720	23
24 PHYSICAL THERAPY VISIT CHARGES	130,795		925	1,480	133,200	24
25 OCCUPATIONAL THERAPY VISITS	24			7	31	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	4,440			1,295	5,735	26
27 SPEECH PATHOLOGY VISITS	10				10	27
28 SPEECH PATHOLOGY VISIT CHARGES	1,850				1,850	28
29 MEDICAL SOCIAL SERVICE VISITS	83	1			84	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	19,090	230			19,320	30
31 HOME HEALTH AIDE VISITS	266		1		267	31
32 HOME HEALTH AIDE VISIT CHARGES	27,930		105		28,035	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	3,658	33	89	27	3,807	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	659,185	6,150	16,385	4,995	686,715	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	311		32	3	346	36
37 TOTAL NUMBER OF OUTLIER EPISODES		1			1	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	26,197	146	2,965	207	29,515	38

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

	GROUP	SNF	SWING BED	TOTAL
	1	DAYS	SNF DAYS	(COLS.
		2	3	2 + 3)
				4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL	449		449 8
9	RMX	333		333 9
10	RML			10
11	RLX	167		167 11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA			17
18	RHC	2		2 18
19	RHB	16		16 19
20	RHA	30		30 20
21	RMC	340		340 21
22	RMB	401		401 22
23	RMA	754		754 23
24	RLB	64		64 24
25	RLA	81		81 25
26	ES3			26
27	ES2	6		6 27
28	ES1	186		186 28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1	127		127 32
33	HC2	15		15 33
34	HC1	177		177 34
35	HB2			35
36	HB1	441		441 36
37	LE2			37
38	LE1			38
39	LD2	11		11 39
40	LD1	14		14 40
41	LC2			41
42	LC1	13		13 42
43	LB2			43
44	LB1	12		12 44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1	59		59 48
49	CC2			49
50	CC1	37		37 50
51	CB2			51
52	CB1	260		260 52
53	CA2			53
54	CA1	88		88 54
55	SE3	144		144 55
56	SE2	182		182 56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA	45		45 60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1	10		10 66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1		13		13 72
73	PC2				73
74	PC1		3		3 74
75	PB2				75
76	PB1		4		4 76
77	PA2				77
78	PA1				78
199	AAA		2		2 199
200	TOTAL		4,486		4,486 200

		CBSA AT	CBSA	
		BEGINNING	ON/AFTER	
		OF COST	REPORTING	
		REPORTING	PERIOD (IF	
		PERIOD	APPLICABLE)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	99914	99914	201

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

		EXPENSES	PERCENTAGE	ASSOCIATED	
		1	2	WITH	
				DIRECT	
				PATIENT	
				CARE AND	
				RELATED	
				EXPENSES?	
				3	
202	STAFFING			N	202
203	RECRUITMENT			N	203
204	RETENTION OF EMPLOYEES			N	204
205	TRAINING			N	205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	1,854,925			207

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.313784	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,658,927	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				17,355,516	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				5,445,883	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				3,786,956	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				57,746	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				3,786,956	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	8,188,053	336,916	8,524,969		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	2,569,280	105,719	2,674,999		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	52,450	41,405	93,855		22
23	COST OF CHARITY CARE	2,516,830	64,314	2,581,144		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)			2,221,709		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			250,923		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,970,786		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			618,401		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			3,199,545		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			6,986,501		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,669,656	1,669,656	-121,874	1
2	00200		3,315,866	3,315,866	15,966	2
3	00300		50,814	50,814	-50,814	3
4	00400	203,554	8,112,960	8,316,514		4
5	00500	3,799,870	8,834,516	12,634,386	-1,070,743	5
6	00600	592,503	611,808	1,204,311		6
7	00700	126,618	1,156,113	1,282,731		7
8	00800	26,559	233,849	260,408		8
9	00900	651,775	119,668	771,443		9
10	01000	472,491	132,296	604,787		10
11	01100	64,694	98,592	163,286		11
12	01200					12
13	01300	709,363	43,278	752,641		13
14	01400	129,552	383,224	512,776	-345,954	14
15	01500	564,490	1,294,247	1,858,737	-1,243,286	15
16	01600	491,844	172,824	664,668		16
17	01700				14,605	17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,735,925	136,439	2,872,364		30
31	03100	852,652	27,866	880,518		31
43	04300	126,019	7,575	133,594		43
44	04400	1,173,149	34,820	1,207,969		44
ANCILLARY SERVICE COST CENTERS						
50	05000	1,317,487	2,471,704	3,789,191	-2,019,358	50
52	05200	126,326	33,149	159,475		52
53	05300		143,540	143,540	1,099,685	53
54	05400	1,247,339	1,401,823	2,649,162		54
57	05700	141,345	180,685	322,030		57
58	05800	132,047	64,750	196,797		58
60	06000	954,075	1,693,741	2,647,816		60
62.30	06250					62.30
65	06500	518,757	71,526	590,283	-64,031	65
66	06600	632,237	326,275	958,512	51,194	66
67	06700	158,221	77,421	235,642	832	67
68	06800	50,382	246	50,628	943	68
68.01	03040	60,585	111,555	172,140		68.01
69	06900	33,822	49,333	83,155		69
69.01	03951					69.01
70	07000	1,011	113,865	114,876		70
71	07100				1,201,343	71
72	07200				1,288,638	72
73	07300				1,243,286	73
73.01	03480					73.01
76	03950					76
76.97	07697	73,548	4,904	78,452		76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	200,120	9,766	209,886		90
90.01	09001	643,935	1,435,324	2,079,259	76,979	90.01
91	09100	851,595	1,696,438	2,548,033	-43,960	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	676,332	50,697	727,029	-118,012	101
113	11300		211,079	211,079		113
118		20,540,222	36,584,232	57,124,454	-84,561	118
NONREIMBURSABLE COST CENTERS						
190	19000		35,919	35,919		190
192	19200	-11,577	3,567,714	3,556,137	79,743	192
194	07950	297,026	141,463	438,489	4,818	194
200		20,825,671	40,329,328	61,154,999		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,547,782	-10,178	1,537,604	1
2	00200	3,331,832	-155,482	3,176,350	2
3	00300				3
4	00400	8,316,514	-2,309,062	6,007,452	4
5	00500	11,563,643	-2,867,272	8,696,371	5
6	00600	1,204,311		1,204,311	6
7	00700	1,282,731	-17,376	1,265,355	7
8	00800	260,408		260,408	8
9	00900	771,443		771,443	9
10	01000	604,787	-21,098	583,689	10
11	01100	163,286	-156,413	6,873	11
12	01200				12
13	01300	752,641	-820	751,821	13
14	01400	166,822		166,822	14
15	01500	615,451		615,451	15
16	01600	664,668	-21,557	643,111	16
17	01700	14,605		14,605	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,872,364		2,872,364	30
31	03100	880,518		880,518	31
43	04300	133,594		133,594	43
44	04400	1,207,969		1,207,969	44
ANCILLARY SERVICE COST CENTERS					
50	05000	1,769,833		1,769,833	50
52	05200	159,475		159,475	52
53	05300	1,243,225	-1,099,685	143,540	53
54	05400	2,649,162	-16,831	2,632,331	54
57	05700	322,030		322,030	57
58	05800	196,797		196,797	58
60	06000	2,647,816		2,647,816	60
62.30	06250				62.30
65	06500	526,252		526,252	65
66	06600	1,009,706		1,009,706	66
67	06700	236,474		236,474	67
68	06800	51,571		51,571	68
68.01	03040	172,140		172,140	68.01
69	06900	83,155	-45,319	37,836	69
69.01	03951				69.01
70	07000	114,876		114,876	70
71	07100	1,201,343	-1,600	1,199,743	71
72	07200	1,288,638		1,288,638	72
73	07300	1,243,286		1,243,286	73
73.01	03480				73.01
76	03950				76
76.97	07697	78,452		78,452	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	209,886		209,886	90
90.01	09001	2,156,238	-1,013,531	1,142,707	90.01
91	09100	2,504,073	-1,507,688	996,385	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
101	10100	609,017		609,017	101
SPECIAL PURPOSE COST CENTERS					
113	11300	211,079	-211,079		113
118		57,039,893	-9,454,991	47,584,902	118
NONREIMBURSABLE COST CENTERS					
190	19000	35,919		35,919	190
192	19200	3,635,880		3,635,880	192
194	07950	443,307		443,307	194
200		61,154,999	-9,454,991	51,700,008	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER 2	INCREASE LINE #	SALARY		OTHER	
				4	5	5	500
1 SUPPLY CHARGED TO PATIENTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	MEDICAL SUPPLIES CHRGED TO PA	71		345,954	1	345,954 500
1 DRUGS CHARGED TO PATIENTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - B	B	DRUGS CHARGED TO PATIENTS	73		1,243,286	1	1,243,286 500
1 MED/SURG ER RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - C	C	MEDICAL SUPPLIES CHRGED TO PA	71		43,960	1	43,960 500
1 MED/SURG SURGERY RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	MEDICAL SUPPLIES CHRGED TO PA	71		730,720	1	730,720 500
1 MED/SURG RESP THER RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - E	E	MEDICAL SUPPLIES CHRGED TO PA	71		64,031	1	64,031 500
1 MED/SURG P.T. RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - F	F	MEDICAL SUPPLIES CHRGED TO PA	71		5,359	1	5,359 500
1 MED/SURG O.T. RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - G	G	MEDICAL SUPPLIES CHRGED TO PA	71		1,865	1	1,865 500
1 PHY PRIV OFC DIRECT DEPR 500 TOTAL RECLASSIFICATIONS CODE LETTER - H	H	PHYSICIANS' PRIVATE OFFICES	192		76,681	1	76,681 500
1 P.T. SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - I	I	PHYSICAL THERAPY	66	56,553	56,553	1	500
1 MSW SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - K	K	SOCIAL SERVICE	17	14,605	14,605	1	500
1 O.T. SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - L	L	OCCUPATIONAL THERAPY	67	2,697	2,697	1	500
1 HHA COST BILLERS 500 TOTAL RECLASSIFICATIONS CODE LETTER - M	M	ADMINISTRATIVE & GENERAL	5	28,942	28,942	1	500
1 HHA MANAGER SALARY HOSPICE 500 TOTAL RECLASSIFICATIONS CODE LETTER - N	N	OTHER NONREIMBURSABLE COST	194	4,818	4,818	1	500
1 MED SURG HH RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - O	O	MEDICAL SUPPLIES CHRGED TO PA	71		9,454	1	9,454 500
1 ANESTHESIA PHY 500 TOTAL RECLASSIFICATIONS CODE LETTER - P	P	ANESTHESIOLOGY	53		1,099,685	1	1,099,685 500

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		
			LINE #	SALARY	
	1	2	3	4	5
1 PHY PRIV OFC DIRECT DEPT	Q	PHYSICIANS' PRIVATE OFFICES	192		3,062 1
500 TOTAL RECLASSIFICATIONS					3,062 500
1 OTTAWA CLINIC DIRECT DEPT	R	OTTAWA CLINIC	90.01		76,979 1
500 TOTAL RECLASSIFICATIONS					76,979 500
1 MED/SURG SURGERY RELACC	S	IMPL. DEV. CHARGED TO PATIENT	72		1,288,638 1
500 TOTAL RECLASSIFICATIONS					1,288,638 500
1 S.T. SALARY	T	SPEECH PATHOLOGY	68	943	1
500 TOTAL RECLASSIFICATIONS				943	500
GRAND TOTAL (INCREASES)				108,558	4,989,674

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 SUPPLY CHARGED TO PATIENTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	CENTRAL SERVICES & SUPPLY	14		345,954	1 500
1 DRUGS CHARGED TO PATIENTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - B	B	PHARMACY	15		1,243,286	1 500
1 MED/SURG ER RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - C	C	EMERGENCY	91		43,960	1 500
1 MED/SURG SURGERY RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	OPERATING ROOM	50		730,720	1 500
1 MED/SURG RESP THER RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - E	E	RESPIRATORY THERAPY	65		64,031	1 500
1 MED/SURG P.T. RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - F	F	PHYSICAL THERAPY	66		5,359	1 500
1 MED/SURG O.T. RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - G	G	OCCUPATIONAL THERAPY	67		1,865	1 500
1 PHY PRIV OFC DIRECT DEPR 500 TOTAL RECLASSIFICATIONS CODE LETTER - H	H	CAP REL COSTS-BLDG & FIXT	1		76,681	9 1 500
1 P.T. SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - I	I	HOME HEALTH AGENCY	101	56,553	56,553	1 500
1 MSW SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - K	K	HOME HEALTH AGENCY	101	14,605	14,605	1 500
1 O.T. SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - L	L	HOME HEALTH AGENCY	101	2,697	2,697	1 500
1 HHA COST BILLERS 500 TOTAL RECLASSIFICATIONS CODE LETTER - M	M	HOME HEALTH AGENCY	101	28,942	28,942	1 500
1 HHA MANAGER SALARY HOSPICE 500 TOTAL RECLASSIFICATIONS CODE LETTER - N	N	HOME HEALTH AGENCY	101	4,818	4,818	1 500
1 MED SURG HH RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - O	O	HOME HEALTH AGENCY	101		9,454	1 500
1 ANESTHESIA PHY 500 TOTAL RECLASSIFICATIONS CODE LETTER - P	P	ADMINISTRATIVE & GENERAL	5		1,099,685	1 500

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE		OTHER 9	WKST A-7	
			LINE # 7	SALARY 8		REF. 10	
1 PHY PRIV OFC DIRECT DEPT 500 TOTAL RECLASSIFICATIONS CODE LETTER - Q	Q	CAP REL COSTS-BLDG & FIXT	1		3,062	9	1 500
1 OTTAWA CLINIC DIRECT DEPT 500 TOTAL RECLASSIFICATIONS CODE LETTER - R	R	CAP REL COSTS-BLDG & FIXT	1		76,979	9	1 500
1 MED/SURG SURGERY RELACC 500 TOTAL RECLASSIFICATIONS CODE LETTER - S	S	OPERATING ROOM	50		1,288,638		1 500
1 S.T. SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - T	T	HOME HEALTH AGENCY	101	943	943		1 500
GRAND TOTAL (DECREASES)				108,558	4,989,674		

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	1,146,583	88,317		88,317		1,234,900		1
2 LAND IMPROVEMENTS	930,105	49,872		49,872		979,977		2
3 BUILDINGS AND FIXTURES	50,794,799	693,244		693,244	93,955	51,394,088		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	24,222,920	1,643,719		1,643,719	608,314	25,258,325		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	77,094,407	2,475,152		2,475,152	702,269	78,867,290		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	77,094,407	2,475,152		2,475,152	702,269	78,867,290		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,669,656						1,669,656 1
2 CAP REL COSTS-MVBLE EQUIP	3,315,866						3,315,866 2
3 TOTAL (SUM OF LINES 1-2)	4,985,522						4,985,522 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	52,871,487		52,871,487	0.685802	34,848			34,848 1
2 CAP REL COSTS-MVBLE EQUIP	24,222,920		24,222,920	0.314198	15,966			15,966 2
3 TOTAL (SUM OF LINES 1-2)	77,094,407		77,094,407	1.000000	50,814			50,814 3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,502,756			34,848			1,537,604 1
2 CAP REL COSTS-MVBLE EQUIP	3,160,384			15,966			3,176,350 2
3 TOTAL	4,663,140			50,814			4,713,954 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-2,536	ADMINISTRATIVE & GENERAL	5	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	-3,600,203			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-785,580			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-156,413	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	-21,557	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT	B	13,246	CAP REL COSTS-MVBLE EQUIP	2	9 27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
33.01 OTHER INCOME	B	-820	NURSING ADMINISTRATION	13	33.01
33.02 OTHER INCOME DIETARY	B	-19,760	DIETARY	10	33.02
33.03 DIETARY INC	B	-1,253	DIETARY	10	33.03
33.04 X-RAY DEPT INC	B	-15,091	RADIOLOGY-DIAGNOSTIC	54	33.04
33.08 EDUCATION	B	-3,979	ADMINISTRATIVE & GENERAL	5	33.08
33.11 OTHER INCOME	B	-85	DIETARY	10	33.11
33.12 OTHER INCOME	B	-1,600	MEDICAL SUPPLIES CHRGD TO PATI	71	33.12
33.17 OTHER INCOME	B	-17,376	OPERATION OF PLANT	7	33.17
33.19 OTHER INCOME	B	-1,977	ADMINISTRATIVE & GENERAL	5	33.19
33.20 OTHER INCOME	B	-1,472	OTTAWA CLINIC	90.01	33.20
33.21 NON ALLOW ADVER	A	-66,288	OTTAWA CLINIC	90.01	33.21
33.23 OTHER INCOME	B	-98,641	ADMINISTRATIVE & GENERAL	5	33.23
33.25 ASSOC DUE LOBBY	A	-19,812	ADMINISTRATIVE & GENERAL	5	33.25
33.26 OTHER INCOME	B	-61	ADMINISTRATIVE & GENERAL	5	33.26
33.28 OTHER INCOME	B	-31,100	ADMINISTRATIVE & GENERAL	5	33.28
33.30 INTEREST EXPENSE	B	-211,079	INTEREST EXPENSE	113	33.30
33.33 HSHS SELF IND EXP OFFSET	B	-2,309,062	EMPLOYEE BENEFITS	4	33.33
33.35 OTHER INCOME	B	-4,185	ADMINISTRATIVE & GENERAL	5	33.35
33.38 A&G NON ALLOWABLE	A	-2,079,690	ADMINISTRATIVE & GENERAL	5	33.38
33.39 OTHER INCOME	B	-9,167	ADMINISTRATIVE & GENERAL	5	33.39
33.42 OTHER INCOME	B	-9,450	ADMINISTRATIVE & GENERAL	5	33.42
34					34
35					35
36					36
37					37
38					38
39					39
40					40

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER 3	LINE NO. 4	
					41
					42
					43
					44
					45
					46
					47
					48
					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-9,454,991			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL				
		CENTRAL MGMT SERVICE	1,951,060	2,557,734	-606,674	1
2						2
3		HOME OFFICE				3
4	1	CAP REL COSTS-BLDG & FIXT	32,731	42,909	-10,178	9 4
4.01	2	CAP REL COSTS-MVBLE EQUIP	542,629	711,357	-168,728	9 4.01
5		TOTALS (SUM OF LINES 1-4)	2,526,420	3,312,000	-785,580	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6	B	HOSPITAL SISTERS	100.00			6
7						7
8						8
9						9
10						10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9	
2	69	ELECTROCARDIOLOGY	AGGREGATE	45,319	45,319		159,800			2
3	91	EMERGENCY	AGGREGATE	1,627,538	1,338,938	288,600	159,800	1,560	119,850	5,993
4	60	LABORATORY		25,000		25,000	208,000	1,250	125,000	6,250
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	1,740	1,740		217,600			5
6	53	ANESTHESIOLOGY	AGGREGATE	1,099,685	1,099,685		162,500			6
7	90.01	OTTAWA CLINIC	AGGREGATE	1,035,351	819,703	215,648	159,800	1,166	89,580	4,479
200		TOTAL		3,834,633	3,305,385	529,248		3,976	334,430	16,722

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
2	69	ELECTROCARDIOLOGY	AGGREGATE						45,319	2
3	91	EMERGENCY	AGGREGATE				119,850	168,750	1,507,688	3
4	60	LABORATORY					125,000			4
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE						1,740	5
6	53	ANESTHESIOLOGY	AGGREGATE						1,099,685	6
7	90.01	OTTAWA CLINIC	AGGREGATE				89,580	126,068	945,771	7
200		TOTAL					334,430	294,818	3,600,203	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP- REL COSTS BLDG&FIXT 1	NEW CAP- REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,537,604	1,537,604				1
2 CAP REL COSTS-MVBLE EQUIP	3,176,350		3,176,350			2
4 EMPLOYEE BENEFITS	6,007,452	6,367	324	6,014,143		4
5 ADMINISTRATIVE & GENERAL	8,696,371	336,542	258,142	1,115,992	10,407,047	5
6 MAINTENANCE & REPAIRS	1,204,311	36,942	15,765	172,698	1,429,716	6
7 OPERATION OF PLANT	1,265,355	323,481	4,986	36,906	1,630,728	7
8 LAUNDRY & LINEN SERVICE	260,408	13,170		7,741	281,319	8
9 HOUSEKEEPING	771,443	18,116	3,092	189,974	982,625	9
10 DIETARY	583,689	48,347	28,596	137,718	798,350	10
11 CAFETERIA	6,873	11,927	482	18,856	38,138	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	751,821	10,301		206,759	968,881	13
14 CENTRAL SERVICES & SUPPLY	166,822	20,570	147,955	37,761	373,108	14
15 PHARMACY	615,451	15,791	90,719	164,533	886,494	15
16 MEDICAL RECORDS & LIBRARY	643,111	20,559	12,079	143,359	819,108	16
17 SOCIAL SERVICE	14,605			4,257	18,862	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,872,364	151,531	86,316	797,446	3,907,657	30
31 INTENSIVE CARE UNIT	880,518	27,599	98,525	248,524	1,255,166	31
43 NURSERY	133,594	19,547	19,286	36,731	209,158	43
44 SKILLED NURSING FACILITY	1,207,969	61,414	10,290	341,940	1,621,613	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,769,833	96,225	404,994	384,011	2,655,063	50
52 DELIVERY ROOM & LABOR ROOM	159,475	24,144	38,807	36,820	259,246	52
53 ANESTHESIOLOGY	143,540	2,777	95,255		241,572	53
54 RADIOLOGY-DIAGNOSTIC	2,632,331	78,405	675,264	363,564	3,749,564	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	322,030	6,911	318,952	41,198	689,091	57
58 MAGNETIC RESONANCE IMAGING (MRI)	196,797	8,046	302,518	38,488	545,849	58
60 LABORATORY	2,647,816	42,626	70,353	278,086	3,038,881	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	526,252	8,455	15,263	151,203	701,173	65
66 PHYSICAL THERAPY	1,009,706	26,646	9,974	200,763	1,247,089	66
67 OCCUPATIONAL THERAPY	236,474	21,926	555	46,903	305,858	67
68 SPEECH PATHOLOGY	51,571	3,767	46	14,960	70,344	68
68.01 AUDIOLOGY	172,140	2,352	4,936	17,659	197,087	68.01
69 ELECTROCARDIOLOGY	37,836	2,298	28,583	9,858	78,575	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	114,876	603		295	115,774	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,199,743				1,199,743	71
72 IMPL. DEV. CHARGED TO PATIENT	1,288,638				1,288,638	72
73 DRUGS CHARGED TO PATIENTS	1,243,286				1,243,286	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	78,452	14,214	18,154	21,437	132,257	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	209,886	8,730	469	58,329	277,414	90
90.01 OTTAWA CLINIC	1,142,707		92,031	187,689	1,422,427	90.01
91 EMERGENCY	996,385	42,593	21,478	248,216	1,308,672	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	609,017	19,967		165,490	794,474	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	47,584,902	1,532,889	2,874,189	5,926,164	47,190,047	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,919	2,024	250		38,193	190
192 PHYSICIANS' PRIVATE OFFICES	3,635,880		264,145		3,900,025	192
194 OTHER NONREIMBURSABLE COST	443,307	2,691	37,766	87,979	571,743	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	51,700,008	1,537,604	3,176,350	6,014,143	51,700,008	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL 5	MAINTEN- ANCE AND REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	10,407,047					5
6 MAINTENANCE & REPAIRS	360,331	1,790,047				6
7 OPERATION OF PLANT	410,992	769,057	2,810,777			7
8 LAUNDRY & LINEN SERVICE	70,901	418	44,371	397,009		8
9 HOUSEKEEPING	247,651	22,985	61,035	5,572	1,319,868	9
10 DIETARY	201,208	40,625	162,887	3,188	6,911	10
11 CAFETERIA	9,612	6,014	40,182		19,074	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	244,187	10,817	34,706			13
14 CENTRAL SERVICES & SUPPLY	94,034	91,733	69,303	2,886	15,559	14
15 PHARMACY	223,423	7,059	53,202		15,954	15
16 MEDICAL RECORDS & LIBRARY	206,440	3,411	69,267		7,187	16
17 SOCIAL SERVICE	4,754					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	984,830	93,055	510,526	131,375	399,767	30
31 INTENSIVE CARE UNIT	316,339	40,806	92,985	33,406	76,218	31
43 NURSERY	52,714	668	65,858	7,411	18,758	43
44 SKILLED NURSING FACILITY	408,695	33,121	206,913	58,796	109,272	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	669,156	147,268	324,196	34,158	52,010	50
52 DELIVERY ROOM & LABOR ROOM	65,338	35,251	81,344	7,367	9,715	52
53 ANESTHESIOLOGY	60,883	724	9,357			53
54 RADIOLOGY-DIAGNOSTIC	945,003	74,678	264,158	34,493	87,315	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	173,672	3,188	23,282	1,592	6,674	57
58 MAGNETIC RESONANCE IMAGING (MRI)	137,570	3,063	27,108	1,911		58
60 LABORATORY	765,889	47,864	143,611	426	62,119	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	176,717	23,417	28,487		20,180	65
66 PHYSICAL THERAPY	314,304	33,302	89,775	9,366	10,465	66
67 OCCUPATIONAL THERAPY	77,085	12,948	73,873	5,811	10,268	67
68 SPEECH PATHOLOGY	17,729	404	12,693			68
68.01 AUDIOLOGY	49,672	2,241	7,924		197	68.01
69 ELECTROCARDIOLOGY	19,803	3,160	7,743	1,640	1,501	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	29,179	10,859	2,031	2,508	3,475	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	302,371					71
72 IMPL. DEV. CHARGED TO PATIENT	324,775					72
73 DRUGS CHARGED TO PATIENTS	313,345					73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	33,333	26,257	47,889	4,490	10,426	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	69,917	75,806	29,411	7,853	29,697	90
90.01 OTTAWA CLINIC	358,494	46,736		5,146	34,397	90.01
91 EMERGENCY	329,825	37,144	143,503	37,124	108,679	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	200,231	8,172	67,273			101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	9,270,402	1,712,251	2,794,893	396,519	1,115,818	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,626	1,559	6,818		1,303	190
192 PHYSICIANS' PRIVATE OFFICES	982,923	73,801			198,008	192
194 OTHER NONREIMBURSABLE COST	144,096	2,436	9,066	490	4,739	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	10,407,047	1,790,047	2,810,777	397,009	1,319,868	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	1,213,169					10
11 CAFETERIA		113,020				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		4,628	1,263,219			13
14 CENTRAL SERVICES & SUPPLY		1,622		648,245		14
15 PHARMACY		2,848	48,302	462	1,237,744	15
16 MEDICAL RECORDS & LIBRARY		5,855		2		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	740,912	24,488	415,259	27,532		30
31 INTENSIVE CARE UNIT	86,855	6,329	107,337	5,813		31
43 NURSERY		870	14,759	715		43
44 SKILLED NURSING FACILITY	342,726	9,217	156,309	6,510		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	35,995	9,692	164,359	262,021		50
52 DELIVERY ROOM & LABOR ROOM		870	14,759	820		52
53 ANESTHESIOLOGY				25,791		53
54 RADIOLOGY-DIAGNOSTIC		9,375		185,981	1,302	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		910		11		57
58 MAGNETIC RESONANCE IMAGING (MRI)		791		94		58
60 LABORATORY		8,901		2,138		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		3,798	64,402	71		65
66 PHYSICAL THERAPY		4,233		103		66
67 OCCUPATIONAL THERAPY		1,147		15		67
68 SPEECH PATHOLOGY		198				68
68.01 AUDIOLOGY		396		1		68.01
69 ELECTROCARDIOLOGY		475	8,050	85		69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				112,850		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					1,222,545	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION		554	9,392	364		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,699	1,266	21,467	2,260		90
90.01 OTTAWA CLINIC				2,306	4,356	90.01
91 EMERGENCY	2,982	7,318	124,108	9,931		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		4,549	77,148	2,042		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,213,169	110,330	1,225,651	647,918	1,228,203	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES				262	6,881	192
194 OTHER NONREIMBURSABLE COST		2,690	37,568	65	2,660	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,213,169	113,020	1,263,219	648,245	1,237,744	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,111,270					16
17 SOCIAL SERVICE		23,616				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	477,845		7,713,246		7,713,246	30
31 INTENSIVE CARE UNIT	55,564		2,076,818		2,076,818	31
43 NURSERY	11,113		382,024		382,024	43
44 SKILLED NURSING FACILITY	33,338		2,986,510		2,986,510	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	166,691		4,520,609		4,520,609	50
52 DELIVERY ROOM & LABOR ROOM			474,710		474,710	52
53 ANESTHESIOLOGY			338,327		338,327	53
54 RADIOLOGY-DIAGNOSTIC			5,351,869		5,351,869	54
57 COMPUTED TOMOGRAPHY (CT) SCAN			898,420		898,420	57
58 MAGNETIC RESONANCE IMAGING (MRI)			716,386		716,386	58
60 LABORATORY			4,069,829		4,069,829	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY			1,018,245		1,018,245	65
66 PHYSICAL THERAPY			1,708,637		1,708,637	66
67 OCCUPATIONAL THERAPY			487,005		487,005	67
68 SPEECH PATHOLOGY			101,368		101,368	68
68.01 AUDIOLOGY			257,518		257,518	68.01
69 ELECTROCARDIOLOGY			121,032		121,032	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY			163,826		163,826	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,614,964		1,614,964	71
72 IMPL. DEV. CHARGED TO PATIENT			1,613,413		1,613,413	72
73 DRUGS CHARGED TO PATIENTS			2,779,176		2,779,176	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION			264,962		264,962	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			518,790		518,790	90
90.01 OTTAWA CLINIC			1,873,862		1,873,862	90.01
91 EMERGENCY	366,719		2,476,005		2,476,005	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		22,589	1,176,478		1,176,478	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,111,270	22,589	45,704,029		45,704,029	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			57,499		57,499	190
192 PHYSICIANS' PRIVATE OFFICES			5,161,900		5,161,900	192
194 OTHER NONREIMBURSABLE COST		1,027	776,580		776,580	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,111,270	23,616	51,700,008		51,700,008	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	NEW CAP-	NEW CAP-	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	REL COSTS	REL COSTS		BENEFITS	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		6,367	324	6,691	6,691	4
5 ADMINISTRATIVE & GENERAL	575,360	336,542	258,142	1,170,044	1,245	5
6 MAINTENANCE & REPAIRS		36,942	15,765	52,707	192	6
7 OPERATION OF PLANT		323,481	4,986	328,467	41	7
8 LAUNDRY & LINEN SERVICE		13,170		13,170		9
9 HOUSEKEEPING		18,116	3,092	21,208	211	9
10 DIETARY		48,347	28,596	76,943	153	10
11 CAFETERIA		11,927	482	12,409	21	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		10,301		10,301	230	13
14 CENTRAL SERVICES & SUPPLY		20,570	147,955	168,525	42	14
15 PHARMACY		15,791	90,719	106,510	183	15
16 MEDICAL RECORDS & LIBRARY		20,559	12,079	32,638	159	16
17 SOCIAL SERVICE					5	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		151,531	86,316	237,847	886	30
31 INTENSIVE CARE UNIT		27,599	98,525	126,124	276	31
43 NURSERY		19,547	19,286	38,833	41	43
44 SKILLED NURSING FACILITY		61,414	10,290	71,704	380	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		96,225	404,994	501,219	427	50
52 DELIVERY ROOM & LABOR ROOM		24,144	38,807	62,951	41	52
53 ANESTHESIOLOGY		2,777	95,255	98,032		53
54 RADIOLOGY-DIAGNOSTIC		78,405	675,264	753,669	404	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		6,911	318,952	325,863	46	57
58 MAGNETIC RESONANCE IMAGING (MRI)		8,046	302,518	310,564	43	58
60 LABORATORY		42,626	70,353	112,979	309	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		8,455	15,263	23,718	168	65
66 PHYSICAL THERAPY		26,646	9,974	36,620	223	66
67 OCCUPATIONAL THERAPY		21,926	555	22,481	52	67
68 SPEECH PATHOLOGY		3,767	46	3,813	17	68
68.01 AUDIOLOGY		2,352	4,936	7,288	20	68.01
69 ELECTROCARDIOLOGY		2,298	28,583	30,881	11	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY		603		603		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION		14,214	18,154	32,368	24	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		8,730	469	9,199	65	90
90.01 OTTAWA CLINIC						90.01
91 EMERGENCY		42,593	92,031	134,624	209	91
92 OBSERVATION BEDS			21,478	21,478	276	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		19,967		19,967	184	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	575,360	1,532,889	2,874,189	4,982,438	6,593	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,024	250	2,274		190
192 PHYSICIANS' PRIVATE OFFICES			264,145	264,145		192
194 OTHER NONREIMBURSABLE COST		2,691	37,766	40,457	98	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	575,360	1,537,604	3,176,350	5,289,314	6,691	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL 5	MAINTEN- ANCE AND REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	1,171,289					5
6 MAINTENANCE & REPAIRS	40,554	93,453				6
7 OPERATION OF PLANT	46,256	40,149	414,913			7
8 LAUNDRY & LINEN SERVICE	7,980	22	6,550	27,731		8
9 HOUSEKEEPING	27,872	1,200	9,010	389	59,890	9
10 DIETARY	22,645	2,121	24,045	223	314	10
11 CAFETERIA	1,082	314	5,931		866	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	27,482	565	5,123			13
14 CENTRAL SERVICES & SUPPLY	10,583	4,789	10,230	202	706	14
15 PHARMACY	25,145	369	7,853		724	15
16 MEDICAL RECORDS & LIBRARY	23,234	178	10,225		326	16
17 SOCIAL SERVICE	535					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	110,856	4,858	75,361	9,176	18,138	30
31 INTENSIVE CARE UNIT	35,603	2,130	13,726	2,333	3,458	31
43 NURSERY	5,933	35	9,722	518	851	43
44 SKILLED NURSING FACILITY	45,997	1,729	30,543	4,107	4,958	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	75,311	7,688	47,856	2,386	2,360	50
52 DELIVERY ROOM & LABOR ROOM	7,354	1,840	12,008	515	441	52
53 ANESTHESIOLOGY	6,852	38	1,381			53
54 RADIOLOGY-DIAGNOSTIC	106,356	3,899	38,994	2,409	3,962	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	19,546	166	3,437	111	303	57
58 MAGNETIC RESONANCE IMAGING (MRI)	15,483	160	4,002	133		58
60 LABORATORY	86,198	2,499	21,199	30	2,819	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	19,889	1,223	4,205		916	65
66 PHYSICAL THERAPY	35,374	1,739	13,252	654	475	66
67 OCCUPATIONAL THERAPY	8,676	676	10,905	406	466	67
68 SPEECH PATHOLOGY	1,995	21	1,874			68
68.01 AUDIOLOGY	5,590	117	1,170		9	68.01
69 ELECTROCARDIOLOGY	2,229	165	1,143	115	68	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	3,284	567	300	175	158	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	34,031					71
72 IMPL. DEV. CHARGED TO PATIENT	36,552					72
73 DRUGS CHARGED TO PATIENTS	35,266					73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	3,751	1,371	7,069	314	473	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	7,869	3,958	4,342	549	1,348	90
90.01 OTTAWA CLINIC	40,347	2,440		359	1,561	90.01
91 EMERGENCY	37,120	1,939	21,183	2,593	4,931	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	22,535	427	9,930			101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,043,365	89,392	412,569	27,697	50,631	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,083	81	1,006		59	190
192 PHYSICIANS' PRIVATE OFFICES	110,624	3,853			8,985	192
194 OTHER NONREIMBURSABLE COST	16,217	127	1,338	34	215	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,171,289	93,453	414,913	27,731	59,890	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	126,444					10
11 CAFETERIA		20,623				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		845	44,546			13
14 CENTRAL SERVICES & SUPPLY		296		195,373		14
15 PHARMACY		520	1,703	139	143,146	15
16 MEDICAL RECORDS & LIBRARY		1,068		1		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	77,221	4,468	14,644	8,297		30
31 INTENSIVE CARE UNIT	9,053	1,155	3,785	1,752		31
43 NURSERY		159	520	215		43
44 SKILLED NURSING FACILITY	35,721	1,682	5,512	1,962		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,752	1,769	5,796	78,985		50
52 DELIVERY ROOM & LABOR ROOM		159	520	247		52
53 ANESTHESIOLOGY				7,772		53
54 RADIOLOGY-DIAGNOSTIC		1,711		56,045	151	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		166		3		57
58 MAGNETIC RESONANCE IMAGING (MRI)		144		28		58
60 LABORATORY		1,624		644		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		693	2,271	21		65
66 PHYSICAL THERAPY		772		31		66
67 OCCUPATIONAL THERAPY		209		5		67
68 SPEECH PATHOLOGY		36				68
68.01 AUDIOLOGY		72				68.01
69 ELECTROCARDIOLOGY		87	284	26		69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				34,007		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					141,387	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION		101	331	110		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	386	231	757	681		90
90.01 OTTAWA CLINIC				695	504	90.01
91 EMERGENCY	311	1,335	4,377	2,993		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		830	2,721	615		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	126,444	20,132	43,221	195,274	142,042	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES				79	796	192
194 OTHER NONREIMBURSABLE COST		491	1,325	20	308	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	126,444	20,623	44,546	195,373	143,146	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	67,829					16
17 SOCIAL SERVICE		540				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	29,167		590,919		590,919	30
31 INTENSIVE CARE UNIT	3,391		202,786		202,786	31
43 NURSERY	678		57,505		57,505	43
44 SKILLED NURSING FACILITY	2,035		206,330		206,330	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,174		737,723		737,723	50
52 DELIVERY ROOM & LABOR ROOM			86,076		86,076	52
53 ANESTHESIOLOGY			114,075		114,075	53
54 RADIOLOGY-DIAGNOSTIC			967,600		967,600	54
57 COMPUTED TOMOGRAPHY (CT) SCAN			349,641		349,641	57
58 MAGNETIC RESONANCE IMAGING (MRI)			330,557		330,557	58
60 LABORATORY			228,301		228,301	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY			53,104		53,104	65
66 PHYSICAL THERAPY			89,140		89,140	66
67 OCCUPATIONAL THERAPY			43,876		43,876	67
68 SPEECH PATHOLOGY			7,756		7,756	68
68.01 AUDIOLOGY			14,266		14,266	68.01
69 ELECTROCARDIOLOGY			35,009		35,009	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY			5,087		5,087	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			68,038		68,038	71
72 IMPL. DEV. CHARGED TO PATIENT			36,552		36,552	72
73 DRUGS CHARGED TO PATIENTS			176,653		176,653	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION			45,912		45,912	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			29,385		29,385	90
90.01 OTTAWA CLINIC			138,146		138,146	90.01
91 EMERGENCY	22,384		163,513		163,513	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		517	57,726		57,726	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	67,829	517	4,835,676		4,835,676	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			4,503		4,503	190
192 PHYSICIANS' PRIVATE OFFICES			388,482		388,482	192
194 OTHER NONREIMBURSABLE COST		23	60,653		60,653	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	67,829	540	5,289,314		5,289,314	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP- REL COSTS MOV EQUIP DOLLAR VA OR SQ. FEE	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	285,693					1
2 CAP REL COSTS-MVBLE EQUIP		2,748,269				2
4 EMPLOYEE BENEFITS	1,183	280	20,633,694			4
5 ADMINISTRATIVE & GENERAL	62,531	223,352	3,828,812	-10,407,047	41,292,961	5
6 MAINTENANCE & REPAIRS	6,864	13,640	592,503		1,429,716	6
7 OPERATION OF PLANT	60,104	4,314	126,618		1,630,728	7
8 LAUNDRY & LINEN SERVICE	2,447		26,559		281,319	8
9 HOUSEKEEPING	3,366	2,675	651,775		982,625	9
10 DIETARY	8,983	24,742	472,491		798,350	10
11 CAFETERIA	2,216	417	64,694		38,138	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,914		709,363		968,881	13
14 CENTRAL SERVICES & SUPPLY	3,822	128,015	129,552		373,108	14
15 PHARMACY	2,934	78,493	564,490		886,494	15
16 MEDICAL RECORDS & LIBRARY	3,820	10,451	491,844		819,108	16
17 SOCIAL SERVICE			14,605		18,862	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	28,155	74,683	2,735,925		3,907,657	30
31 INTENSIVE CARE UNIT	5,128	85,247	852,652		1,255,166	31
43 NURSERY	3,632	16,687	126,019		209,158	43
44 SKILLED NURSING FACILITY	11,411	8,903	1,173,149		1,621,613	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	17,879	350,412	1,317,487		2,655,063	50
52 DELIVERY ROOM & LABOR ROOM	4,486	33,577	126,326		259,246	52
53 ANESTHESIOLOGY	516	82,417			241,572	53
54 RADIOLOGY-DIAGNOSTIC	14,568	584,260	1,247,339		3,749,564	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,284	275,966	141,345		689,091	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,495	261,747	132,047		545,849	58
60 LABORATORY	7,920	60,871	954,075		3,038,881	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	1,571	13,206	518,757		701,173	65
66 PHYSICAL THERAPY	4,951	8,630	688,790		1,247,089	66
67 OCCUPATIONAL THERAPY	4,074	480	160,918		305,858	67
68 SPEECH PATHOLOGY	700	40	51,325		70,344	68
68.01 AUDIOLOGY	437	4,271	60,585		197,087	68.01
69 ELECTROCARDIOLOGY	427	24,731	33,822		78,575	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	112		1,011		115,774	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					1,199,743	71
72 IMPL. DEV. CHARGED TO PATIENT					1,288,638	72
73 DRUGS CHARGED TO PATIENTS					1,243,286	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	2,641	15,707	73,548		132,257	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,622	406	200,120		277,414	90
90.01 OTTAWA CLINIC		79,628	643,935		1,422,427	90.01
91 EMERGENCY	7,914	18,583	851,595		1,308,672	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	3,710		567,774		794,474	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	284,817	2,486,831	20,331,850	-10,407,047	36,783,000	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	376	216			38,193	190
192 PHYSICIANS' PRIVATE OFFICES		228,546			3,900,025	192
194 OTHER NONREIMBURSABLE COST	500	32,676	301,844		571,743	194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET 1	NEW CAP- REL COSTS MOV EQUIP DOLLAR VA OR SQ. FEE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINI- STRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,537,604	3,176,350	6,014,143		10,407,047	202
203	UNIT COST MULT-WS B PT I	5.382015	1.155764	0.291472		0.252030	203
204	COST TO BE ALLOC PER B PT II			6,691		1,171,289	204
205	UNIT COST MULT-WS B PT II			0.000324		0.028365	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTEN- ANCE AND REPAIRS MAINTENANC HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	128,576					6
7 OPERATION OF PLANT	55,240	155,011				7
8 LAUNDRY & LINEN SERVICE	30	2,447	99,745			8
9 HOUSEKEEPING	1,651	3,366	1,400	33,422		9
10 DIETARY	2,918	8,983	801	175	52,477	10
11 CAFETERIA	432	2,216		483		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	777	1,914				13
14 CENTRAL SERVICES & SUPPLY	6,589	3,822	725	394		14
15 PHARMACY	507	2,934		404		15
16 MEDICAL RECORDS & LIBRARY	245	3,820		182		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,684	28,155	33,007	10,123	32,049	30
31 INTENSIVE CARE UNIT	2,931	5,128	8,393	1,930	3,757	31
43 NURSERY	3	3,632	1,862	475		43
44 SKILLED NURSING FACILITY	2,379	11,411	14,772	2,767	14,825	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,578	17,879	8,582	1,317	1,557	50
52 DELIVERY ROOM & LABOR ROOM	2,532	4,486	1,851	246		52
53 ANESTHESIOLOGY	52	516				53
54 RADIOLOGY-DIAGNOSTIC	5,364	14,568	8,666	2,211		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	229	1,284	400	169		57
58 MAGNETIC RESONANCE IMAGING (MRI)	220	1,495	480			58
60 LABORATORY	3,438	7,920	107	1,573		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	1,682	1,571		511		65
66 PHYSICAL THERAPY	2,392	4,951	2,353	265		66
67 OCCUPATIONAL THERAPY	930	4,074	1,460	260		67
68 SPEECH PATHOLOGY	29	700				68
68.01 AUDIOLOGY	161	437		5		68.01
69 ELECTROCARDIOLOGY	227	427	412	38		69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	780	112	630	88		70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	1,886	2,641	1,128	264		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	5,445	1,622	1,973	752	160	90
90.01 OTTAWA CLINIC	3,357		1,293	871		90.01
91 EMERGENCY	2,668	7,914	9,327	2,752	129	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	587	3,710				101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	122,988	154,135	99,622	28,255	52,477	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	112	376		33		190
192 PHYSICIANS' PRIVATE OFFICES	5,301			5,014		192
194 OTHER NONREIMBURSABLE COST	175	500	123	120		194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAINTEN- ANCE AND REPAIRS MAINTENANC HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,790,047	2,810,777	397,009	1,319,868	1,213,169	202
203	UNIT COST MULT-WS B PT I	13.922093	18.132758	3.980240	39.490994	23.118109	203
204	COST TO BE ALLOC PER B PT II	93,453	414,913	27,731	59,890	126,444	204
205	UNIT COST MULT-WS B PT II	0.726831	2.676668	0.278019	1.791933	2.409513	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL		
	DIRECT HO OF SERVICE 11	ADMINI- STRATION (DIRECT NRSG HRS) 13	& SUPPLY (COSTED REQUIS) 14	(COSTED REQUIS) 15	RECORDS & LIBRARY (TIME SPENT) 16		
GENERAL SERVICE COST CENTERS							
1 CAP REL COSTS-BLDG & FIXT							1
2 CAP REL COSTS-MVBLE EQUIP							2
4 EMPLOYEE BENEFITS							4
5 ADMINISTRATIVE & GENERAL							5
6 MAINTENANCE & REPAIRS							6
7 OPERATION OF PLANT							7
8 LAUNDRY & LINEN SERVICE							8
9 HOUSEKEEPING							9
10 DIETARY							10
11 CAFETERIA	2,857						11
12 MAINTENANCE OF PERSONNEL							12
13 NURSING ADMINISTRATION	117	1,883					13
14 CENTRAL SERVICES & SUPPLY	41		198,736,799				14
15 PHARMACY	72	72	141,611	125,874,312			15
16 MEDICAL RECORDS & LIBRARY	148		763		100		16
17 SOCIAL SERVICE							17
19 NONPHYSICIAN ANESTHETISTS							19
20 NURSING SCHOOL							20
21 I&R SRVCES-SALARY & FRINGES APPRVD							21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD							22
23 PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS							
30 ADULTS & PEDIATRICS	619	619	8,440,364		43		30
31 INTENSIVE CARE UNIT	160	160	1,782,045		5		31
43 NURSERY	22	22	219,146		1		43
44 SKILLED NURSING FACILITY	233	233	1,995,701		3		44
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	245	245	80,336,103		15		50
52 DELIVERY ROOM & LABOR ROOM	22	22	251,267				52
53 ANESTHESIOLOGY			7,906,410				53
54 RADIOLOGY-DIAGNOSTIC	237		57,014,487	132,412			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	23		3,302				57
58 MAGNETIC RESONANCE IMAGING (MRI)	20		28,768				58
60 LABORATORY	225		655,287				60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS							62.30
65 RESPIRATORY THERAPY	96	96	21,613				65
66 PHYSICAL THERAPY	107		31,503				66
67 OCCUPATIONAL THERAPY	29		4,746				67
68 SPEECH PATHOLOGY	5						68
68.01 AUDIOLOGY	10		195				68.01
69 ELECTROCARDIOLOGY	12	12	26,107				69
69.01 CARDIAC REHAB							69.01
70 ELECTROENCEPHALOGRAPHY							70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			34,595,449				71
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS				124,328,610			73
73.01 ONCOLOGY							73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY							76
76.97 CARDIAC REHABILITATION	14	14	111,493				76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	32	32	692,861				90
90.01 OTTAWA CLINIC			707,029	443,000			90.01
91 EMERGENCY	185	185	3,044,360		33		91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
99.10 CORF							99.10
99.20 OUTPATIENT PHYSICAL THERAPY							99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40 OUTPATIENT SPEECH PATHOLOGY							99.40
101 HOME HEALTH AGENCY	115	115	625,870				101
SPECIAL PURPOSE COST CENTERS							
118 SUBTOTALS (SUM OF LINES 1-117)	2,789	1,827	198,636,480	124,904,022	100		118
NONREIMBURSABLE COST CENTERS							
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192 PHYSICIANS' PRIVATE OFFICES			80,362	699,810			192
194 OTHER NONREIMBURSABLE COST	68	56	19,957	270,480			194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAFETERIA DIRECT HO OF SERVICE 11	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	113,020	1,263,219	648,245	1,237,744	1,111,270	202
203	UNIT COST MULT-WS B PT I	39.558978	670.854488	0.003262	0.009833	11,112.700000	203
204	COST TO BE ALLOC PER B PT II	20,623	44,546	195,373	143,146	67,829	204
205	UNIT COST MULT-WS B PT II	7.218411	23.656930	0.000983	0.001137	678.290000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	(TIME SPENT)	
		17	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE	690		17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS			30
31 INTENSIVE CARE UNIT			31
43 NURSERY			43
44 SKILLED NURSING FACILITY			44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
52 DELIVERY ROOM & LABOR ROOM			52
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC			54
57 COMPUTED TOMOGRAPHY (CT) SCAN			57
58 MAGNETIC RESONANCE IMAGING (MRI)			58
60 LABORATORY			60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS			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
69.01 CARDIAC REHAB			69.01
70 ELECTROENCEPHALOGRAPHY			70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS			73
73.01 ONCOLOGY			73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY			76
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
90.01 OTTAWA CLINIC			90.01
91 EMERGENCY			91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
101 HOME HEALTH AGENCY	660		101
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	660		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
192 PHYSICIANS' PRIVATE OFFICES			192
194 OTHER NONREIMBURSABLE COST	30		194

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		SOCIAL SERVICE	
		(TIME SPENT)	
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	23,616	202
203	UNIT COST MULT-WS B PT I	34.226087	203
204	COST TO BE ALLOC PER B PT II	540	204
205	UNIT COST MULT-WS B PT II	0.782609	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,713,246		7,713,246		7,713,246	30
31 INTENSIVE CARE UNIT	2,076,818		2,076,818		2,076,818	31
43 NURSERY	382,024		382,024		382,024	43
44 SKILLED NURSING FACILITY	2,986,510		2,986,510		2,986,510	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,520,609		4,520,609		4,520,609	50
52 DELIVERY ROOM & LABOR ROOM	474,710		474,710		474,710	52
53 ANESTHESIOLOGY	338,327		338,327		338,327	53
54 RADIOLOGY-DIAGNOSTIC	5,351,869		5,351,869		5,351,869	54
57 COMPUTED TOMOGRAPHY (CT) SC	898,420		898,420		898,420	57
58 MAGNETIC RESONANCE IMAGING	716,386		716,386		716,386	58
60 LABORATORY	4,069,829		4,069,829		4,069,829	60
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	1,018,245		1,018,245		1,018,245	65
66 PHYSICAL THERAPY	1,708,637		1,708,637		1,708,637	66
67 OCCUPATIONAL THERAPY	487,005		487,005		487,005	67
68 SPEECH PATHOLOGY	101,368		101,368		101,368	68
68.01 AUDIOLOGY	257,518		257,518		257,518	68.01
69 ELECTROCARDIOLOGY	121,032		121,032		121,032	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	163,826		163,826		163,826	70
71 MEDICAL SUPPLIES CHRGED TO	1,614,964		1,614,964		1,614,964	71
72 IMPL. DEV. CHARGED TO PATIE	1,613,413		1,613,413		1,613,413	72
73 DRUGS CHARGED TO PATIENTS	2,779,176		2,779,176		2,779,176	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DE						76
76.97 CARDIAC REHABILITATION	264,962		264,962		264,962	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	518,790		518,790		518,790	90
90.01 OTTAWA CLINIC	1,873,862		1,873,862	126,068	1,999,930	90.01
91 EMERGENCY	2,476,005		2,476,005	168,750	2,644,755	91
92 OBSERVATION BEDS	1,107,490		1,107,490		1,107,490	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,176,478		1,176,478		1,176,478	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	46,811,519		46,811,519	294,818	47,106,337	200
201 LESS OBSERVATION BEDS	1,107,490		1,107,490		1,107,490	201
202 TOTAL (SEE INSTRUCTIONS)	45,704,029		45,704,029	294,818	45,998,847	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	8,054,546		8,054,546			30
31 INTENSIVE CARE UNIT	2,628,718		2,628,718			31
43 NURSERY	548,406		548,406			43
44 SKILLED NURSING FACILITY	1,854,925		1,854,925			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,458,487	14,636,644	20,095,131	0.224960	0.224960	0.224960 50
52 DELIVERY ROOM & LABOR ROOM	251,210	193,291	444,501	1.067962	1.067962	1.067962 52
53 ANESTHESIOLOGY	1,294,240	2,243,689	3,537,929	0.095629	0.095629	0.095629 53
54 RADIOLOGY-DIAGNOSTIC	5,397,838	19,598,958	24,996,796	0.214102	0.214102	0.214102 54
57 COMPUTED TOMOGRAPHY (CT) SC	2,456,676	9,298,855	11,755,531	0.076425	0.076425	0.076425 57
58 MAGNETIC RESONANCE IMAGING	169,762	4,293,558	4,463,320	0.160505	0.160505	0.160505 58
60 LABORATORY	6,221,520	14,362,557	20,584,077	0.197717	0.197717	0.197717 60
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	2,021,027	264,512	2,285,539	0.445516	0.445516	0.445516 65
66 PHYSICAL THERAPY	1,040,846	2,470,450	3,511,296	0.486611	0.486611	0.486611 66
67 OCCUPATIONAL THERAPY	383,020	1,155,218	1,538,238	0.316599	0.316599	0.316599 67
68 SPEECH PATHOLOGY	90,800	182,947	273,747	0.370298	0.370298	0.370298 68
68.01 AUDIOLOGY	242	208,273	208,515	1.235009	1.235009	1.235009 68.01
69 ELECTROCARDIOLOGY	465,703	1,007,484	1,473,187	0.082157	0.082157	0.082157 69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	4,320	471,509	475,829	0.344296	0.344296	0.344296 70
71 MEDICAL SUPPLIES CHRGED TO	3,546,938	2,769,781	6,316,719	0.255665	0.255665	0.255665 71
72 IMPL. DEV. CHARGED TO PATIE	2,054,511	728,223	2,782,734	0.579794	0.579794	0.579794 72
73 DRUGS CHARGED TO PATIENTS	10,244,059	3,973,484	14,217,543	0.195475	0.195475	0.195475 73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DE						76
76.97 CARDIAC REHABILITATION	1,458	396,396	397,854	0.665978	0.665978	0.665978 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	271,377	1,894,285	2,165,662	0.239553	0.239553	0.239553 90
90.01 OTTAWA CLINIC		2,075,812	2,075,812	0.902713	0.902713	0.963445 90.01
91 EMERGENCY	1,910,717	6,241,807	8,152,524	0.303710	0.303710	0.324409 91
92 OBSERVATION BEDS	127,762	3,329,467	3,457,229	0.320340	0.320340	0.320340 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		887,546	887,546			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	56,499,108	92,684,746	149,183,854			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	56,499,108	92,684,746	149,183,854			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED ADJUSTMENT	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26) 1	2	(COL.1 MINUS COL.2) 3	4	(COL.3 ÷ COL.4) 5	6	(COL.5 x COL.6) 7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	590,919		590,919	10,029	58.92	6,323	372,551	30
31 INTENSIVE CARE UNIT	202,786		202,786	1,265	160.31	759	121,675	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	57,505		57,505	511	112.53			43
44 SKILLED NURSING FACILITY	206,330		206,330	4,941	41.76	4,486	187,335	44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,057,540		1,057,540	16,746		11,568	681,561	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0026) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL (COL. 3 x COL. 4)	
	(FROM WKST B, PT. II, COL. 26)	(FROM WKST C, PT. I, COL. 8)	(COL. 1 + COL. 2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	737,723	20,095,131	0.036712	4,123,148	151,369	50
52 DELIVERY ROOM & LABOR ROOM	86,076	444,501	0.193646			52
53 ANESTHESIOLOGY	114,075	3,537,929	0.032243	717,902	23,147	53
54 RADIOLOGY-DIAGNOSTIC	967,600	24,996,796	0.038709	2,887,479	111,771	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	349,641	11,755,531	0.029743	1,845,727	54,897	57
58 MAGNETIC RESONANCE IMAGING (M	330,557	4,463,320	0.074061	118,406	8,769	58
60 LABORATORY	228,301	20,584,077	0.011091	4,309,066	47,792	60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY	53,104	2,285,539	0.023235	1,209,450	28,102	65
66 PHYSICAL THERAPY	89,140	3,511,296	0.025387	344,910	8,756	66
67 OCCUPATIONAL THERAPY	43,876	1,538,238	0.028524	97,695	2,787	67
68 SPEECH PATHOLOGY	7,756	273,747	0.028333	31,880	903	68
68.01 AUDIOLOGY	14,266	208,515	0.068417	66	5	68.01
69 ELECTROCARDIOLOGY	35,009	1,473,187	0.023764	385,220	9,154	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	5,087	475,829	0.010691	4,320	46	70
71 MEDICAL SUPPLIES CHRGD TO PA	68,038	6,316,719	0.010771	2,329,038	25,086	71
72 IMPL. DEV. CHARGED TO PATIENT	36,552	2,782,734	0.013135	1,542,779	20,264	72
73 DRUGS CHARGED TO PATIENTS	176,653	14,217,543	0.012425	6,328,635	78,633	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPE						76
76.97 CARDIAC REHABILITATION	45,912	397,854	0.115399	1,458	168	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	29,385	2,165,662	0.013569	10,024	136	90
90.01 OTTAWA CLINIC	138,146	2,075,812	0.066550			90.01
91 EMERGENCY	163,513	8,152,524	0.020057	1,566,400	31,417	91
92 OBSERVATION BEDS	84,846	3,457,229	0.024542	127,762	3,136	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	3,805,256	135,209,713	135,209,713	27,981,365	606,338	200

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

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

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	10,029		6,323		30
31 INTENSIVE CARE UNIT	1,265		759		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	511				43
44 SKILLED NURSING FACILITY	4,941		4,486		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	16,746		11,568		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FACTORS ADMIN						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
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPE						76
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
90.01 OTTAWA CLINIC						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (14-0026)	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	20,095,131		4,123,148		6,850,577	50
52	DELIVERY ROOM & LABOR ROOM	444,501				102	52
53	ANESTHESIOLOGY	3,537,929		717,902		793,358	53
54	RADIOLOGY-DIAGNOSTIC	24,996,796		2,887,479		7,188,038	54
57	COMPUTED TOMOGRAPHY (CT) SCA	11,755,531		1,845,727		3,540,762	57
58	MAGNETIC RESONANCE IMAGING (4,463,320		118,406		1,123,059	58
60	LABORATORY	20,584,077		4,309,066		634,804	60
62.30	BLOOD CLOTTING FACTORS ADMIN						62.30
65	RESPIRATORY THERAPY	2,285,539		1,209,450		93,059	65
66	PHYSICAL THERAPY	3,511,296		344,910		12,924	66
67	OCCUPATIONAL THERAPY	1,538,238		97,695			67
68	SPEECH PATHOLOGY	273,747		31,880			68
68.01	AUDIOLOGY	208,515		66		36,602	68.01
69	ELECTROCARDIOLOGY	1,473,187		385,220		471,166	69
69.01	CARDIAC REHAB						69.01
70	ELECTROENCEPHALOGRAPHY	475,829		4,320		102,526	70
71	MEDICAL SUPPLIES CHRGED TO P	6,316,719		2,329,038		992,067	71
72	IMPL. DEV. CHARGED TO PATIEN	2,782,734		1,542,779		728,223	72
73	DRUGS CHARGED TO PATIENTS	14,217,543		6,328,635		2,248,654	73
73.01	ONCOLOGY						73.01
76	OTHER ANCILLARY CHEMICAL DEP						76
76.97	CARDIAC REHABILITATION	397,854		1,458		266,763	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,165,662		10,024		270,542	90
90.01	OTTAWA CLINIC	2,075,812				89,682	90.01
91	EMERGENCY	8,152,524		1,566,400		1,213,531	91
92	OBSERVATION BEDS	3,457,229		127,762		620,051	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	135,209,713		27,981,365		27,276,490	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.224960	6,850,577			1,541,106		50
52 DELIVERY ROOM & LABOR ROOM	1.067962	102			109		52
53 ANESTHESIOLOGY	0.095629	793,358			75,868		53
54 RADIOLOGY-DIAGNOSTIC	0.214102	7,188,038	818		1,538,973	175	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076425	3,540,762			270,603		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.160505	1,123,059			180,257		58
60 LABORATORY	0.197717	634,804		-720	125,512	-142	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.445516	93,059			41,459		65
66 PHYSICAL THERAPY	0.486611	12,924	-1,635		6,289	-796	66
67 OCCUPATIONAL THERAPY	0.316599						67
68 SPEECH PATHOLOGY	0.370298						68
68.01 AUDIOLOGY	1.235009	36,602			45,204		68.01
69 ELECTROCARDIOLOGY	0.082157	471,166			38,710		69
69.01 CARDIAC REHAB							69.01
70 ELECTROENCEPHALOGRAPHY	0.344296	102,526			35,299		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.255665	992,067	2,224		253,637	569	71
72 IMPL. DEV. CHARGED TO PATIENT	0.579794	728,223			422,219		72
73 DRUGS CHARGED TO PATIENTS	0.195475	2,248,654		7,223	439,556		1,412 73
73.01 ONCOLOGY							73.01
76 OTHER ANCILLARY CHEMICAL DEPEND							76
76.97 CARDIAC REHABILITATION	0.665978	266,763			177,658		76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.239553	270,542			64,809		90
90.01 OTTAWA CLINIC	0.902713	89,682			80,957		90.01
91 EMERGENCY	0.303710	1,213,531			368,562		91
92 OBSERVATION BEDS	0.320340	620,051			198,627		92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		27,276,490	687	7,223	5,905,414	-194	1,412 200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		27,276,490	687	7,223	5,905,414	-194	1,412 202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5594) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FACTORS ADMIN						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
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPE						76
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
90.01 OTTAWA CLINIC						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [XX] SNF (14-5594) [] NF	[] ICF/MR	[] PPS [] TEFRA						
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)				
	7	8	9	10	11	12	13				
ANCILLARY SERVICE COST CENTERS											
50	OPERATING ROOM	20,095,131			5,121						50
52	DELIVERY ROOM & LABOR ROOM	444,501									52
53	ANESTHESIOLOGY	3,537,929			1,004						53
54	RADIOLOGY-DIAGNOSTIC	24,996,796			116,197						54
57	COMPUTED TOMOGRAPHY (CT) SCA	11,755,531			2,522						57
58	MAGNETIC RESONANCE IMAGING (4,463,320									58
60	LABORATORY	20,584,077			500,275						60
62.30	BLOOD CLOTTING FACTORS ADMIN										62.30
65	RESPIRATORY THERAPY	2,285,539			497,292						65
66	PHYSICAL THERAPY	3,511,296			537,235						66
67	OCCUPATIONAL THERAPY	1,538,238			227,385						67
68	SPEECH PATHOLOGY	273,747			47,600						68
68.01	AUDIOLOGY	208,515									68.01
69	ELECTROCARDIOLOGY	1,473,187			13,633						69
69.01	CARDIAC REHAB										69.01
70	ELECTROENCEPHALOGRAPHY	475,829									70
71	MEDICAL SUPPLIES CHRGD TO P	6,316,719			351,574						71
72	IMPL. DEV. CHARGED TO PATIEN	2,782,734									72
73	DRUGS CHARGED TO PATIENTS	14,217,543			1,724,242						73
73.01	ONCOLOGY										73.01
76	OTHER ANCILLARY CHEMICAL DEP										76
76.97	CARDIAC REHABILITATION	397,854									76.97
76.98	HYPERBARIC OXYGEN THERAPY										76.98
76.99	LITHOTRIPSY										76.99
OUTPATIENT SERVICE COST CENTERS											
90	CLINIC	2,165,662									90
90.01	OTTAWA CLINIC	2,075,812									90.01
91	EMERGENCY	8,152,524									91
92	OBSERVATION BEDS	3,457,229									92
OTHER REIMBURSABLE COST CENTERS											
200	TOTAL (SUM OF LINES 50-199)	135,209,713			4,024,080						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [XX] SNF (14-5594) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.224960						50
52 DELIVERY ROOM & LABOR ROOM	1.067962						52
53 ANESTHESIOLOGY	0.095629						53
54 RADIOLOGY-DIAGNOSTIC	0.214102						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076425						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.160505						58
60 LABORATORY	0.197717						60
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.445516						65
66 PHYSICAL THERAPY	0.486611						66
67 OCCUPATIONAL THERAPY	0.316599						67
68 SPEECH PATHOLOGY	0.370298						68
68.01 AUDIOLOGY	1.235009						68.01
69 ELECTROCARDIOLOGY	0.082157						69
69.01 CARDIAC REHAB							69.01
70 ELECTROENCEPHALOGRAPHY	0.344296						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.255665						71
72 IMPL. DEV. CHARGED TO PATIENT	0.579794						72
73 DRUGS CHARGED TO PATIENTS	0.195475			3,523		689	73
73.01 ONCOLOGY							73.01
76 OTHER ANCILLARY CHEMICAL DEPEND							76
76.97 CARDIAC REHABILITATION	0.665978						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.239553						90
90.01 OTTAWA CLINIC	0.902713						90.01
91 EMERGENCY	0.303710						91
92 OBSERVATION BEDS	0.320340						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)				3,523		689	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)				3,523		689	202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3		5		7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	590,919		590,919	10,029	58.92	873	51,437	30
31 INTENSIVE CARE UNIT	202,786		202,786	1,265	160.31	45	7,214	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	57,505		57,505	511	112.53	243	27,345	43
44 SKILLED NURSING FACILITY	206,330		206,330	4,941	41.76			44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,057,540		1,057,540	16,746		1,161	85,996	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0026) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL
	(FROM WKST B, PT. II, COL. 26)	(FROM WKST C, PT. I, COL. 8)	(COL.1 + COL.2)		(COL.3 x COL.4)
	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	737,723	20,095,131	0.036712		50
52 DELIVERY ROOM & LABOR ROOM	86,076	444,501	0.193646		52
53 ANESTHESIOLOGY	114,075	3,537,929	0.032243		53
54 RADIOLOGY-DIAGNOSTIC	967,600	24,996,796	0.038709		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	349,641	11,755,531	0.029743		57
58 MAGNETIC RESONANCE IMAGING (M	330,557	4,463,320	0.074061		58
60 LABORATORY	228,301	20,584,077	0.011091		60
62.30 BLOOD CLOTTING FACTORS ADMIN					62.30
65 RESPIRATORY THERAPY	53,104	2,285,539	0.023235		65
66 PHYSICAL THERAPY	89,140	3,511,296	0.025387		66
67 OCCUPATIONAL THERAPY	43,876	1,538,238	0.028524		67
68 SPEECH PATHOLOGY	7,756	273,747	0.028333		68
68.01 AUDIOLOGY	14,266	208,515	0.068417		68.01
69 ELECTROCARDIOLOGY	35,009	1,473,187	0.023764		69
69.01 CARDIAC REHAB					69.01
70 ELECTROENCEPHALOGRAPHY	5,087	475,829	0.010691		70
71 MEDICAL SUPPLIES CHRGD TO PA	68,038	6,316,719	0.010771		71
72 IMPL. DEV. CHARGED TO PATIENT	36,552	2,782,734	0.013135		72
73 DRUGS CHARGED TO PATIENTS	176,653	14,217,543	0.012425		73
73.01 ONCOLOGY					73.01
76 OTHER ANCILLARY CHEMICAL DEPE					76
76.97 CARDIAC REHABILITATION	45,912	397,854	0.115399		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	29,385	2,165,662	0.013569		90
90.01 OTTAWA CLINIC	138,146	2,075,812	0.066550		90.01
91 EMERGENCY	163,513	8,152,524	0.020057		91
92 OBSERVATION BEDS		3,457,229	3,457,229		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	3,720,410	135,209,713	135,209,713		200

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
 01/24/2012 09:19

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
 01/24/2012 09:19

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	10,029		873		30
31 INTENSIVE CARE UNIT	1,265		45		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	511		243		43
44 SKILLED NURSING FACILITY	4,941				44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	16,746		1,161		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FACTORS ADMIN						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
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPE						76
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
90.01 OTTAWA CLINIC						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-0026)	[]	SUB (OTHER)	[]	ICF/MR	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[]	OTHER
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM			
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU			
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS			
	C, PT. I,	(COL. 5 ÷	(COL. 6 ÷	CHARGES	(COL. 8 x		(COL. 9 x			
	COL. 8)	COL. 7)	COL. 7)		COL. 10)		COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM	20,095,131						50		
52	DELIVERY ROOM & LABOR ROOM	444,501						52		
53	ANESTHESIOLOGY	3,537,929						53		
54	RADIOLOGY-DIAGNOSTIC	24,996,796						54		
57	COMPUTED TOMOGRAPHY (CT) SCA	11,755,531						57		
58	MAGNETIC RESONANCE IMAGING (4,463,320						58		
60	LABORATORY	20,584,077						60		
62.30	BLOOD CLOTTING FACTORS ADMIN							62.30		
65	RESPIRATORY THERAPY	2,285,539						65		
66	PHYSICAL THERAPY	3,511,296						66		
67	OCCUPATIONAL THERAPY	1,538,238						67		
68	SPEECH PATHOLOGY	273,747						68		
68.01	AUDIOLOGY	208,515						68.01		
69	ELECTROCARDIOLOGY	1,473,187						69		
69.01	CARDIAC REHAB							69.01		
70	ELECTROENCEPHALOGRAPHY	475,829						70		
71	MEDICAL SUPPLIES CHRGD TO P	6,316,719						71		
72	IMPL. DEV. CHARGED TO PATIEN	2,782,734						72		
73	DRUGS CHARGED TO PATIENTS	14,217,543						73		
73.01	ONCOLOGY							73.01		
76	OTHER ANCILLARY CHEMICAL DEP							76		
76.97	CARDIAC REHABILITATION	397,854						76.97		
76.98	HYPERBARIC OXYGEN THERAPY							76.98		
76.99	LITHOTRIPSY							76.99		
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC	2,165,662						90		
90.01	OTTAWA CLINIC	2,075,812						90.01		
91	EMERGENCY	8,152,524						91		
92	OBSERVATION BEDS	3,457,229						92		
OTHER REIMBURSABLE COST CENTERS										
200	TOTAL (SUM OF LINES 50-199)	135,209,713						200		

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.224960						50
52 DELIVERY ROOM & LABOR ROOM	1.067962						52
53 ANESTHESIOLOGY	0.095629						53
54 RADIOLOGY-DIAGNOSTIC	0.214102						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076425						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.160505						58
60 LABORATORY	0.197717						60
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.445516						65
66 PHYSICAL THERAPY	0.486611						66
67 OCCUPATIONAL THERAPY	0.316599						67
68 SPEECH PATHOLOGY	0.370298						68
68.01 AUDIOLOGY	1.235009						68.01
69 ELECTROCARDIOLOGY	0.082157						69
69.01 CARDIAC REHAB							69.01
70 ELECTROENCEPHALOGRAPHY	0.344296						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.255665						71
72 IMPL. DEV. CHARGED TO PATIENT	0.579794						72
73 DRUGS CHARGED TO PATIENTS	0.195475						73
73.01 ONCOLOGY							73.01
76 OTHER ANCILLARY CHEMICAL DEPEND							76
76.97 CARDIAC REHABILITATION	0.665978						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.239553						90
90.01 OTTAWA CLINIC	0.902713						90.01
91 EMERGENCY	0.303710						91
92 OBSERVATION BEDS	0.320340						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	10,029	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,029	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	24	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,005	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	6,323	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	7,713,246	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,713,246	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,098,740	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	22,560	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,076,180	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.952401	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	940.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	807.21	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	132.79	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	126.47	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	3,035	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	7,710,211	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0026) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 769.09 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 4,862,956 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) 4,862,956 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42

43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	2,076,818	1,265	1,641.75	759	1,246,088	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					6,688,561	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					12,797,605	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 494,226 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 606,338 51
 52 TOTAL PROGRAM EXCLUDABLE COST 1,100,564 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 11,697,041 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,440 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 769.09 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,107,490 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	590,919	7,713,246	0.076611	1,107,490	84,846	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5594) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,941	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,941	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	97	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,844	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,486	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,986,510	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,986,510	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,854,925	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	38,800	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,816,125	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1.610044	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	400.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	374.92	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	25.08	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	40.38	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	3,917	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,982,593	37

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/24/2012 09:19

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5594) [] TEFRA
BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,982,593	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	603.64	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	2,707,929	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	2,707,929	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	2,707,929	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	1,125,875	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	3,833,804	86

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	10,029	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,029	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	24	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,005	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	873	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	511	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	243	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	7,713,246	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,713,246	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,098,740	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	22,560	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,076,180	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.952401	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	940.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	807.21	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	132.79	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	126.47	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	3,035	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	7,710,211	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[XX]	HOSPITAL (14-0026)	[]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF			[]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[]	IRF			[]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)				769.09	38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)				671,416	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)				671,416	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)	382,024	511	747.60	243	181,667 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	2,076,818	1,265	1,641.75	45	73,879 43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					926,962 49

PASS-THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					85,996 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					85,996 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					840,966 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)				1,440	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

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		5,900,440		30
31 INTENSIVE CARE UNIT		1,551,029		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.224960	4,123,148	927,543	50
52 DELIVERY ROOM & LABOR ROOM	1.067962			52
53 ANESTHESIOLOGY	0.095629	717,902	68,652	53
54 RADIOLOGY-DIAGNOSTIC	0.214102	2,887,479	618,215	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076425	1,845,727	141,060	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.160505	118,406	19,005	58
60 LABORATORY	0.197717	4,309,066	851,976	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.445516	1,209,450	538,829	65
66 PHYSICAL THERAPY	0.486611	344,910	167,837	66
67 OCCUPATIONAL THERAPY	0.316599	97,695	30,930	67
68 SPEECH PATHOLOGY	0.370298	31,880	11,805	68
68.01 AUDIOLOGY	1.235009	66	82	68.01
69 ELECTROCARDIOLOGY	0.082157	385,220	31,649	69
69.01 CARDIAC REHAB				69.01
70 ELECTROENCEPHALOGRAPHY	0.344296	4,320	1,487	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.255665	2,329,038	595,454	71
72 IMPL. DEV. CHARGED TO PATIENT	0.579794	1,542,779	894,494	72
73 DRUGS CHARGED TO PATIENTS	0.195475	6,328,635	1,237,090	73
73.01 ONCOLOGY				73.01
76 OTHER ANCILLARY CHEMICAL DEPEND				76
76.97 CARDIAC REHABILITATION	0.665978	1,458	971	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.239553	10,024	2,401	90
90.01 OTTAWA CLINIC	0.963445			90.01
91 EMERGENCY	0.324409	1,566,400	508,154	91
92 OBSERVATION BEDS	0.320340	127,762	40,927	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		27,981,365	6,688,561	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		27,981,365		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5594) [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.224960	5,121	1,152	50
52 DELIVERY ROOM & LABOR ROOM	1.067962			52
53 ANESTHESIOLOGY	0.095629	1,004	96	53
54 RADIOLOGY-DIAGNOSTIC	0.214102	116,197	24,878	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076425	2,522	193	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.160505			58
60 LABORATORY	0.197717	500,275	98,913	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.445516	497,292	221,552	65
66 PHYSICAL THERAPY	0.486611	537,235	261,424	66
67 OCCUPATIONAL THERAPY	0.316599	227,385	71,990	67
68 SPEECH PATHOLOGY	0.370298	47,600	17,626	68
68.01 AUDIOLOGY	1.235009			68.01
69 ELECTROCARDIOLOGY	0.082157	13,633	1,120	69
69.01 CARDIAC REHAB				69.01
70 ELECTROENCEPHALOGRAPHY	0.344296			70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.255665	351,574	89,885	71
72 IMPL. DEV. CHARGED TO PATIENT	0.579794			72
73 DRUGS CHARGED TO PATIENTS	0.195475	1,724,242	337,046	73
73.01 ONCOLOGY				73.01
76 OTHER ANCILLARY CHEMICAL DEPEND				76
76.97 CARDIAC REHABILITATION	0.665978			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.239553			90
90.01 OTTAWA CLINIC	0.902713			90.01
91 EMERGENCY	0.303710			91
92 OBSERVATION BEDS	0.320340			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,024,080	1,125,875	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,024,080		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0026) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.224960			50
52 DELIVERY ROOM & LABOR ROOM	1.067962			52
53 ANESTHESIOLOGY	0.095629			53
54 RADIOLOGY-DIAGNOSTIC	0.214102			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076425			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.160505			58
60 LABORATORY	0.197717			60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.445516			65
66 PHYSICAL THERAPY	0.486611			66
67 OCCUPATIONAL THERAPY	0.316599			67
68 SPEECH PATHOLOGY	0.370298			68
68.01 AUDIOLOGY	1.235009			68.01
69 ELECTROCARDIOLOGY	0.082157			69
69.01 CARDIAC REHAB				69.01
70 ELECTROENCEPHALOGRAPHY	0.344296			70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.255665			71
72 IMPL. DEV. CHARGED TO PATIENT	0.579794			72
73 DRUGS CHARGED TO PATIENTS	0.195475			73
73.01 ONCOLOGY				73.01
76 OTHER ANCILLARY CHEMICAL DEPEND				76
76.97 CARDIAC REHABILITATION	0.665978			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.239553			90
90.01 OTTAWA CLINIC	0.963445			90.01
91 EMERGENCY	0.324409			91
92 OBSERVATION BEDS	0.320340			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (14-0026)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	9,263,768	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	484,164	2
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	93.05	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)		30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)		31
32	SUM OF LINES 30 AND 31		32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)		34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	9,747,932	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	12,784,629	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	12,025,455	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	806,145	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0026)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	12,831,600	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	12,831,600	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1,159,520	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	19,514	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	224,014	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	156,810	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	134,447	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	11,809,376	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	11,809,376	71
72	INTERIM PAYMENTS	11,783,723	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	25,653	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

CHECK APPLICABLE BOX: [] HOSPITAL [] IPF [] IRF
 [] SUB (OTHER) [XX] SNF (14-5594)

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	689	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	689	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	3,523	12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)	3,523	14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	3,523	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	2,834	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)	689	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	689	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)	689	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	689	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	689	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	689	40
41	INTERIM PAYMENTS	945	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-256	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
 01/24/2012 09:19

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0026) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		11,783,723		4,340,432	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		11,783,723		4,340,432	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM		-11,783,723	-434,982	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				3,905,450	7

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (14-5594)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,331,841		945
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,331,841		945

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM			6.01 -256 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,331,841		689

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

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK
APPLICABLE BOX

HOSPITAL (14-0026) CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	2,399	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	7,082	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	91	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	9,854	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	149,183,854	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	8,524,969	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

PROSPECTIVE PAYMENT AMOUNT		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1,429,891 1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS	2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS	3
4	SUBTOTAL (SUM OF LINES 1-3)	1,429,891 4
COMPUTATION OF NET COST OF COVERED SERVICES		
5	MEDICAL AND OTHER SERVICES	5
6	DEDUCTIBLES	6
7	COINSURANCE	98,050 7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	10
11	UTILIZATION REVIEW	11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	1,331,841 12
13	INPATIENT PRIMARY PAYER PAYMENTS	13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	1,331,841 15
16	INTERIM PAYMENTS	1,331,841 16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)	18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0026) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

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

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	501,386			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	38,189,251			4
5	OTHER RECEIVABLES	546,408			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-30,645,192			6
7	INVENTORY	1,440,093			7
8	PREPAID EXPENSES	518,462			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	10,550,408			11
FIXED ASSETS					
12	LAND	1,234,900			12
13	LAND IMPROVEMENTS	979,977			13
14	ACCUMULATED DEPRECIATION	-636,606			14
15	BUILDINGS	42,899,299			15
16	ACCUMULATED DEPRECIATION	-13,933,452			16
17	LEASEHOLD IMPROVEMENTS	819,271			17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	8,494,789			19
20	ACCUMULATED DEPRECIATION	-5,052,656			20
21	AUTOMOBILES AND TRUCKS	216,981			21
22	ACCUMULATED DEPRECIATION	-165,976			22
23	MAJOR MOVABLE EQUIPMENT	25,041,344			23
24	ACCUMULATED DEPRECIATION	-17,105,439			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	42,792,432			30
OTHER ASSETS					
31	INVESTMENTS	32,793,376			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	2,924,245			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	35,717,621			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	89,060,461			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	2,201,650			37
38	SALARIES, WAGES & FEES PAYABLE	3,032,366			38
39	PAYROLL TAXES PAYABLE	-1,900			39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME	4,235,138			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	897,543			43
44	OTHER CURRENT LIABILITIES	2,902,456			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	13,267,253			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	10,037,783			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	11,810,196			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	21,847,979			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	35,115,232			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	53,945,229			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	53,945,229			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	89,060,461			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		51,615,688							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		-1,163,914							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		50,451,774							3
4 ADDITIONS (CREDIT ADJUSTMENTS)	316,289								4
5 NET ASSET RELEASED FROM REST		68,723							5
6 MINIMUM PENSION LIABILITY		5,324,664							6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		5,709,676							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		56,161,450							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 TRANSFER TO AFFILIATE	1,757,326								13
14 WRITE OFF OF GOODWILL		458,895							14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		2,216,221							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		53,945,229							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	8,152,277		8,152,277	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	1,854,925		1,854,925	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	10,007,202		10,007,202	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	2,649,637		2,649,637	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	2,649,637		2,649,637	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	12,656,839		12,656,839	18
19 ANCILLARY SERVICES	46,071,609	98,627,194	144,698,803	19
20 OUTPATIENT SERVICES		3,411,372	3,411,372	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY		887,546	887,546	23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER PATIENT REVENUES		180,037	180,037	28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	58,728,448	103,106,149	161,834,597	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		61,154,999	29
30 LAP SCH DEP ADJUSTMENT			30
31 LAP SCH DEP ADJUSTMENT			31
32	-9,634		32
33			33
34			34
35 LAP SCH DEP ADJUSTMENT	-2,531		35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		-12,165	36
37 DEPR. DIFFERENCE	-2		37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)	-2		42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		61,142,832	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	161,834,597	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	107,552,912	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	54,281,685	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	61,142,832	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-6,861,147	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	45,748	6
7	INCOME FROM INVESTMENTS	2,270,486	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	2,536	10
11	REBATES AND REFUNDS OF EXPENSES	-26,089	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	156,498	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	19,760	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	21,557	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	59,621	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	224,486	22
23	GOVERNMENTAL APPROPRIATIONS		23
24			24
24.01	OTHER (NON OPERATING UNREALIZED GAIN (LOSS))	2,484,163	24.01
24.02	OTHER (WK COMP & G/P LIABILITY FUND INCOME)	182,417	24.02
24.03	OTHER (OTHER REVENUE)	256,050	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	5,697,233	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,163,914	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-1,163,914	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7173

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED-BLDGS & FIXTURES						1
2 CAPITAL RELATED-MOVABLE EQUIPMENT						2
3 PLANT OPERATION & MAINTENANCE						3
4 TRANSPORTATION (SEE INSTRUCTIONS)						4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	297,398				41,243	338,641 5
6 SKILLED NURSING CARE	298,743					298,743 6
7 PHYSICAL THERAPY	56,554					56,554 7
8 OCCUPATIONAL THERAPY	2,696					2,696 8
9 SPEECH PATHOLOGY	943					943 9
10 MEDICAL SOCIAL SERVICES	14,605					14,605 10
11 HOME HEALTH AIDE	5,393					5,393 11
12 SUPPLIES (SEE INSTRUCTIONS)					9,454	9,454 12
13 DRUGS						13
14 DME						14
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						15
16 RESPIRATORY THERAPY						16
17 PRIVATE DUTY NURSING						17
18 CLINIC						18
19 HEALTH PROMOTION ACTIVITIES						19
20 DAY CARE PROGRAM						20
21 HOME DELIVERED MEALS PROGRAM						21
22 HOMEMAKER SERVICE						22
23 ALL OTHERS						23
24 TOTAL (SUM OF LINES 1-23)	676,332				50,697	727,029 24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7173

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5	-33,760	304,881		304,881	5
6					6
7	-56,554	298,743		298,743	7
8	-2,696				8
9	-943				9
10	-14,605				10
11		5,393		5,393	11
12	-9,454				12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24	-118,012	609,017		609,017	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7173

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6
	0	1	2	3	4	4A	5	6
1								1
2								2
3								3
4								4
5	304,881					304,881	304,881	5
6	298,743					298,743	299,475	6
7								7
8								8
9								9
10								10
11	5,393					5,393	5,406	11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24	609,017					609,017		24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7173

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-304,881	304,136	5
6 SKILLED NURSING CARE						298,743	6
7 PHYSICAL THERAPY							7
8 OCCUPATIONAL THERAPY							8
9 SPEECH PATHOLOGY							9
10 MEDICAL SOCIAL SERVICES							10
11 HOME HEALTH AIDE						5,393	11
12 SUPPLIES (SEE INSTRUCTIONS)							12
13 DRUGS							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-304,881	304,136	24
25 COST TO BE ALLOC (PER W/S H)						304,881	25
26 UNIT COST MULTIPLIER						1.002450	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7173

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL.4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL.4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	280,393		280,393			1
2 SKILLED NURSING CARE	858,007		858,007	268,478	1,126,485	2
3 PHYSICAL THERAPY						3
4 OCCUPATIONAL THERAPY						4
5 SPEECH PATHOLOGY						5
6 MEDICAL SOCIAL SERVICES	22,589		22,589	7,068	29,657	6
7 HOME HEALTH AIDE	15,489		15,489	4,847	20,336	7
8 SUPPLIES						8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	1,176,478		1,176,478	280,393	1,176,478	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.312909		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7173

WORKSHEET H-2
 PART II

HHA COST CENTER	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP- REL COSTS MOV EQUIP DOLLAR VA OR SQ. FEE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAINTEN- ANCE AND REPAIRS MAINTENANC HOURS	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	3,710			263,638		96,810	587	3,710	1
2 SKILLED NURSING CARE				298,743		685,293			2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE				5,393		12,371			7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	3,710			567,774		794,474	587	3,710	20
21 TOTAL COST TO BE ALLOCATED	19,967			165,490		200,231	8,172	67,273	21
22 UNIT COST MULTIPLIER	5.381941						13.921635		22
22 UNIT COST MULTIPLIER				0.291472		0.252030		18.132884	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7173

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA DIRECT HO OF SERVICE 11	MAINT OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15
1 ADMINISTRATIVE AND GENERAL				115		115	625,870	1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)				115		115	625,870	20
21 TOTAL COST TO BE ALLOCATED				4,549		77,148	2,042	21
22 UNIT COST MULTIPLIER							0.003263	22
22 UNIT COST MULTIPLIER				39.556522		670.852174		22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7173

WORKSHEET H-2
 PART II

HHA COST CENTER	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	I/R-SALARY AND FRINGES (ASSIGNED TIME) 21	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	PARAMEDIC (ASSIGNED TIME) 23	
1 ADMINISTRATIVE AND GENERAL								1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES			660					6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)			660					20
21 TOTAL COST TO BE ALLOCATED			22,589					21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER			34.225758					22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7173

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)		(COL.3 ÷ COL.4)	
		2	1	2	3	4	5	
1	SKILLED NURSING CARE		1,126,485		1,126,485	3,378	333.48	1
2	PHYSICAL THERAPY	3		89,393	89,393	993	90.02	2
3	OCCUPATIONAL THERAPY	4		2,109	2,109	36	58.58	3
4	SPEECH PATHOLOGY	5		1,713	1,713	25	68.52	4
5	MEDICAL SOCIAL SERVICES	6	29,657		29,657	94	315.50	5
6	HOME HEALTH AIDE	7	20,336		20,336	264	77.03	6
7	TOTAL (SUM OF LINES 1-6)		1,176,478	93,215	1,269,693	4,790		7
PATIENT SERVICES								
8	SKILLED NURSING CARE							8
8.01	SKILLED NURSING CARE							8.01
9	PHYSICAL THERAPY							9
9.01	PHYSICAL THERAPY							9.01
10	OCCUPATIONAL THERAPY							10
10.01	OCCUPATIONAL THERAPY							10.01
11	SPEECH PATHOLOGY							11
11.01	SPEECH PATHOLOGY							11.01
12	MEDICAL SOCIAL SERVICES							12
12.01	MEDICAL SOCIAL SERVICES							12.01
13	HOME HEALTH AIDE							13
13.01	HOME HEALTH AIDE							13.01
14	TOTAL (SUM OF LINES 8-13)							14
SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
OTHER PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)	
		8	1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES			8,561	8,561	33,487	0.255651	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7173

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
PATIENT SERVICES	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	1,787	908		595,929	302,800		898,729
2 PHYSICAL THERAPY	574	146		51,671	13,143		64,814
3 OCCUPATIONAL THERAPY	14	17		820	996		1,816
4 SPEECH PATHOLOGY	7	3		480	206		686
5 MEDICAL SOCIAL SERVICES	46	38		14,513	11,989		26,502
6 HOME HEALTH AIDE	132	135		10,168	10,399		20,567
7 TOTAL (SUM OF LINES 1-6)	2,560	1,247		673,581	339,533		1,013,114

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	1	2	3	4
8 SKILLED NURSING CARE	37900	76	65	8
8.01 SKILLED NURSING CARE	99914	1,711	843	8.01
9 PHYSICAL THERAPY	37900	12	6	9
9.01 PHYSICAL THERAPY	99914	562	140	9.01
10 OCCUPATIONAL THERAPY	37900			10
10.01 OCCUPATIONAL THERAPY	99914	14	17	10.01
11 SPEECH PATHOLOGY	37900			11
11.01 SPEECH PATHOLOGY	99914	7	3	11.01
12 MEDICAL SOCIAL SERVICES	37900	1	4	12
12.01 MEDICAL SOCIAL SERVICES	99914	45	34	12.01
13 HOME HEALTH AIDE	37900	5	12	13
13.01 HOME HEALTH AIDE	99914	127	123	13.01
14 TOTAL (SUM OF LINES 8-13)		2,560	1,247	14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES		
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR
OTHER PATIENT SERVICES	6	7	8	9	10	11
15 COST OF MEDICAL SUPPLIES	19,359	10,156		4,949	2,596	
16 COST OF DRUGS						15

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

FROM WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
1 PHYSICAL THERAPY	66	0.486611	183,705	89,393	COL 2, LINE 2
2 OCCUPATIONAL THERAPY	67	0.316599	6,660	2,109	COL 2, LINE 3
3 SPEECH PATHOLOGY	68	0.370298	4,625	1,713	COL 2, LINE 4
3.01 AUDIOLOGY	68.01	1.235009			COL 2, LINE 4
4 MEDICAL SUPPLIES CHRGD TO PAT	71	0.255665	33,487	8,561	COL 2, LINE 15
5 DRUGS CHARGED TO PATIENTS	73	0.195475			COL 2, LINE 16
5.01 ONCOLOGY	73.01				COL 2, LINE 16

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7173

WORKSHEET H-4
 PARTS I & II

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

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

DESCRIPTION	PART A 1	----- PART B -----		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PART A & PART B SERVICES				1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				2
3 TOTAL CHARGES				3
CUSTOMARY CHARGES				
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				4
5 AMOUNT 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(B)				5
6 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				6
7 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				7
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)				8
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				9
PRIMARY PAYER PAYMENTS				

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	453,518	199,158	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS		1,831	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	4,424	5,840	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	2,702	903	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	460,644	207,732	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	460,644	207,732	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	460,644	207,732	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	460,644	207,732	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	460,644	207,732	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	460,644	207,733	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)		-1	34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7173

WORKSHEET H-5

DESCRIPTION	PART A		PART B	
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		460,644		207,733
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				NONE
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		460,644		207,733
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				NONE
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		460,644		207,732
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____		DATE: _____

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-002) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT			
2	CAPITAL DRG OTHER THAN OUTLIER	746,958		1
3	CAPITAL DRG OUTLIER PAYMENTS	59,187		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	27.00		3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)			4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)			5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)			6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)			7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)			8
10	SUM OF LINES 7 AND 8			9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)			10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)			11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	806,145		12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-002) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1					1
2					2
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
19					19
20					20
21					21
22					22
23					23
INPATIENT ROUTINE SERV COST CENTERS					
30					30
31					31
43					43
44					44
ANCILLARY SERVICE COST CENTERS					
50					50
52					52
53					53
54					54
57					57
58					58
60					60
62.30					62.30
65					65
66					66
67					67
68					68
68.01					68.01
69					69
69.01					69.01
70					70
71					71
72					72
73					73
73.01					73.01
76					76
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
90					90
90.01					90.01
91					91
92					92
OTHER REIMBURSABLE COST CENTERS					
99.10					99.10
99.20					99.20
99.30					99.30
99.40					99.40
101					101
SPECIAL PURPOSE COST CENTERS					
113					113
118					118
NONREIMBURSABLE COST CENTERS					
190					190
192					192
194					194

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

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ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	0	2A	24	25	26	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)						202
203 TOTAL STATISTICAL BASIS						203
204 UNIT COST MULTIPLIER						204
204 UNIT COST MULTIPLIER						204

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	63.05		8.70				71.75 30
31 INTENSIVE CARE UNIT	60.00		3.56				63.56 31
43 NURSERY			47.55				47.55 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	20.52	34.09					54.61 50
52 DELIVERY ROOM & LABOR ROOM		0.02					0.02 52
53 ANESTHESIOLOGY	20.29	22.42					42.71 53
54 RADIOLOGY-DIAGNOSTIC	11.55	28.76					40.31 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	15.70	30.12					45.82 57
58 MAGNETIC RESONANCE IMAGING (MRI)	2.65	25.16					27.81 58
60 LABORATORY	20.93	3.08					24.01 60
65 RESPIRATORY THERAPY	52.92	4.07					56.99 65
66 PHYSICAL THERAPY	9.82	0.37					10.19 66
67 OCCUPATIONAL THERAPY	6.35						6.35 67
68 SPEECH PATHOLOGY	11.65						11.65 68
68.01 AUDIOLOGY	0.03	17.55					17.58 68.01
69 ELECTROCARDIOLOGY	26.15	31.98					58.13 69
70 ELECTROENCEPHALOGRAPHY	0.91	21.55					22.46 70
71 MEDICAL SUPPLIES CHRGED TO PATI	36.87	15.71					52.58 71
72 IMPL. DEV. CHARGED TO PATIENT	55.44	26.17					81.61 72
73 DRUGS CHARGED TO PATIENTS	44.51	15.82					60.33 73
76.97 CARDIAC REHABILITATION	0.37	67.05					67.42 76.97
90 CLINIC	0.46	12.49					12.95 90
90.01 OTTAWA CLINIC		4.32					4.32 90.01
91 EMERGENCY	19.21	14.89					34.10 91
92 OBSERVATION BEDS	3.70	17.93					21.63 92
200 TOTAL CHARGES	20.69	20.17					40.86 200

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

SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
44 SKILLED NURSING FACILITY	90.79						90.79 44
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	0.03						0.03 50
53 ANESTHESIOLOGY	0.03						0.03 53
54 RADIOLOGY-DIAGNOSTIC	0.46						0.46 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.02						0.02 57
60 LABORATORY	2.43						2.43 60
65 RESPIRATORY THERAPY	21.76						21.76 65
66 PHYSICAL THERAPY	15.30						15.30 66
67 OCCUPATIONAL THERAPY	14.78						14.78 67
68 SPEECH PATHOLOGY	17.39						17.39 68
69 ELECTROCARDIOLOGY	0.93						0.93 69
71 MEDICAL SUPPLIES CHRGED TO PATI	5.57						5.57 71
73 DRUGS CHARGED TO PATIENTS	12.13						12.13 73
200 TOTAL CHARGES	2.98						2.98 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,537,604	2.97	-1,537,604	-5.98		1
2	CAP REL COSTS-MVBLE EQUIP	3,176,350	6.14	-3,176,350	-12.36		2
3	OTHER CAPITAL RELATED COSTS						
4	EMPLOYEE BENEFITS	6,007,452	11.62	-6,007,452	-23.37		4
5	ADMINISTRATIVE & GENERAL	8,696,371	16.82	-8,696,371	-33.84		5
6	MAINTENANCE & REPAIRS	1,204,311	2.33	-1,204,311	-4.69		6
7	OPERATION OF PLANT	1,265,355	2.45	-1,265,355	-4.92		7
8	LAUNDRY & LINEN SERVICE	260,408	0.50	-260,408	-1.01		8
9	HOUSEKEEPING	771,443	1.49	-771,443	-3.00		9
10	DIETARY	583,689	1.13	-583,689	-2.27		10
11	CAFETERIA	6,873	0.01	-6,873	-0.03		11
12	MAINTENANCE OF PERSONNEL						
13	NURSING ADMINISTRATION	751,821	1.45	-751,821	-2.93		13
14	CENTRAL SERVICES & SUPPLY	166,822	0.32	-166,822	-0.65		14
15	PHARMACY	615,451	1.19	-615,451	-2.39		15
16	MEDICAL RECORDS & LIBRARY	643,111	1.24	-643,111	-2.50		16
17	SOCIAL SERVICE	14,605	0.03	-14,605	-0.06		17
19	NONPHYSICIAN ANESTHETISTS						
20	NURSING SCHOOL						
21	I&R SRVCES-SALARY & FRINGES APP						21
22	I&R SRVCES-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,872,364	5.56	4,840,882	18.83	7,713,246	14.92
31	INTENSIVE CARE UNIT	880,518	1.70	1,196,300	4.65	2,076,818	4.02
43	NURSERY	133,594	0.26	248,430	0.97	382,024	0.74
44	SKILLED NURSING FACILITY	1,207,969	2.34	1,778,541	6.92	2,986,510	5.78
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,769,833	3.42	2,750,776	10.70	4,520,609	8.74
52	DELIVERY ROOM & LABOR ROOM	159,475	0.31	315,235	1.23	474,710	0.92
53	ANESTHESIOLOGY	143,540	0.28	194,787	0.76	338,327	0.65
54	RADIOLOGY-DIAGNOSTIC	2,632,331	5.09	2,719,538	10.58	5,351,869	10.35
57	COMPUTED TOMOGRAPHY (CT) SCAN	322,030	0.62	576,390	2.24	898,420	1.74
58	MAGNETIC RESONANCE IMAGING (MRI)	196,797	0.38	519,589	2.02	716,386	1.39
60	LABORATORY	2,647,816	5.12	1,422,013	5.53	4,069,829	7.87
62.30	BLOOD CLOTTING FACTORS ADMIN CO						62.30
65	RESPIRATORY THERAPY	526,252	1.02	491,993	1.91	1,018,245	1.97
66	PHYSICAL THERAPY	1,009,706	1.95	698,931	2.72	1,708,637	3.30
67	OCCUPATIONAL THERAPY	236,474	0.46	250,531	0.97	487,005	0.94
68	SPEECH PATHOLOGY	51,571	0.10	49,797	0.19	101,368	0.20
68.01	AUDIOLOGY	172,140	0.33	85,378	0.33	257,518	0.50
69	ELECTROCARDIOLOGY	37,836	0.07	83,196	0.32	121,032	0.23
69.01	CARDIAC REHAB						69.01
70	ELECTROENCEPHALOGRAPHY	114,876	0.22	48,950	0.19	163,826	0.32
71	MEDICAL SUPPLIES CHRGED TO PATI	1,199,743	2.32	415,221	1.62	1,614,964	3.12
72	IMPL. DEV. CHARGED TO PATIENT	1,288,638	2.49	324,775	1.26	1,613,413	3.12
73	DRUGS CHARGED TO PATIENTS	1,243,286	2.40	1,535,890	5.98	2,779,176	5.38
73.01	ONCOLOGY						73.01
76	OTHER ANCILLARY CHEMICAL DEPEND						
76.97	CARDIAC REHABILITATION	78,452	0.15	186,510	0.73	264,962	0.51
76.98	HYPERBARIC OXYGEN THERAPY						
76.99	LITHOTRIPSY						
90	CLINIC	209,886	0.41	308,904	1.20	518,790	1.00
90.01	OTTAWA CLINIC	1,142,707	2.21	731,155	2.84	1,873,862	3.62
91	EMERGENCY	996,385	1.93	1,479,620	5.76	2,476,005	4.79
92	OBSERVATION BEDS						
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
99.10	CORF						
99.20	OUTPATIENT PHYSICAL THERAPY						
99.30	OUTPATIENT OCCUPATIONAL THERAPY						
99.40	OUTPATIENT SPEECH PATHOLOGY						
101	HOME HEALTH AGENCY	609,017	1.18	567,461	2.21	1,176,478	2.28
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN	35,919	0.07	21,580	0.08	57,499	0.11
192	PHYSICIANS' PRIVATE OFFICES	3,635,880	7.03	1,526,020	5.94	5,161,900	9.98
194	OTHER NONREIMBURSABLE COST	443,307	0.86	333,273	1.30	776,580	1.50
200	CROSS FOOT ADJUSTMENTS						
201	NEGATIVE COST CENTER						
202	TOTAL	51,700,008	100.00			51,700,008	100.00

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED		COST TO		INPATIENT	
	COSTS	CHARGES	CHARGES	PROGRAM	COSTS	
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	737,723	20,095,131	0.036712	4,123,148	151,369	50
52 DELIVERY ROOM & LABOR ROOM	86,076	444,501	0.193646			52
53 ANESTHESIOLOGY	114,075	3,537,929	0.032243	717,902	23,147	53
54 RADIOLOGY-DIAGNOSTIC	967,600	24,996,796	0.038709	2,887,479	111,771	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	349,641	11,755,531	0.029743	1,845,727	54,897	57
58 MAGNETIC RESONANCE IMAGING (MRI)	330,557	4,463,320	0.074061	118,406	8,769	58
60 LABORATORY	228,301	20,584,077	0.011091	4,309,066	47,792	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO						62.30
65 RESPIRATORY THERAPY	53,104	2,285,539	0.023235	1,209,450	28,102	65
66 PHYSICAL THERAPY	89,140	3,511,296	0.025387	344,910	8,756	66
67 OCCUPATIONAL THERAPY	43,876	1,538,238	0.028524	97,695	2,787	67
68 SPEECH PATHOLOGY	7,756	273,747	0.028333	31,880	903	68
68.01 AUDIOLOGY	14,266	208,515	0.068417	66	5	68.01
69 ELECTROCARDIOLOGY	35,009	1,473,187	0.023764	385,220	9,154	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	5,087	475,829	0.010691	4,320	46	70
71 MEDICAL SUPPLIES CHRGD TO PATI	68,038	6,316,719	0.010771	2,329,038	25,086	71
72 IMPL. DEV. CHARGED TO PATIENT	36,552	2,782,734	0.013135	1,542,779	20,264	72
73 DRUGS CHARGED TO PATIENTS	176,653	14,217,543	0.012425	6,328,635	78,633	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPEND						76
76.97 CARDIAC REHABILITATION	45,912	397,854	0.115399	1,458	168	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	29,385	2,165,662	0.013569	10,024	136	90
90.01 OTTAWA CLINIC	138,146	2,075,812	0.066550			90.01
91 EMERGENCY	163,513	8,152,524	0.020057	1,566,400	31,417	91
92 OBSERVATION BEDS	84,846	3,457,229	0.024542	127,762	3,136	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	3,805,256	135,209,713		27,981,365	606,338	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	SWING-BED	REDUCED	TOTAL	PER	INPATIENT	MEDICARE
	RELATED	ADJUSTMENT	CAPITAL	PATIENT	DIEM	PROGRAM	INPATIENT
	COSTS	AMOUNT	RELATED	DAYS		DAYS	PPS CAPITAL
	1	2	COST	4	5	6	COSTS
			3				7
INPATIENT ROUTINE SERVICE COST CENTERS							
30 ADULTS & PEDIATRICS	590,919		590,919	10,029	58.92	6,323	372,551 30
31 INTENSIVE CARE UNIT	202,786		202,786	1,265	160.31	759	121,675 31
200 TOTAL	793,705		793,705	11,294		7,082	494,226 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							494,226
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							606,338
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							1,100,564
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)							1,489
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)							7,082
PER DISCHARGE CAPITAL COSTS							739.13
PER DIEM CAPITAL COSTS							155.40

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	11,697,041
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	35,432,834
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.330

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	1,100,564
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.031

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	5,853,921
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	27,226,964
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.215