

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

WORKSHEET S  
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY      1.  ELECTRONICALLY FILED COST REPORT      DATE: \_\_\_\_\_      TIME: \_\_\_\_\_  
                                  2.  MANUALLY SUBMITTED COST REPORT  
                                  3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
                                  4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY      5.  COST REPORT STATUS      6.      DATE RECEIVED: \_\_\_\_\_      10.      NPR DATE: \_\_\_\_\_  
                                  1 - AS SUBMITTED      7.      CONTRACTOR NO: \_\_\_\_\_      11.      CONTRACTOR'S VENDOR CODE: \_\_\_\_  
                                  2 - SETTLED WITHOUT AUDIT      8.  INITIAL REPORT FOR THIS PROVIDER CCN      12.  IF LINE 5, COLUMN 1 IS 4: ENTER  
                                  3 - SETTLED WITH AUDIT      9.  FINAL REPORT FOR THIS PROVIDER CCN      NUMBER OF TIMES REOPENED - 0-9.  
                                  4 - REOPENED  
                                  5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST ANTHONY HOSPITAL (14-0095) (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 PROVIDE 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		-8,776	137,326		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FOHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-8,776	137,326		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 OMD 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: 2875 W. 19TH STREET  
 2 CITY: CHICAGO

STATE: IL

P.O. BOX:  
 ZIP CODE: 60623

COUNTY: COOK

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	14-0095	16974	1	07/01/1967	N	P	P	3
4	SUBPROVIDER - IPF	14-S095	16974	4	11/01/1988	N	P	P	4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								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			1					21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	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.	11,982	823			785	135	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.				1			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.				1			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.							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:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
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.	Y		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
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)	N		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
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/COL.1+COL.2)	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)

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

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/COL.1+COL.2)	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

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			
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>							
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y	70		
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N N	71		
<b>INPATIENT REHABILITATION FACILITY PPS</b>							
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		
<b>LONG TERM CARE HOSPITAL PPS</b>							
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	80		
<b>TEFRA PROVIDERS</b>							
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		
<b>TITLE V AND XIX INPATIENT SERVICES</b>							
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		
<b>RURAL PROVIDERS</b>							
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- SICAL N	OCCUP- ATIONAL N	RESPI- RATORY N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	1 N	2 115
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.	1	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	N 120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 N	2 140
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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:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	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 N	2 N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

MULTICAMPUS

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE	
PROVIDER ORGANIZATION AND OPERATION				
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1
		Y/N	DATE	V/I
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS				
		Y/N	TYPE	DATE
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES				
		Y/N	Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
Y/N				
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14
BED COMPLEMENT				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		Y	15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	01/04/2012	Y	01/04/2012
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	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	200	46,270,576		46,270,576	1,561,821.76	29.63	1
2							2
3							3
4		645,172		645,172	7,356.05	87.71	4
4.01		1,141,277		1,141,277	13,821.00	82.58	4.01
5		1,880,410		1,880,410	27,761.00	67.74	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		6,227,608		6,227,608	146,365.62	42.55	10
11		193,681		193,681	2,834.00	68.34	11
12							12
13							13
14							14
15							15
16							16
17		8,910,417	-1,114,235	7,796,182			17
18							18
19		835,037		835,037			19
20							20
21							21
22		120,818		120,818			22
23		158,380		158,380			23
24							24
25							25
26		510,755		510,755	16,354.15	31.23	26
27		6,612,946		6,612,946	229,572.53	28.81	27
28		708,020		708,020	4,620.55	153.23	28
29		373,310		373,310	13,474.84	27.70	29
30		1,116,373		1,116,373	55,134.93	20.25	30
31							31
32		859,762		859,762	65,641.78	13.10	32
33		187,353		187,353	6,448.00	29.06	33
34		892,410	-456,116	436,294	33,039.00	13.21	34
35							35
36			456,116	456,116	31,743.48	14.37	36
37							37
38		890,967		890,967	44,627.86	19.96	38
39		305,291		305,291	21,069.10	14.49	39
40		974,855		974,855	28,747.93	33.91	40
41		476,430		476,430	20,295.72	23.47	41
42		554,375		554,375	17,265.15	32.11	42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	44,144,262		44,144,262	1,531,308.3	28.83	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	6,227,608		6,227,608	146,365.62	42.55	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	37,916,654		37,916,654	1,384,942.6	27.38	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	193,681		193,681	2,834.00	68.34	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	9,031,235	-1,114,235	7,917,000		20.88%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	47,141,570	-1,114,235	46,027,335	1,387,776.6	33.17	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	14,462,847		14,462,847	588,035.02	24.60	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT	
	REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	1,024,843	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	3,985,863	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	159,877	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	57,310	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	119,313	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE		15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	3,251,173	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	82,165	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	229,873	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	8,910,417	24

PART B - OTHER THAN CORE RELATED COST

25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25
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PROVIDER CCN: 14-0095 ST ANTHONY 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  
01/26/2012 15:47

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	194,740	1
2	HOSPITAL	193,681	2
3	SUBPROVIDER - IPF	1,059	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1 COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8) 0.299302 1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2 NET REVENUE FROM MEDICAID 44,285,528 2  
 3 DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? Y 3  
 4 IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? Y 4  
 5 IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID 5  
 6 MEDICAID CHARGES 113,103,208 6  
 7 MEDICAID COST (LINE 1 TIMES LINE 6) 33,852,018 7  
 8 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) 8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)

9 NET REVENUE FROM STAND-ALONE SCHIP 9  
 10 STAND-ALONE SCHIP CHARGES 10  
 11 STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10) 11  
 12 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) 12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)

13 NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9) 13  
 14 CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10) 14  
 15 STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14) 15  
 16 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) 16

UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)

17 PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE 17  
 18 GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS 18  
 19 TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16) 19

	UNINSURED PATIENTS	INSURED PATIENTS	TOTAL	
	1	2	3	
20	21,582,575	2,467,897	24,050,472	20
21	6,459,708	738,647	7,198,355	21
22	150,851	339,046	489,897	22
23	6,308,857	399,601	6,708,458	23
24				N 24
25				25
26			6,643,448	26
27			559,852	27
28			6,083,596	28
29			1,820,833	29
30			8,529,291	30
31			8,529,291	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		2,431,835	2,431,835	5,328	1
2	00200		358,369	358,369		2
3	00300					3
4	00400	510,755	6,213,682	6,724,437		4
5.01	00540					5.01
5.02	00561					5.02
5.03	00571					5.03
5.04	00581					5.04
5.05	00551					5.05
5.06	00590	6,612,946	17,038,589	23,651,535		5.06
6	00600	373,310	1,239,834	1,613,144		6
7	00700	1,116,373	1,501,977	2,618,350		7
8	00800				493,741	8
9	00900	859,762	506,242	1,366,004		9
10	01000	892,410	1,006,901	1,899,311	-970,749	10
11	01100				970,749	11
12	01200					12
13	01300	890,967	90,088	981,055		13
14	01400	305,291	719,395	1,024,686	-493,741	14
15	01500	974,855	3,352,315	4,327,170	-3,607,360	15
16	01600	476,430	258,208	734,638		16
17	01700	554,375	86,344	640,719		17
19	01900					19
20	02000					20
21	02100					21
22	02200	1,432,023	624,326	2,056,349		22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	6,331,381	970,983	7,302,364		30
31	03100	1,933,691	317,651	2,251,342		31
40	04000	1,971,024	212,174	2,183,198		40
43	04300	1,268,955	115,424	1,384,379		43
ANCILLARY SERVICE COST CENTERS						
50	05000	1,404,333	3,049,262	4,453,595	-782,142	50
51	05100	324,159	35,592	359,751		51
52	05200	3,478,335	647,115	4,125,450		52
53	05300		1,082,314	1,082,314		53
54	05400	2,077,863	1,073,376	3,151,239		54
57	05700	335,771	130,557	466,328		57
58	05800	152,911	32,809	185,720		58
60	06000	1,522,758	1,505,376	3,028,134		60
62.30	06250					62.30
63	06300	38,906	519,220	558,126		63
65	06500	666,237	292,176	958,413		65
66	06600	647,027	121,520	768,547		66
69	06900	458,632	147,211	605,843		69
70	07000	54,964	8,231	63,195		70
72	07200				782,142	72
73	07300				3,607,360	73
75	07500	318,423	46,869	365,292		75
76	03950		295,764	295,764		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	1,393,952	499,171	1,893,123		90
91	09100	2,635,173	586,734	3,221,907		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
SPECIAL PURPOSE COST CENTERS						
113	11300		5,328	5,328	-5,328	113
118		42,013,992	47,122,962	89,136,954		118
NONREIMBURSABLE COST CENTERS						
190	19000	47,115	52,876	99,991		190
192	19200	4,209,469	1,843,452	6,052,921		192
192.01	19210					192.01
200		46,270,576	49,019,290	95,289,866		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	2,437,163	2,431,608	4,868,771	1
2	00200	CAP REL COSTS-MVBLE EQUIP	358,369		358,369	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	6,724,437	-27	6,724,410	4
5.01	00540	COMMUNICATIONS				5.01
5.02	00561	PURCHASING, RECEIVING				5.02
5.03	00571	ADMITTING				5.03
5.04	00581	CASHERING/ACCOUNTS RECEIVABLE				5.04
5.05	00551	DATA PROCESSING				5.05
5.06	00590	ADMINISTRATIVE & GENERAL	23,651,535	-488,856	23,162,679	5.06
6	00600	MAINTENANCE & REPAIRS	1,613,144		1,613,144	6
7	00700	OPERATION OF PLANT	2,618,350	-17,210	2,601,140	7
8	00800	LAUNDRY & LINEN SERVICE	493,741		493,741	8
9	00900	HOUSEKEEPING	1,366,004		1,366,004	9
10	01000	DIETARY	928,562		928,562	10
11	01100	CAFETERIA	970,749	-483,540	487,209	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	981,055		981,055	13
14	01400	CENTRAL SERVICES & SUPPLY	530,945		530,945	14
15	01500	PHARMACY	719,810	-8,211	711,599	15
16	01600	MEDICAL RECORDS & LIBRARY	734,638	-229	734,409	16
17	01700	SOCIAL SERVICE	640,719	-486	640,233	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APRVD	2,056,349	-714,044	1,342,305	22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	7,302,364	-828,042	6,474,322	30
31	03100	INTENSIVE CARE UNIT	2,251,342	-500	2,250,842	31
40	04000	SUBPROVIDER - IPF	2,183,198	-26,573	2,156,625	40
43	04300	NURSERY	1,384,379	-402,394	981,985	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	3,671,453		3,671,453	50
51	05100	RECOVERY ROOM	359,751		359,751	51
52	05200	DELIVERY ROOM & LABOR ROOM	4,125,450	-911,438	3,214,012	52
53	05300	ANESTHESIOLOGY	1,082,314		1,082,314	53
54	05400	RADIOLOGY-DIAGNOSTIC	3,151,239	-385	3,150,854	54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	466,328		466,328	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	185,720		185,720	58
60	06000	LABORATORY	3,028,134	-3,175	3,024,959	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	558,126		558,126	63
65	06500	RESPIRATORY THERAPY	958,413		958,413	65
66	06600	PHYSICAL THERAPY	768,547		768,547	66
69	06900	ELECTROCARDIOLOGY	605,843		605,843	69
70	07000	ELECTROENCEPHALOGRAPHY	63,195		63,195	70
72	07200	IMPL. DEV. CHARGED TO PATIENT	782,142		782,142	72
73	07300	DRUGS CHARGED TO PATIENTS	3,607,360		3,607,360	73
75	07500	ASC (NON-DISTINCT PART)	365,292		365,292	75
76	03950	HEMODIALYSIS	295,764		295,764	76
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	CLINIC	1,893,123	-61,112	1,832,011	90
91	09100	EMERGENCY	3,221,907		3,221,907	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	89,136,954	-1,514,614	87,622,340	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	99,991		99,991	190
192	19200	PHYSICIANS' PRIVATE OFFICES	6,052,921		6,052,921	192
192.01	19210	FUND DEVELOPMENT				192.01
200		TOTAL (SUM OF LINES 118-199)	95,289,866	-1,514,614	93,775,252	200

PROVIDER CCN: 14-0095 ST ANTHONY 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  
 01/26/2012 15:47

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
		COST CENTER 2	LINE # 3	SALARY 4	OTHER 5
1 INTEREST & INSURANC 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	CAP REL COSTS-BLDG & FIXT	1		5,328 1 5,328 500
1 CAFETERIA RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - B	B	CAFETERIA	11	456,116 456,116	514,633 1 514,633 500
1 COST OF MEDICAL SUPPLIES 500 TOTAL RECLASSIFICATIONS CODE LETTER - C	C	IMPL. DEV. CHARGED TO PATIENT	72		782,142 1 782,142 500
1 COST OF DRUGS SOLD 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	DRUGS CHARGED TO PATIENTS	73		3,607,360 1 3,607,360 500
1 RECLASS LAUNDRY COSTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - E GRAND TOTAL (INCREASES)	E	LAUNDRY & LINEN SERVICE	8		493,741 1 493,741 500 456,116 5,403,204

PROVIDER CCN: 14-0095 ST ANTHONY HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
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VERSION: 2011.10  
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7	
			LINE #	SALARY	OTHER	REF.	
	1	6	7	8	9	10	
1 INTEREST & INSURANC	A	INTEREST EXPENSE	113		5,328	11	1
500 TOTAL RECLASSIFICATIONS					5,328		500
CODE LETTER - A							
1 CAFETERIA RECLASS	B	DIETARY	10	456,116	514,633		1
500 TOTAL RECLASSIFICATIONS				456,116	514,633		500
CODE LETTER - B							
1 COST OF MEDICAL SUPPLIES	C	OPERATING ROOM	50		782,142		1
500 TOTAL RECLASSIFICATIONS					782,142		500
CODE LETTER - C							
1 COST OF DRUGS SOLD	D	PHARMACY	15		3,607,360		1
500 TOTAL RECLASSIFICATIONS					3,607,360		500
CODE LETTER - D							
1 RECLASS LAUNDRY COSTS	E	CENTRAL SERVICES & SUPPLY	14		493,741		1
500 TOTAL RECLASSIFICATIONS					493,741		500
CODE LETTER - E							
GRAND TOTAL (DECREASES)				456,116	5,403,204		

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	472,850					472,850		1
2 LAND IMPROVEMENTS	330,859					330,859		2
3 BUILDINGS AND FIXTURES	23,357,471	724,454		724,454		24,081,925		3
4 BUILDING IMPROVEMENTS	2,489,909				528,318	1,961,591		4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	18,389,084	7,447,249		7,447,249	4,061,446	21,774,887		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	45,040,173	8,171,703		8,171,703	4,589,764	48,622,112		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	45,040,173	8,171,703		8,171,703	4,589,764	48,622,112		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)
1 CAP REL COSTS-BLDG & FIXT	2,431,835						2,431,835 1
2 CAP REL COSTS-MVBLE EQUIP	358,369						358,369 2
3 TOTAL (SUM OF LINES 1-2)	2,790,204						2,790,204 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 (SEE INSTR.) 7	TOTAL
								(SUM OF COLS. 5-7)
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								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)
1 CAP REL COSTS-BLDG & FIXT	4,863,443		5,328				4,868,771 1
2 CAP REL COSTS-MVBLE EQUIP	358,369						358,369 2
3 TOTAL	5,221,812		5,328				5,227,140 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
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					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	-2,381,409			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST				
	A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-468,524	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-8,211	PHARMACY	15	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-229	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-14,513	CAFETERIA	11	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
34 RENTAL REVENUE	B	-5,328	ADMINISTRATIVE & GENERAL	5.06	34
35 CAPITAL IMPAIRMENT AMORTIZATION	A	2,431,608	CAP REL COSTS-BLDG & FIXT	1	9
36 OTHER REVENUE	B	-27	EMPLOYEE BENEFITS	4	36
36.01 OTHER REVENUE	B	-227,230	ADMINISTRATIVE & GENERAL	5.06	36.01
36.02 OTHER REVENUE	B	-17,210	OPERATION OF PLANT	7	36.02
36.03 OTHER REVENUE	B	-503	CAFETERIA	11	36.03
36.04 OTHER REVENUE	B	-611,952	I&R SRVCES-OTHER PRGM COSTS APP	22	36.04
36.08 OTHER REVENUE	B	-592	DELIVERY ROOM & LABOR ROOM	52	36.08
36.09 OTHER REVENUE	B	-385	RADIOLOGY-DIAGNOSTIC	54	36.09
37 MILLENIUM BLDG 1ST FLOOR 33% GL	A	-193,062	ADMINISTRATIVE & GENERAL	5.06	37
38 OTHER REVENUE	B	-486	SOCIAL SERVICE	17	38
39 OTHER REVENUE	B	-500	INTENSIVE CARE UNIT	31	39
40 OTHER REVENUE	B	-11,343	DELIVERY ROOM & LABOR ROOM	52	40
41 OTHER REVENUE	B	-3,175	LABORATORY	60	41
42 OTHER REVENUE	B	-1,543	CLINIC	90	42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,514,614			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 ADJUSTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4)					
	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					
7					
8					
9					
10					

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	5.06 ADMINISTRATIVE & GENERAL CHAIRMAN	140,286		140,286	154,100	1,040	77,050	3,853	1
2	22 I&R SRVCES-OTHER PRGM CO TEACHING PHYSIC	1,280,864		1,280,864	177,400	13,821	1,178,772	58,939	2
3	30 ADULTS & PEDIATRICS AGGREGATE	828,042	828,042						3
4	40 SUBPROVIDER - IPF CHAIRMAN	101,030		101,030	154,100	1,005	74,457	3,723	4
5	43 NURSERY CHAIRMAN	252,258		252,258	177,400	2,306	196,675	9,834	5
6	43 NURSERY AGGREGATE	346,811	346,811						6
7	52 DELIVERY ROOM & LABOR RO CHAIRMAN	112,226		112,226	177,400	1,040	88,700	4,435	7
8	52 DELIVERY ROOM & LABOR RO AGGREGATE	875,977	875,977						8
9	90 CLINIC CHAIRMAN	118,282		118,282	198,000	1,965	187,053	9,353	9
10	90 CLINIC AGGREGATE	59,569	59,569						10
200	TOTAL	4,115,345	2,110,399	2,004,946		21,177	1,802,707	90,137	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	5.06 ADMINISTRATIVE & GENERAL	CHAIRMAN				77,050	63,236	63,236	1
2	22 I&R SRVCES-OTHER PRGM CO	TEACHING PHYSIC				1,178,772	102,092	102,092	2
3	30 ADULTS & PEDIATRICS	AGGREGATE						828,042	3
4	40 SUBPROVIDER - IPF	CHAIRMAN				74,457	26,573	26,573	4
5	43 NURSERY	CHAIRMAN				196,675	55,583	55,583	5
6	43 NURSERY	AGGREGATE						346,811	6
7	52 DELIVERY ROOM & LABOR RO	CHAIRMAN				88,700	23,526	23,526	7
8	52 DELIVERY ROOM & LABOR RO	AGGREGATE						875,977	8
9	90 CLINIC	CHAIRMAN				187,053			9
10	90 CLINIC	AGGREGATE						59,569	10
200	TOTAL					1,802,707	271,010	2,381,409	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	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	4,868,771	4,868,771				1
2 CAP REL COSTS-MVBLE EQUIP	358,369		358,369			2
4 EMPLOYEE BENEFITS	6,724,410	19,148	202	6,743,760		4
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL	23,162,679	600,620	19,417	974,567	24,757,283	5.06
6 MAINTENANCE & REPAIRS	1,613,144	181,940	5,976	55,016	1,856,076	6
7 OPERATION OF PLANT	2,601,140	600,332	32,356	164,523	3,398,351	7
8 LAUNDRY & LINEN SERVICE	493,741	84,880			578,621	8
9 HOUSEKEEPING	1,366,004	43,701	350	126,706	1,536,761	9
10 DIETARY	928,562	210,097	2,916	64,298	1,205,873	10
11 CAFETERIA	487,209			67,219	554,428	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	981,055	85,216	1,603	131,304	1,199,178	13
14 CENTRAL SERVICES & SUPPLY	530,945	125,650	4,277	44,992	705,864	14
15 PHARMACY	711,599	69,480	1,018	143,667	925,764	15
16 MEDICAL RECORDS & LIBRARY	734,409	88,772	1,415	70,213	894,809	16
17 SOCIAL SERVICE	640,233	23,977		81,700	745,910	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	1,342,305			211,042	1,553,347	22
23 PARAMED ED PRGM (SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,474,322	1,012,522	8,241	933,075	8,428,160	30
31 INTENSIVE CARE UNIT	2,250,842	137,758	6,301	284,974	2,679,875	31
40 SUBPROVIDER - IPF	2,156,625	302,881	561	290,476	2,750,543	40
43 NURSERY	981,985	30,463	525	187,010	1,199,983	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,671,453	139,296	37,119	206,961	4,054,829	50
51 RECOVERY ROOM	359,751			47,772	407,523	51
52 DELIVERY ROOM & LABOR ROOM	3,214,012	93,288	6,324	512,613	3,826,237	52
53 ANESTHESIOLOGY	1,082,314	17,971	17		1,100,302	53
54 RADIOLOGY-DIAGNOSTIC	3,150,854	258,243	171,183	306,221	3,886,501	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	466,328			49,484	515,812	57
58 MAGNETIC RESONANCE IMAGING (MRI)	185,720			22,535	208,255	58
60 LABORATORY	3,024,959	171,273	21,939	224,413	3,442,584	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	558,126			5,734	563,860	63
65 RESPIRATORY THERAPY	958,413	31,545	5,884	98,185	1,094,027	65
66 PHYSICAL THERAPY	768,547	41,515	101	95,354	905,517	66
69 ELECTROCARDIOLOGY	605,843	24,073	2,205	67,590	699,711	69
70 ELECTROENCEPHALOGRAPHY	63,195	15,208	1,027	8,100	87,530	70
72 IMPL. DEV. CHARGED TO PATIENT	782,142				782,142	72
73 DRUGS CHARGED TO PATIENTS	3,607,360				3,607,360	73
75 ASC (NON-DISTINCT PART)	365,292			46,927	412,219	75
76 HEMODIALYSIS	295,764				295,764	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	1,832,011	145,158	20	205,431	2,182,620	90
91 EMERGENCY	3,221,907	89,252	7,140	388,353	3,706,652	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
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	87,622,340	4,644,259	338,117	6,116,455	86,750,271	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	99,991	3,604	57	6,943	110,595	190
192 PHYSICIANS' PRIVATE OFFICES	6,052,921	220,908	20,195	620,362	6,914,386	192
192.01 FUND DEVELOPMENT						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	93,775,252	4,868,771	358,369	6,743,760	93,775,252	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	A+G	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	
	5.06	6	7	8	9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL	24,757,283					5.06
6 MAINTENANCE & REPAIRS	665,789	2,521,865				6
7 OPERATION OF PLANT	1,219,016	372,248	4,989,615			7
8 LAUNDRY & LINEN SERVICE	207,556	52,631	122,166	960,974		8
9 HOUSEKEEPING	551,248	27,098	62,898		2,178,005	9
10 DIETARY	432,556	130,275	302,389			10
11 CAFETERIA	198,878					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	430,155	52,840	122,650			13
14 CENTRAL SERVICES & SUPPLY	253,199	77,912	180,846			14
15 PHARMACY	332,079	43,082	100,001			15
16 MEDICAL RECORDS & LIBRARY	320,975	55,045	127,768		13,082	16
17 SOCIAL SERVICE	267,564	14,867	34,509			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	557,198				183,454	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,023,232	627,836	1,457,313	499,707	484,193	30
31 INTENSIVE CARE UNIT	961,293	85,420	198,273	96,098	96,340	31
40 SUBPROVIDER - IPF	986,642	187,807	435,932	259,464	188,067	40
43 NURSERY	430,444	18,889	43,846	105,705		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,454,500	86,373	200,486		210,375	50
51 RECOVERY ROOM	146,182					51
52 DELIVERY ROOM & LABOR ROOM	1,372,502	57,845	134,268		438,066	52
53 ANESTHESIOLOGY	394,687	11,143	25,865			53
54 RADIOLOGY-DIAGNOSTIC	1,394,119	160,129	371,685		193,285	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	185,026					57
58 MAGNETIC RESONANCE IMAGING (MRI)	74,703					58
60 LABORATORY	1,234,882	106,201	246,510		32,063	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	202,261					63
65 RESPIRATORY THERAPY	392,436	19,560	45,402		9,831	65
66 PHYSICAL THERAPY	324,816	25,742	59,752		14,746	66
69 ELECTROCARDIOLOGY	250,992	14,927	34,648		13,082	69
70 ELECTROENCEPHALOGRAPHY	31,398	9,430	21,888			70
72 IMPL. DEV. CHARGED TO PATIENT	280,561					72
73 DRUGS CHARGED TO PATIENTS	1,293,989				9,150	73
75 ASC (NON-DISTINCT PART)	147,866					75
76 HEMODIALYSIS	106,093					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	782,923	90,008	208,924		29,492	90
91 EMERGENCY	1,329,606	55,343	128,459		155,928	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
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	22,237,366	2,382,651	4,666,478	960,974	2,071,154	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,671	2,235	5,187		45,901	190
192 PHYSICIANS' PRIVATE OFFICES	2,480,246	136,979	317,950		60,950	192
192.01 FUND DEVELOPMENT						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	24,757,283	2,521,865	4,989,615	960,974	2,178,005	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
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	2,071,093					10
11 CAFETERIA		753,306				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		30,308	1,835,131			13
14 CENTRAL SERVICES & SUPPLY		14,308		1,232,129		14
15 PHARMACY		19,523			1,420,449	15
16 MEDICAL RECORDS & LIBRARY		13,784				16
17 SOCIAL SERVICE		11,725				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		13,992				22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,207,856	145,620	641,677			30
31 INTENSIVE CARE UNIT	238,132	30,249	191,218			31
40 SUBPROVIDER - IPF	625,105	48,890	120,801			40
43 NURSERY		15,949	78,608			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		30,051	120,762	1,232,129		50
51 RECOVERY ROOM		4,837	34,608			51
52 DELIVERY ROOM & LABOR ROOM		63,354	294,232			52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		49,218	5,835			54
57 COMPUTED TOMOGRAPHY (CT) SCAN		5,102				57
58 MAGNETIC RESONANCE IMAGING (MRI)		2,996				58
60 LABORATORY		43,075				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.		929				63
65 RESPIRATORY THERAPY		15,994				65
66 PHYSICAL THERAPY		13,058				66
69 ELECTROCARDIOLOGY		9,820				69
70 ELECTROENCEPHALOGRAPHY		1,728				70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					1,420,449	73
75 ASC (NON-DISTINCT PART)		6,190	33,656			75
76 HEMODIALYSIS						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		44,455	41,245			90
91 EMERGENCY		67,968	245,902			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
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,071,093	703,123	1,808,544	1,232,129	1,420,449	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,093				190
192 PHYSICIANS' PRIVATE OFFICES		48,090	26,587			192
192.01 FUND DEVELOPMENT						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,071,093	753,306	1,835,131	1,232,129	1,420,449	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,425,463					16
17 SOCIAL SERVICE		1,074,575				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			2,307,991			22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	177,622	584,804	923,197	18,201,217	-923,197	30
31 INTENSIVE CARE UNIT	58,194	72,821		4,707,913		31
40 SUBPROVIDER - IPF	71,797	278,334		5,953,382		40
43 NURSERY	24,777	138,616		2,056,817		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	105,948			7,495,453		50
51 RECOVERY ROOM	6,795			599,945		51
52 DELIVERY ROOM & LABOR ROOM	56,304			6,242,808		52
53 ANESTHESIOLOGY	42,697			1,574,694		53
54 RADIOLOGY-DIAGNOSTIC	117,067			6,177,839		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	95,273			801,213		57
58 MAGNETIC RESONANCE IMAGING (MRI)	17,827			303,781		58
60 LABORATORY	127,738			5,233,053		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	16,516			783,566		63
65 RESPIRATORY THERAPY	58,212			1,635,462		65
66 PHYSICAL THERAPY	21,524			1,365,155		66
69 ELECTROCARDIOLOGY	32,321			1,055,501		69
70 ELECTROENCEPHALOGRAPHY	4,549			156,523		70
72 IMPL. DEV. CHARGED TO PATIENT	10,680			1,073,383		72
73 DRUGS CHARGED TO PATIENTS	174,163			6,505,111		73
75 ASC (NON-DISTINCT PART)	7,916			607,847		75
76 HEMODIALYSIS	5,430			407,287		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	28,574		461,598	3,869,839	-461,598	90
91 EMERGENCY	163,539		923,196	6,776,593	-923,196	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
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,425,463	1,074,575	2,307,991	83,584,382	-2,307,991	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				205,682		190
192 PHYSICIANS' PRIVATE OFFICES				9,985,188		192
192.01 FUND DEVELOPMENT						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,425,463	1,074,575	2,307,991	93,775,252	-2,307,991	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	COMMUNICATIONS		5.01
5.02	PURCHASING, RECEIVING		5.02
5.03	ADMITTING		5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE		5.04
5.05	DATA PROCESSING		5.05
5.06	ADMINISTRATIVE & GENERAL		5.06
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R 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	17,278,020	30
31	INTENSIVE CARE UNIT	4,707,913	31
40	SUBPROVIDER - IPF	5,953,382	40
43	NURSERY	2,056,817	43
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	7,495,453	50
51	RECOVERY ROOM	599,945	51
52	DELIVERY ROOM & LABOR ROOM	6,242,808	52
53	ANESTHESIOLOGY	1,574,694	53
54	RADIOLOGY-DIAGNOSTIC	6,177,839	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	801,213	57
58	MAGNETIC RESONANCE IMAGING (MRI)	303,781	58
60	LABORATORY	5,233,053	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	783,566	63
65	RESPIRATORY THERAPY	1,635,462	65
66	PHYSICAL THERAPY	1,365,155	66
69	ELECTROCARDIOLOGY	1,055,501	69
70	ELECTROENCEPHALOGRAPHY	156,523	70
72	IMPL. DEV. CHARGED TO PATIENT	1,073,383	72
73	DRUGS CHARGED TO PATIENTS	6,505,111	73
75	ASC (NON-DISTINCT PART)	607,847	75
76	HEMODIALYSIS	407,287	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	3,408,241	90
91	EMERGENCY	5,853,397	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
SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE		113
118	SUBTOTALS (SUM OF LINES 1-117)	81,276,391	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	205,682	190
192	PHYSICIANS' PRIVATE OFFICES	9,985,188	192
192.01	FUND DEVELOPMENT		192.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	91,467,261	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP- REL COSTS BLDG&FIXT 1	NEW CAP- REL COSTS MOV EQUIP 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		19,148	202	19,350	19,350	4
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL		600,620	19,417	620,037	2,788	5.06
6 MAINTENANCE & REPAIRS		181,940	5,976	187,916	158	6
7 OPERATION OF PLANT		600,332	32,356	632,688	472	7
8 LAUNDRY & LINEN SERVICE		84,880		84,880		8
9 HOUSEKEEPING		43,701	350	44,051	364	9
10 DIETARY		210,097	2,916	213,013	185	10
11 CAFETERIA					193	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		85,216	1,603	86,819	377	13
14 CENTRAL SERVICES & SUPPLY		125,650	4,277	129,927	129	14
15 PHARMACY		69,480	1,018	70,498	412	15
16 MEDICAL RECORDS & LIBRARY		88,772	1,415	90,187	202	16
17 SOCIAL SERVICE		23,977		23,977	235	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					606	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		1,012,522	8,241	1,020,763	2,678	30
31 INTENSIVE CARE UNIT		137,758	6,301	144,059	818	31
40 SUBPROVIDER - IPF		302,881	561	303,442	834	40
43 NURSERY		30,463	525	30,988	537	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		139,296	37,119	176,415	594	50
51 RECOVERY ROOM					137	51
52 DELIVERY ROOM & LABOR ROOM		93,288	6,324	99,612	1,471	52
53 ANESTHESIOLOGY		17,971	17	17,988		53
54 RADIOLOGY-DIAGNOSTIC		258,243	171,183	429,426	879	54
57 COMPUTED TOMOGRAPHY (CT) SCAN					142	57
58 MAGNETIC RESONANCE IMAGING (MRI)					65	58
60 LABORATORY		171,273	21,939	193,212	644	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.					16	63
65 RESPIRATORY THERAPY		31,545	5,884	37,429	282	65
66 PHYSICAL THERAPY		41,515	101	41,616	274	66
69 ELECTROCARDIOLOGY		24,073	2,205	26,278	194	69
70 ELECTROENCEPHALOGRAPHY		15,208	1,027	16,235	23	70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)					135	75
76 HEMODIALYSIS						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		145,158	20	145,178	590	90
91 EMERGENCY		89,252	7,140	96,392	1,115	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
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		4,644,259	338,117	4,982,376	17,549	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,604	57	3,661	20	190
192 PHYSICIANS' PRIVATE OFFICES		220,908	20,195	241,103	1,781	192
192.01 FUND DEVELOPMENT						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		4,868,771	358,369	5,227,140	19,350	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	A+G	MAINTEN- ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	
	5.06	6	7	8	9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL	622,825					5.06
6 MAINTENANCE & REPAIRS	16,749	204,823				6
7 OPERATION OF PLANT	30,667	30,234	694,061			7
8 LAUNDRY & LINEN SERVICE	5,221	4,275	16,993	111,369		8
9 HOUSEKEEPING	13,868	2,201	8,749		69,233	9
10 DIETARY	10,882	10,581	42,063			10
11 CAFETERIA	5,003					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	10,821	4,292	17,061			13
14 CENTRAL SERVICES & SUPPLY	6,370	6,328	25,156			14
15 PHARMACY	8,354	3,499	13,910			15
16 MEDICAL RECORDS & LIBRARY	8,075	4,471	17,773		416	16
17 SOCIAL SERVICE	6,731	1,208	4,800			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	14,017				5,832	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	76,064	50,991	202,712	57,912	15,392	30
31 INTENSIVE CARE UNIT	24,183	6,938	27,580	11,137	3,062	31
40 SUBPROVIDER - IPF	24,821	15,253	60,639	30,070	5,978	40
43 NURSERY	10,829	1,534	6,099	12,250		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	36,591	7,015	27,888		6,687	50
51 RECOVERY ROOM	3,677					51
52 DELIVERY ROOM & LABOR ROOM	34,528	4,698	18,677		13,925	52
53 ANESTHESIOLOGY	9,929	905	3,598			53
54 RADIOLOGY-DIAGNOSTIC	35,072	13,005	51,702		6,144	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	4,655					57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,879					58
60 LABORATORY	31,066	8,626	34,290		1,019	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	5,088					63
65 RESPIRATORY THERAPY	9,872	1,589	6,315		312	65
66 PHYSICAL THERAPY	8,171	2,091	8,312		469	66
69 ELECTROCARDIOLOGY	6,314	1,212	4,820		416	69
70 ELECTROENCEPHALOGRAPHY	790	766	3,045			70
72 IMPL. DEV. CHARGED TO PATIENT	7,058					72
73 DRUGS CHARGED TO PATIENTS	32,553				291	73
75 ASC (NON-DISTINCT PART)	3,720					75
76 HEMODIALYSIS	2,669					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	19,696	7,310	29,062		937	90
91 EMERGENCY	33,449	4,495	17,869		4,957	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
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	559,432	193,517	649,113	111,369	65,837	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	998	181	721		1,459	190
192 PHYSICIANS' PRIVATE OFFICES	62,395	11,125	44,227		1,937	192
192.01 FUND DEVELOPMENT						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	622,825	204,823	694,061	111,369	69,233	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
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	276,724					10
11 CAFETERIA		5,196				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		209	119,579			13
14 CENTRAL SERVICES & SUPPLY		99		168,009		14
15 PHARMACY		135			96,808	15
16 MEDICAL RECORDS & LIBRARY		95				16
17 SOCIAL SERVICE		81				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		97				22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	161,385	1,004	41,813			30
31 INTENSIVE CARE UNIT	31,817	209	12,460			31
40 SUBPROVIDER - IPF	83,522	337	7,872			40
43 NURSERY		110	5,122			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		207	7,869	168,009		50
51 RECOVERY ROOM		33	2,255			51
52 DELIVERY ROOM & LABOR ROOM		437	19,172			52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		339	380			54
57 COMPUTED TOMOGRAPHY (CT) SCAN		35				57
58 MAGNETIC RESONANCE IMAGING (MRI)		21				58
60 LABORATORY		297				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.		6				63
65 RESPIRATORY THERAPY		110				65
66 PHYSICAL THERAPY		90				66
69 ELECTROCARDIOLOGY		68				69
70 ELECTROENCEPHALOGRAPHY		12				70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					96,808	73
75 ASC (NON-DISTINCT PART)		43	2,193			75
76 HEMODIALYSIS						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		307	2,688			90
91 EMERGENCY		469	16,023			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
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	276,724	4,850	117,847	168,009	96,808	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		14				190
192 PHYSICIANS' PRIVATE OFFICES		332	1,732			192
192.01 FUND DEVELOPMENT						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	276,724	5,196	119,579	168,009	96,808	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 COMMUNICATIONS					5.01
5.02 PURCHASING, RECEIVING					5.02
5.03 ADMITTING					5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 DATA PROCESSING					5.05
5.06 ADMINISTRATIVE & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	121,219				16
17 SOCIAL SERVICE		37,032			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			20,552		22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	15,149	20,153		1,666,016	30
31 INTENSIVE CARE UNIT	4,947	2,510		269,720	31
40 SUBPROVIDER - IPF	6,103	9,592		548,463	40
43 NURSERY	2,106	4,777		74,352	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	9,006			440,281	50
51 RECOVERY ROOM	578			6,680	51
52 DELIVERY ROOM & LABOR ROOM	4,786			197,306	52
53 ANESTHESIOLOGY	3,629			36,049	53
54 RADIOLOGY-DIAGNOSTIC	9,951			546,898	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	8,098			12,930	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,515			3,480	58
60 LABORATORY	10,858			280,012	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRANS.	1,404			6,514	63
65 RESPIRATORY THERAPY	4,948			60,857	65
66 PHYSICAL THERAPY	1,830			62,853	66
69 ELECTROCARDIOLOGY	2,747			42,049	69
70 ELECTROENCEPHALOGRAPHY	387			21,258	70
72 IMPL. DEV. CHARGED TO PATIENT				7,966	72
73 DRUGS CHARGED TO PATIENTS	14,804			144,456	73
75 ASC (NON-DISTINCT PART)	673			6,764	75
76 HEMODIALYSIS	462			3,131	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	2,429			208,197	90
91 EMERGENCY	13,901			188,670	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
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	121,219	37,032		4,834,902	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				7,054	190
192 PHYSICIANS' PRIVATE OFFICES				364,632	192
192.01 FUND DEVELOPMENT					192.01
200 CROSS FOOT ADJUSTMENTS			20,552	20,552	200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	121,219	37,032	20,552	5,227,140	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	COMMUNICATIONS		5.01
5.02	PURCHASING, RECEIVING		5.02
5.03	ADMITTING		5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE		5.04
5.05	DATA PROCESSING		5.05
5.06	ADMINISTRATIVE & GENERAL		5.06
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R 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	1,666,016	30
31	INTENSIVE CARE UNIT	269,720	31
40	SUBPROVIDER - IPF	548,463	40
43	NURSERY	74,352	43
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	440,281	50
51	RECOVERY ROOM	6,680	51
52	DELIVERY ROOM & LABOR ROOM	197,306	52
53	ANESTHESIOLOGY	36,049	53
54	RADIOLOGY-DIAGNOSTIC	546,898	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	12,930	57
58	MAGNETIC RESONANCE IMAGING (MRI)	3,480	58
60	LABORATORY	280,012	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,514	63
65	RESPIRATORY THERAPY	60,857	65
66	PHYSICAL THERAPY	62,853	66
69	ELECTROCARDIOLOGY	42,049	69
70	ELECTROENCEPHALOGRAPHY	21,258	70
72	IMPL. DEV. CHARGED TO PATIENT	7,966	72
73	DRUGS CHARGED TO PATIENTS	144,456	73
75	ASC (NON-DISTINCT PART)	6,764	75
76	HEMODIALYSIS	3,131	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	208,197	90
91	EMERGENCY	188,670	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
SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE		113
118	SUBTOTALS (SUM OF LINES 1-117)	4,834,902	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,054	190
192	PHYSICIANS' PRIVATE OFFICES	364,632	192
192.01	FUND DEVELOPMENT		192.01
200	CROSS FOOT ADJUSTMENTS	20,552	200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	5,227,140	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 VALUE	EMPLOYEE BENEFITS  GROSS SALARIES	RECON- CILIATION	A+G  ACCUM COST	
	1	2	4	5A.06	5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	202,656					1
2 CAP REL COSTS-MVBLE EQUIP		1,656,033				2
4 EMPLOYEE BENEFITS	797	935	45,759,821			4
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL	25,000	89,727	6,612,946	-24,757,283	69,017,969	5.06
6 MAINTENANCE & REPAIRS	7,573	27,614	373,310		1,856,076	6
7 OPERATION OF PLANT	24,988	149,517	1,116,373		3,398,351	7
8 LAUNDRY & LINEN SERVICE	3,533				578,621	8
9 HOUSEKEEPING	1,819	1,618	859,762		1,536,761	9
10 DIETARY	8,745	13,477	436,294		1,205,873	10
11 CAFETERIA			456,116		554,428	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,547	7,408	890,967		1,199,178	13
14 CENTRAL SERVICES & SUPPLY	5,230	19,763	305,291		705,864	14
15 PHARMACY	2,892	4,702	974,855		925,764	15
16 MEDICAL RECORDS & LIBRARY	3,695	6,537	476,430		894,809	16
17 SOCIAL SERVICE	998		554,375		745,910	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			1,432,023		1,553,347	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	42,145	38,081	6,331,381		8,428,160	30
31 INTENSIVE CARE UNIT	5,734	29,115	1,933,691		2,679,875	31
40 SUBPROVIDER - IPF	12,607	2,592	1,971,024		2,750,543	40
43 NURSERY	1,268	2,426	1,268,955		1,199,983	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,798	171,529	1,404,333		4,054,829	50
51 RECOVERY ROOM			324,159		407,523	51
52 DELIVERY ROOM & LABOR ROOM	3,883	29,224	3,478,335		3,826,237	52
53 ANESTHESIOLOGY	748	77			1,100,302	53
54 RADIOLOGY-DIAGNOSTIC	10,749	791,050	2,077,863		3,886,501	54
57 COMPUTED TOMOGRAPHY (CT) SCAN			335,771		515,812	57
58 MAGNETIC RESONANCE IMAGING (MRI)			152,911		208,255	58
60 LABORATORY	7,129	101,380	1,522,758		3,442,584	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			38,906		563,860	63
65 RESPIRATORY THERAPY	1,313	27,190	666,237		1,094,027	65
66 PHYSICAL THERAPY	1,728	469	647,027		905,517	66
69 ELECTROCARDIOLOGY	1,002	10,188	458,632		699,711	69
70 ELECTROENCEPHALOGRAPHY	633	4,744	54,964		87,530	70
72 IMPL. DEV. CHARGED TO PATIENT					782,142	72
73 DRUGS CHARGED TO PATIENTS					3,607,360	73
75 ASC (NON-DISTINCT PART)			318,423		412,219	75
76 HEMODIALYSIS					295,764	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	6,042	92	1,393,952		2,182,620	90
91 EMERGENCY	3,715	32,994	2,635,173		3,706,652	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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	193,311	1,562,449	41,503,237	-24,757,283	61,992,988	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	264	47,115		110,595	190
192 PHYSICIANS' PRIVATE OFFICES	9,195	93,320	4,209,469		6,914,386	192
192.01 FUND DEVELOPMENT						192.01

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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 VALUE	EMPLOYEE BENEFITS  GROSS SALARIES	RECON- CILIATION	A+G  ACCUM COST	
		1	2	4	5A.06	5.06	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	4,868,771	358,369	6,743,760		24,757,283	202
203	UNIT COST MULT-WS B PT I	24.024806	0.216402	0.147373		0.358708	203
204	COST TO BE ALLOC PER B PT II			19,350		622,825	204
205	UNIT COST MULT-WS B PT II			0.000423		0.009024	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTEN- ANCE AND REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE PATIENT DAYS 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
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL						5.06
6 MAINTENANCE & REPAIRS	169,286					6
7 OPERATION OF PLANT	24,988	144,298				7
8 LAUNDRY & LINEN SERVICE	3,533	3,533	680,476			8
9 HOUSEKEEPING	1,819	1,819		28,802		9
10 DIETARY	8,745	8,745			92,130	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,547	3,547				13
14 CENTRAL SERVICES & SUPPLY	5,230	5,230				14
15 PHARMACY	2,892	2,892				15
16 MEDICAL RECORDS & LIBRARY	3,695	3,695		173		16
17 SOCIAL SERVICE	998	998				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				2,426		22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	42,145	42,145	353,848	6,403	53,730	30
31 INTENSIVE CARE UNIT	5,734	5,734	68,048	1,274	10,593	31
40 SUBPROVIDER - IPF	12,607	12,607	183,729	2,487	27,807	40
43 NURSERY	1,268	1,268	74,851			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,798	5,798		2,782		50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM	3,883	3,883		5,793		52
53 ANESTHESIOLOGY	748	748				53
54 RADIOLOGY-DIAGNOSTIC	10,749	10,749		2,556		54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY	7,129	7,129		424		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
65 RESPIRATORY THERAPY	1,313	1,313		130		65
66 PHYSICAL THERAPY	1,728	1,728		195		66
69 ELECTROCARDIOLOGY	1,002	1,002		173		69
70 ELECTROENCEPHALOGRAPHY	633	633				70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS				121		73
75 ASC (NON-DISTINCT PART)						75
76 HEMODIALYSIS						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	6,042	6,042		390		90
91 EMERGENCY	3,715	3,715		2,062		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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	159,941	134,953	680,476	27,389	92,130	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	150		607		190
192 PHYSICIANS' PRIVATE OFFICES	9,195	9,195		806		192
192.01 FUND DEVELOPMENT						192.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAINTEN- ANCE AND REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING  (HOURS OF SERVICE)	DIETARY  (MEALS SERVED)	
		6	7	8	9	10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,521,865	4,989,615	960,974	2,178,005	2,071,093	202
203	UNIT COST MULT-WS B PT I	14.897068	34.578546	1.412209	75.619922	22.480115	203
204	COST TO BE ALLOC PER B PT II	204,823	694,061	111,369	69,233	276,724	204
205	UNIT COST MULT-WS B PT II	1.209923	4.809914	0.163663	2.403757	3.003625	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA FULL TIME HOURS 11	NURSING ADMINI- STRATION (FULL TIME TIME) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 PURCHASING, RECEIVING						5.02
5.03 ADMITTING						5.03
5.04 CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05 DATA PROCESSING						5.05
5.06 ADMINISTRATIVE & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	1,109,231					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	44,628	377,702				13
14 CENTRAL SERVICES & SUPPLY	21,069		100			14
15 PHARMACY	28,748			100		15
16 MEDICAL RECORDS & LIBRARY	20,296				271,696,138	16
17 SOCIAL SERVICE	17,265					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	20,603					22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	214,418	132,068			33,876,378	30
31 INTENSIVE CARE UNIT	44,541	39,356			11,090,884	31
40 SUBPROVIDER - IPF	71,990	24,863			13,683,345	40
43 NURSERY	23,485	16,179			4,722,178	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	44,250	24,855	100		20,192,075	50
51 RECOVERY ROOM	7,123	7,123			1,294,978	51
52 DELIVERY ROOM & LABOR ROOM	93,288	60,558			10,730,695	52
53 ANESTHESIOLOGY					8,137,390	53
54 RADIOLOGY-DIAGNOSTIC	72,473	1,201			22,311,298	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	7,513				18,157,651	57
58 MAGNETIC RESONANCE IMAGING (MRI)	4,412				3,397,483	58
60 LABORATORY	63,427				24,344,991	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	1,368				3,147,667	63
65 RESPIRATORY THERAPY	23,551				11,094,403	65
66 PHYSICAL THERAPY	19,228				4,102,132	66
69 ELECTROCARDIOLOGY	14,460				6,159,863	69
70 ELECTROENCEPHALOGRAPHY	2,545				867,052	70
72 IMPL. DEV. CHARGED TO PATIENT					2,035,357	72
73 DRUGS CHARGED TO PATIENTS				100	33,192,872	73
75 ASC (NON-DISTINCT PART)	9,115	6,927			1,508,653	75
76 HEMODIALYSIS					1,034,882	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	65,459	8,489			5,445,760	90
91 EMERGENCY	100,082	50,611			31,168,151	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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,035,337	372,230	100	100	271,696,138	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,082					190
192 PHYSICIANS' PRIVATE OFFICES	70,812	5,472				192
192.01 FUND DEVELOPMENT						192.01

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COST ALLOCATION - STATISTICAL BASIS

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COST CENTER DESCRIPTION		CAFETERIA	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	GROSS REVENUE	
		FULL TIME HOURS	(FULL TIME TIME)	(COSTED REQUIS)	(COSTED REQUIS)			
		11	13	14	15	16		
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	753,306	1,835,131	1,232,129	1,420,449	1,425,463		202
203	UNIT COST MULT-WS B PT I	0.679125	4.858674	12,321.290000	14,204.490000	0.005247		203
204	COST TO BE ALLOC PER B PT II	5,196	119,579	168,009	96,808	121,219		204
205	UNIT COST MULT-WS B PT II	0.004684	0.316596	1,680.090000	968.080000	0.000446		205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL	I/R-OTHER	
	SERVICE	PROGRAM	
	PATIENT	COSTS	
	DAYS	(ASSIGNED	
	17	TIME)	
		22	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5.01 COMMUNICATIONS			5.01
5.02 PURCHASING, RECEIVING			5.02
5.03 ADMITTING			5.03
5.04 CASHERING/ACCOUNTS RECEIVABLE			5.04
5.05 DATA PROCESSING			5.05
5.06 ADMINISTRATIVE & GENERAL			5.06
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE	36,094		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		250	22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	19,643	100	30
31 INTENSIVE CARE UNIT	2,446		31
40 SUBPROVIDER - IPF	9,349		40
43 NURSERY	4,656		43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
51 RECOVERY ROOM			51
52 DELIVERY ROOM & LABOR ROOM			52
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC			54
57 COMPUTED TOMOGRAPHY (CT) SCAN			57
58 MAGNETIC RESONANCE IMAGING (MRI)			58
60 LABORATORY			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63 BLOOD STORING, PROCESSING & TRANS.			63
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
69 ELECTROCARDIOLOGY			69
70 ELECTROENCEPHALOGRAPHY			70
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS			73
75 ASC (NON-DISTINCT PART)			75
76 HEMODIALYSIS			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		50	90
91 EMERGENCY		100	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
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	36,094	250	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
192 PHYSICIANS' PRIVATE OFFICES			192
192.01 FUND DEVELOPMENT			192.01

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COST CENTER DESCRIPTION	SOCIAL SERVICE  PATIENT DAYS 17	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I	1,074,575	2,307,991	202
203 UNIT COST MULT-WS B PT I	29.771569	9,231.964000	203
204 COST TO BE ALLOC PER B PT II	37,032	20,552	204
205 UNIT COST MULT-WS B PT II	1.025988	82.208000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	17,278,020		17,278,020		17,278,020	30
31 INTENSIVE CARE UNIT	4,707,913		4,707,913		4,707,913	31
40 SUBPROVIDER - IPF	5,953,382		5,953,382	26,573	5,979,955	40
43 NURSERY	2,056,817		2,056,817	55,583	2,112,400	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,495,453		7,495,453		7,495,453	50
51 RECOVERY ROOM	599,945		599,945		599,945	51
52 DELIVERY ROOM & LABOR ROOM	6,242,808		6,242,808	23,526	6,266,334	52
53 ANESTHESIOLOGY	1,574,694		1,574,694		1,574,694	53
54 RADIOLOGY-DIAGNOSTIC	6,177,839		6,177,839		6,177,839	54
57 COMPUTED TOMOGRAPHY (CT) SC	801,213		801,213		801,213	57
58 MAGNETIC RESONANCE IMAGING	303,781		303,781		303,781	58
60 LABORATORY	5,233,053		5,233,053		5,233,053	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	783,566		783,566		783,566	63
65 RESPIRATORY THERAPY	1,635,462		1,635,462		1,635,462	65
66 PHYSICAL THERAPY	1,365,155		1,365,155		1,365,155	66
69 ELECTROCARDIOLOGY	1,055,501		1,055,501		1,055,501	69
70 ELECTROENCEPHALOGRAPHY	156,523		156,523		156,523	70
72 IMPL. DEV. CHARGED TO PATIE	1,073,383		1,073,383		1,073,383	72
73 DRUGS CHARGED TO PATIENTS	6,505,111		6,505,111		6,505,111	73
75 ASC (NON-DISTINCT PART)	607,847		607,847		607,847	75
76 HEMODIALYSIS	407,287		407,287		407,287	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	3,408,241		3,408,241		3,408,241	90
91 EMERGENCY	5,853,397		5,853,397		5,853,397	91
92 OBSERVATION BEDS	42,675		42,675		42,675	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
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	81,319,066		81,319,066	105,682	81,424,748	200
201 LESS OBSERVATION BEDS	42,675		42,675		42,675	201
202 TOTAL (SEE INSTRUCTIONS)	81,276,391		81,276,391	105,682	81,382,073	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	30,257,395		30,257,395			30
31 INTENSIVE CARE UNIT	11,090,884		11,090,884			31
40 SUBPROVIDER - IPF	13,683,345		13,683,345			40
43 NURSERY	4,722,178		4,722,178			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,272,651	11,919,424	20,192,075	0.371208	0.371208	0.371208 50
51 RECOVERY ROOM	355,493	939,485	1,294,978	0.463286	0.463286	0.463286 51
52 DELIVERY ROOM & LABOR ROOM	9,195,089	1,535,606	10,730,695	0.581771	0.581771	0.583963 52
53 ANESTHESIOLOGY	2,906,538	5,230,852	8,137,390	0.193513	0.193513	0.193513 53
54 RADIOLOGY-DIAGNOSTIC	4,966,827	17,344,471	22,311,298	0.276893	0.276893	0.276893 54
57 COMPUTED TOMOGRAPHY (CT) SC	5,473,885	12,683,766	18,157,651	0.044125	0.044125	0.044125 57
58 MAGNETIC RESONANCE IMAGING	415,805	2,981,678	3,397,483	0.089414	0.089414	0.089414 58
60 LABORATORY	12,512,818	11,832,173	24,344,991	0.214954	0.214954	0.214954 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	2,596,590	551,077	3,147,667	0.248935	0.248935	0.248935 63
65 RESPIRATORY THERAPY	10,524,786	569,617	11,094,403	0.147413	0.147413	0.147413 65
66 PHYSICAL THERAPY	516,681	3,585,451	4,102,132	0.332792	0.332792	0.332792 66
69 ELECTROCARDIOLOGY	2,746,135	3,413,728	6,159,863	0.171351	0.171351	0.171351 69
70 ELECTROENCEPHALOGRAPHY	246,387	620,665	867,052	0.180523	0.180523	0.180523 70
72 IMPL. DEV. CHARGED TO PATIE	812,967	1,222,390	2,035,357	0.527368	0.527368	0.527368 72
73 DRUGS CHARGED TO PATIENTS	20,542,717	12,650,155	33,192,872	0.195979	0.195979	0.195979 73
75 ASC (NON-DISTINCT PART)	80,165	1,428,488	1,508,653	0.402907	0.402907	0.402907 75
76 HEMODIALYSIS	955,187	79,695	1,034,882	0.393559	0.393559	0.393559 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	4,122	5,441,638	5,445,760	0.625852	0.625852	0.625852 90
91 EMERGENCY	6,270,531	24,897,620	31,168,151	0.187801	0.187801	0.187801 91
92 OBSERVATION BEDS	134,953	3,484,030	3,618,983	0.011792	0.011792	0.011792 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
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	149,284,129	122,412,009	271,696,138			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	149,284,129	122,412,009	271,696,138			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		REDUCED	TOTAL PATIENT DAYS	PER DIEM (COL.3 ÷ COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)					
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,666,016		1,666,016	17,005	97.97	6,548	641,508	30
31 INTENSIVE CARE UNIT	269,720		269,720	3,531	76.39	1,543	117,870	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	548,463		548,463	9,269	59.17	2,715	160,647	40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	74,352		74,352	3,648	20.38			43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	2,558,551		2,558,551	33,453		10,806	920,025	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[XX] HOSPITAL (14-0095) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[XX] PPS [ ] TEFRA			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	440,281	20,192,075	0.021805	2,249,767	49,056	50
51	RECOVERY ROOM	6,680	1,294,978	0.005158	105,681	545	51
52	DELIVERY ROOM & LABOR ROOM	197,306	10,730,695	0.018387	9,524	175	52
53	ANESTHESIOLOGY	36,049	8,137,390	0.004430	551,712	2,444	53
54	RADIOLOGY-DIAGNOSTIC	546,898	22,311,298	0.024512	2,040,368	50,014	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	12,930	18,157,651	0.000712	1,643,163	1,170	57
58	MAGNETIC RESONANCE IMAGING (M	3,480	3,397,483	0.001024	162,139	166	58
60	LABORATORY	280,012	24,344,991	0.011502	4,155,167	47,793	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	6,514	3,147,667	0.002069	834,878	1,727	63
65	RESPIRATORY THERAPY	60,857	11,094,403	0.005485	5,092,485	27,932	65
66	PHYSICAL THERAPY	62,853	4,102,132	0.015322	285,260	4,371	66
69	ELECTROCARDIOLOGY	42,049	6,159,863	0.006826	1,203,053	8,212	69
70	ELECTROENCEPHALOGRAPHY	21,258	867,052	0.024518	110,884	2,719	70
72	IMPL. DEV. CHARGED TO PATIENT	7,966	2,035,357	0.003914	291,374	1,140	72
73	DRUGS CHARGED TO PATIENTS	144,456	33,192,872	0.004352	6,569,026	28,588	73
75	ASC (NON-DISTINCT PART)	6,764	1,508,653	0.004483	18,425	83	75
76	HEMODIALYSIS	3,131	1,034,882	0.003025	474,227	1,435	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	208,197	5,445,760	0.038231	308	12	90
91	EMERGENCY	188,670	31,168,151	0.006053	1,585,387	9,596	91
92	OBSERVATION BEDS	4,115	3,618,983	0.001137	40,486	46	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	2,280,466	211,942,336	211,942,336	27,423,314	237,224	200

PROVIDER CCN: 14-0095 ST ANTHONY 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  
 01/26/2012 15:47

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: 14-0095 ST ANTHONY 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  
 01/26/2012 15:47

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	17,005		6,548		30
31 INTENSIVE CARE UNIT	3,531		1,543		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	9,269		2,715		40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	3,648				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	33,453		10,806		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0095) [ ] 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			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
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 FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 HEMODIALYSIS						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
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 (14-0095)	[ ] 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) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	20,192,075		2,249,767		1,820,586	50
51	RECOVERY ROOM	1,294,978		105,681		249,865	51
52	DELIVERY ROOM & LABOR ROOM	10,730,695		9,524		2,891	52
53	ANESTHESIOLOGY	8,137,390		551,712		994,807	53
54	RADIOLOGY-DIAGNOSTIC	22,311,298		2,040,368		2,184,307	54
57	COMPUTED TOMOGRAPHY (CT) SCA	18,157,651		1,643,163		2,140,062	57
58	MAGNETIC RESONANCE IMAGING (	3,397,483		162,139		518,475	58
60	LABORATORY	24,344,991		4,155,167		248,615	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
63	BLOOD STORING, PROCESSING &	3,147,667		834,878		58,638	63
65	RESPIRATORY THERAPY	11,094,403		5,092,485		316,593	65
66	PHYSICAL THERAPY	4,102,132		285,260		23,444	66
69	ELECTROCARDIOLOGY	6,159,863		1,203,053		1,025,859	69
70	ELECTROENCEPHALOGRAPHY	867,052		110,884		158,435	70
72	IMPL. DEV. CHARGED TO PATIEN	2,035,357		291,374		173,864	72
73	DRUGS CHARGED TO PATIENTS	33,192,872		6,569,026		4,667,144	73
75	ASC (NON-DISTINCT PART)	1,508,653		18,425		233,823	75
76	HEMODIALYSIS	1,034,882		474,227		16,224	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	5,445,760		308		2,169,511	90
91	EMERGENCY	31,168,151		1,585,387		1,543,873	91
92	OBSERVATION BEDS	3,618,983		40,486		728,896	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	211,942,336		27,423,314		19,275,912	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0095) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO		PROGRAM CHARGES				PROGRAM COSTS		
	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	0.371208	1,820,586			675,816			50	
51 RECOVERY ROOM	0.463286	249,865			115,759			51	
52 DELIVERY ROOM & LABOR ROOM	0.581771	2,891			1,682			52	
53 ANESTHESIOLOGY	0.193513	994,807			192,508			53	
54 RADIOLOGY-DIAGNOSTIC	0.276893	2,184,307			604,819			54	
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.044125	2,140,062			94,430			57	
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089414	518,475			46,359			58	
60 LABORATORY	0.214954	248,615			53,441			60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30	
63 BLOOD STORING, PROCESSING & TRA	0.248935	58,638			14,597			63	
65 RESPIRATORY THERAPY	0.147413	316,593			46,670			65	
66 PHYSICAL THERAPY	0.332792	23,444			7,802			66	
69 ELECTROCARDIOLOGY	0.171351	1,025,859			175,782			69	
70 ELECTROENCEPHALOGRAPHY	0.180523	158,435			28,601			70	
72 IMPL. DEV. CHARGED TO PATIENT	0.527368	173,864			91,690			72	
73 DRUGS CHARGED TO PATIENTS	0.195979	4,667,144		12,497	914,662		2,449	73	
75 ASC (NON-DISTINCT PART)	0.402907	233,823			94,209			75	
76 HEMODIALYSIS	0.393559	16,224			6,385			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	0.625852	2,169,511			1,357,793			90	
91 EMERGENCY	0.187801	1,543,873			289,941			91	
92 OBSERVATION BEDS	0.011792	728,896			8,595			92	
OTHER REIMBURSABLE COST CENTERS									
200 SUBTOTAL (SEE INSTRUCTIONS)		19,275,912		12,497	4,821,541		2,449	200	
201 LESS PBP CLINIC LAB SERVICES								201	
202 NET CHARGES (LINE 200 - LINE 201)		19,275,912		12,497	4,821,541		2,449	202	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[ ] HOSPITAL [XX] IPF (14-S095) [ ] IRF	[ ] SUB (OTHER)	[XX] PPS [ ] TEFRA			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	440,281	20,192,075	0.021805	11,895	259	50
51	RECOVERY ROOM	6,680	1,294,978	0.005158	784	4	51
52	DELIVERY ROOM & LABOR ROOM	197,306	10,730,695	0.018387			52
53	ANESTHESIOLOGY	36,049	8,137,390	0.004430	3,240	14	53
54	RADIOLOGY-DIAGNOSTIC	546,898	22,311,298	0.024512	45,309	1,111	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	12,930	18,157,651	0.000712	34,757	25	57
58	MAGNETIC RESONANCE IMAGING (M	3,480	3,397,483	0.001024	5,683	6	58
60	LABORATORY	280,012	24,344,991	0.011502	300,321	3,454	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	6,514	3,147,667	0.002069	15,798	33	63
65	RESPIRATORY THERAPY	60,857	11,094,403	0.005485	184,964	1,015	65
66	PHYSICAL THERAPY	62,853	4,102,132	0.015322	10,076	154	66
69	ELECTROCARDIOLOGY	42,049	6,159,863	0.006826	36,680	250	69
70	ELECTROENCEPHALOGRAPHY	21,258	867,052	0.024518	12,562	308	70
72	IMPL. DEV. CHARGED TO PATIENT	7,966	2,035,357	0.003914			72
73	DRUGS CHARGED TO PATIENTS	144,456	33,192,872	0.004352	819,146	3,565	73
75	ASC (NON-DISTINCT PART)	6,764	1,508,653	0.004483	215	1	75
76	HEMODIALYSIS	3,131	1,034,882	0.003025	11,968	36	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	208,197	5,445,760	0.038231			90
91	EMERGENCY	188,670	31,168,151	0.006053	110,409	668	91
92	OBSERVATION BEDS	4,115	3,618,983	0.001137			92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	2,280,466	211,942,336	211,942,336	1,603,807	10,903	200

PROVIDER CCN: 14-0095 ST ANTHONY 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 ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S095) [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 HEMODIALYSIS						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
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	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[XX] IPF (14-S095)	[ ] SNF		[ ] TEFRA		
BOXES	[ ] TITLE XIX	[ ] IRF	[ ] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES (COL. 9 x COL. 12) 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	20,192,075			11,895		50
51	RECOVERY ROOM	1,294,978			784		51
52	DELIVERY ROOM & LABOR ROOM	10,730,695					52
53	ANESTHESIOLOGY	8,137,390			3,240		53
54	RADIOLOGY-DIAGNOSTIC	22,311,298			45,309		54
57	COMPUTED TOMOGRAPHY (CT) SCA	18,157,651			34,757		57
58	MAGNETIC RESONANCE IMAGING (	3,397,483			5,683		58
60	LABORATORY	24,344,991			300,321		60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
63	BLOOD STORING, PROCESSING &	3,147,667			15,798		63
65	RESPIRATORY THERAPY	11,094,403			184,964		65
66	PHYSICAL THERAPY	4,102,132			10,076		66
69	ELECTROCARDIOLOGY	6,159,863			36,680		69
70	ELECTROENCEPHALOGRAPHY	867,052			12,562		70
72	IMPL. DEV. CHARGED TO PATIEN	2,035,357					72
73	DRUGS CHARGED TO PATIENTS	33,192,872			819,146		73
75	ASC (NON-DISTINCT PART)	1,508,653			215		75
76	HEMODIALYSIS	1,034,882			11,968		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	5,445,760					90
91	EMERGENCY	31,168,151			110,409		91
92	OBSERVATION BEDS	3,618,983					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	211,942,336			1,603,807		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [XX] IPF (14-S095) [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	REIMBURSED	SUBJECT TO	SVCES NOT	SUBJECT TO	SVCES NOT	
	FROM WKST C,	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	PT I, COL. 9						
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.371208						50
51 RECOVERY ROOM	0.463286						51
52 DELIVERY ROOM & LABOR ROOM	0.581771						52
53 ANESTHESIOLOGY	0.193513						53
54 RADIOLOGY-DIAGNOSTIC	0.276893						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.044125						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089414						58
60 LABORATORY	0.214954						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63 BLOOD STORING, PROCESSING & TRA	0.248935						63
65 RESPIRATORY THERAPY	0.147413						65
66 PHYSICAL THERAPY	0.332792						66
69 ELECTROCARDIOLOGY	0.171351						69
70 ELECTROENCEPHALOGRAPHY	0.180523						70
72 IMPL. DEV. CHARGED TO PATIENT	0.527368						72
73 DRUGS CHARGED TO PATIENTS	0.195979						73
75 ASC (NON-DISTINCT PART)	0.402907						75
76 HEMODIALYSIS	0.393559						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	0.625852						90
91 EMERGENCY	0.187801						91
92 OBSERVATION BEDS	0.011792						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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER DIEM (COL.3 ÷ COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)					
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,666,016		1,666,016	17,005	97.97	8,495	832,255	30
31 INTENSIVE CARE UNIT	269,720		269,720	3,531	76.39	1,932	147,585	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	548,463		548,463	9,269	59.17	5,347	316,382	40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	74,352		74,352	3,648	20.38	1,996	40,678	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	2,558,551		2,558,551	33,453		17,770	1,336,900	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0095) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[XX] PPS [ ] TEFRA [ ] OTHER	
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	440,281	20,192,075	0.021805	50
51	RECOVERY ROOM	6,680	1,294,978	0.005158	51
52	DELIVERY ROOM & LABOR ROOM	197,306	10,730,695	0.018387	52
53	ANESTHESIOLOGY	36,049	8,137,390	0.004430	53
54	RADIOLOGY-DIAGNOSTIC	546,898	22,311,298	0.024512	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	12,930	18,157,651	0.000712	57
58	MAGNETIC RESONANCE IMAGING (M	3,480	3,397,483	0.001024	58
60	LABORATORY	280,012	24,344,991	0.011502	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
63	BLOOD STORING, PROCESSING & T	6,514	3,147,667	0.002069	63
65	RESPIRATORY THERAPY	60,857	11,094,403	0.005485	65
66	PHYSICAL THERAPY	62,853	4,102,132	0.015322	66
69	ELECTROCARDIOLOGY	42,049	6,159,863	0.006826	69
70	ELECTROENCEPHALOGRAPHY	21,258	867,052	0.024518	70
72	IMPL. DEV. CHARGED TO PATIENT	7,966	2,035,357	0.003914	72
73	DRUGS CHARGED TO PATIENTS	144,456	33,192,872	0.004352	73
75	ASC (NON-DISTINCT PART)	6,764	1,508,653	0.004483	75
76	HEMODIALYSIS	3,131	1,034,882	0.003025	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	208,197	5,445,760	0.038231	90
91	EMERGENCY	188,670	31,168,151	0.006053	91
92	OBSERVATION BEDS		3,618,983	3,618,983	92
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (SUM OF LINES 50-199)	2,276,351	211,942,336	211,942,336	200

PROVIDER CCN: 14-0095 ST ANTHONY 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  
01/26/2012 15:47

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

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

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

PROVIDER CCN: 14-0095 ST ANTHONY 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 [ ] 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	17,005		8,495		30
31 INTENSIVE CARE UNIT	3,531		1,932		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	9,269		5,347		40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	3,648		1,996		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	33,453		17,770		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0095) [ ] 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			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 HEMODIALYSIS						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
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 (14-0095)	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS		
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[XX] TITLE XIX	[ ] IRF	[ ] NF		[ ] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	20,192,075					50
51	RECOVERY ROOM	1,294,978					51
52	DELIVERY ROOM & LABOR ROOM	10,730,695					52
53	ANESTHESIOLOGY	8,137,390					53
54	RADIOLOGY-DIAGNOSTIC	22,311,298					54
57	COMPUTED TOMOGRAPHY (CT) SCA	18,157,651					57
58	MAGNETIC RESONANCE IMAGING (	3,397,483					58
60	LABORATORY	24,344,991					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
63	BLOOD STORING, PROCESSING &	3,147,667					63
65	RESPIRATORY THERAPY	11,094,403					65
66	PHYSICAL THERAPY	4,102,132					66
69	ELECTROCARDIOLOGY	6,159,863					69
70	ELECTROENCEPHALOGRAPHY	867,052					70
72	IMPL. DEV. CHARGED TO PATIEN	2,035,357					72
73	DRUGS CHARGED TO PATIENTS	33,192,872					73
75	ASC (NON-DISTINCT PART)	1,508,653					75
76	HEMODIALYSIS	1,034,882					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	5,445,760					90
91	EMERGENCY	31,168,151					91
92	OBSERVATION BEDS	3,618,983					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	211,942,336					200



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [XX] IPF (14-S095) [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL
	COST	CHARGES	COST TO		(COL. 3 x
(FROM WKST	(FROM WKST	CHARGES	(COL.1 ÷	PROGRAM	COL. 4)
B, PT. II,	C, PT. I,	(COL.2)	COL.2)	CHARGES	COL. 4)
COL. 26)	COL. 8)				
1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	440,281	20,192,075	0.021805		50
51 RECOVERY ROOM	6,680	1,294,978	0.005158		51
52 DELIVERY ROOM & LABOR ROOM	197,306	10,730,695	0.018387		52
53 ANESTHESIOLOGY	36,049	8,137,390	0.004430		53
54 RADIOLOGY-DIAGNOSTIC	546,898	22,311,298	0.024512		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	12,930	18,157,651	0.000712		57
58 MAGNETIC RESONANCE IMAGING (M	3,480	3,397,483	0.001024		58
60 LABORATORY	280,012	24,344,991	0.011502		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
63 BLOOD STORING, PROCESSING & T	6,514	3,147,667	0.002069		63
65 RESPIRATORY THERAPY	60,857	11,094,403	0.005485		65
66 PHYSICAL THERAPY	62,853	4,102,132	0.015322		66
69 ELECTROCARDIOLOGY	42,049	6,159,863	0.006826		69
70 ELECTROENCEPHALOGRAPHY	21,258	867,052	0.024518		70
72 IMPL. DEV. CHARGED TO PATIENT	7,966	2,035,357	0.003914		72
73 DRUGS CHARGED TO PATIENTS	144,456	33,192,872	0.004352		73
75 ASC (NON-DISTINCT PART)	6,764	1,508,653	0.004483		75
76 HEMODIALYSIS	3,131	1,034,882	0.003025		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	208,197	5,445,760	0.038231		90
91 EMERGENCY	188,670	31,168,151	0.006053		91
92 OBSERVATION BEDS		3,618,983	3,618,983		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	2,276,351	211,942,336	211,942,336		200

PROVIDER CCN: 14-0095 ST ANTHONY 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 ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [XX] IPF (14-S095) [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [ ] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 HEMODIALYSIS						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
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	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS		
APPLICABLE	[ ] TITLE XVIII-PT A	[XX] IPF (14-S095)	[ ] SNF		[ ] TEFRA		
BOXES	[XX] TITLE XIX	[ ] IRF	[ ] NF		[ ] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	20,192,075					50
51	RECOVERY ROOM	1,294,978					51
52	DELIVERY ROOM & LABOR ROOM	10,730,695					52
53	ANESTHESIOLOGY	8,137,390					53
54	RADIOLOGY-DIAGNOSTIC	22,311,298					54
57	COMPUTED TOMOGRAPHY (CT) SCA	18,157,651					57
58	MAGNETIC RESONANCE IMAGING (	3,397,483					58
60	LABORATORY	24,344,991					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
63	BLOOD STORING, PROCESSING &	3,147,667					63
65	RESPIRATORY THERAPY	11,094,403					65
66	PHYSICAL THERAPY	4,102,132					66
69	ELECTROCARDIOLOGY	6,159,863					69
70	ELECTROENCEPHALOGRAPHY	867,052					70
72	IMPL. DEV. CHARGED TO PATIEN	2,035,357					72
73	DRUGS CHARGED TO PATIENTS	33,192,872					73
75	ASC (NON-DISTINCT PART)	1,508,653					75
76	HEMODIALYSIS	1,034,882					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	5,445,760					90
91	EMERGENCY	31,168,151					91
92	OBSERVATION BEDS	3,618,983					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	211,942,336					200



WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0095) [ ] 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)	17,005	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	17,005	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	17,005	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)	6,548	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)	17,278,020	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	17,278,020	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	30,257,395	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	30,257,395	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.571035	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,779.32	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	17,278,020	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0095) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,016.06 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 6,653,161 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) 6,653,161 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
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42 NURSERY (TITLES V AND XIX ONLY) 42

43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	4,707,913	3,531	1,333.31	1,543	2,057,297
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)					5,754,694
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					14,465,152

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 759,378 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 237,224 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 996,602 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 13,468,550 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) 42 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,016.06 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 42,675 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
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COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

90 CAPITAL-RELATED COST	1,666,016	17,278,020	0.096424	42,675	4,115
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S095) [ ] 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)	9,269	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,269	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,269	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)	2,715	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)	5,979,955	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	5,979,955	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.437024	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,476.25	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,979,955	37

WORKSHEET D-1  
PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S095)			[ ]	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)	645.16 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,751,609 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	1,751,609 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	313,721 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	2,065,330 49

PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	160,647 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	10,903 51
52	TOTAL PROGRAM EXCLUDABLE COST	171,550 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	1,893,780 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

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0095) [ ] 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)	17,005	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	17,005	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	17,005	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)	8,495	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)	3,648	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	1,996	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)	17,278,020	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	17,278,020	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	30,257,395	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	30,257,395	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.571035	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,779.32	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	17,278,020	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0095) [ ] 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) 1,016.06 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 8,631,430 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) 8,631,430 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)	2,112,400	3,648	579.06	1,996	1,155,804 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	4,707,913	3,531	1,333.31	1,932	2,575,955 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)					12,363,189 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 1,020,518 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 1,020,518 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 11,342,671 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) 42 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 3	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1			
90 CAPITAL-RELATED COST				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 [ ] TITLE XVIII-PT A [XX] IPF (14-S095) [ ] 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)	9,269 1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,269 2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,269 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)	5,347 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)	5,979,955 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	5,979,955 27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345 28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345 30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.437024 31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,476.25 33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,979,955 37

WORKSHEET D-1  
PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)			[ ]	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)	645.16 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	3,449,671 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)	3,449,671 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	3,449,671 49

PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	316,382 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	316,382 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	3,133,289 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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0095) [ ] 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		10,986,229		30
31 INTENSIVE CARE UNIT		6,255,976		31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.371208	2,249,767	835,132	50
51 RECOVERY ROOM	0.463286	105,681	48,961	51
52 DELIVERY ROOM & LABOR ROOM	0.583963	9,524	5,562	52
53 ANESTHESIOLOGY	0.193513	551,712	106,763	53
54 RADIOLOGY-DIAGNOSTIC	0.276893	2,040,368	564,964	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.044125	1,643,163	72,505	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089414	162,139	14,497	58
60 LABORATORY	0.214954	4,155,167	893,170	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.248935	834,878	207,830	63
65 RESPIRATORY THERAPY	0.147413	5,092,485	750,698	65
66 PHYSICAL THERAPY	0.332792	285,260	94,932	66
69 ELECTROCARDIOLOGY	0.171351	1,203,053	206,144	69
70 ELECTROENCEPHALOGRAPHY	0.180523	110,884	20,017	70
72 IMPL. DEV. CHARGED TO PATIENT	0.527368	291,374	153,661	72
73 DRUGS CHARGED TO PATIENTS	0.195979	6,569,026	1,287,391	73
75 ASC (NON-DISTINCT PART)	0.402907	18,425	7,424	75
76 HEMODIALYSIS	0.393559	474,227	186,636	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	0.625852	308	193	90
91 EMERGENCY	0.187801	1,585,387	297,737	91
92 OBSERVATION BEDS	0.011792	40,486	477	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		27,423,314	5,754,694	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		27,423,314		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B SNF [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S095) [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF		3,960,944		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.371208	11,895	4,416	50
51 RECOVERY ROOM	0.463286	784	363	51
52 DELIVERY ROOM & LABOR ROOM	0.583963			52
53 ANESTHESIOLOGY	0.193513	3,240	627	53
54 RADIOLOGY-DIAGNOSTIC	0.276893	45,309	12,546	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.044125	34,757	1,534	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089414	5,683	508	58
60 LABORATORY	0.214954	300,321	64,555	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.248935	15,798	3,933	63
65 RESPIRATORY THERAPY	0.147413	184,964	27,266	65
66 PHYSICAL THERAPY	0.332792	10,076	3,353	66
69 ELECTROCARDIOLOGY	0.171351	36,680	6,285	69
70 ELECTROENCEPHALOGRAPHY	0.180523	12,562	2,268	70
72 IMPL. DEV. CHARGED TO PATIENT	0.527368			72
73 DRUGS CHARGED TO PATIENTS	0.195979	819,146	160,535	73
75 ASC (NON-DISTINCT PART)	0.402907	215	87	75
76 HEMODIALYSIS	0.393559	11,968	4,710	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	0.625852			90
91 EMERGENCY	0.187801	110,409	20,735	91
92 OBSERVATION BEDS	0.011792			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,603,807	313,721	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,603,807		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0095) [ ] 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
40 SUBPROVIDER - IPF				40
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.371208			50
51 RECOVERY ROOM	0.463286			51
52 DELIVERY ROOM & LABOR ROOM	0.583963			52
53 ANESTHESIOLOGY	0.193513			53
54 RADIOLOGY-DIAGNOSTIC	0.276893			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.044125			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089414			58
60 LABORATORY	0.214954			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.248935			63
65 RESPIRATORY THERAPY	0.147413			65
66 PHYSICAL THERAPY	0.332792			66
69 ELECTROCARDIOLOGY	0.171351			69
70 ELECTROENCEPHALOGRAPHY	0.180523			70
72 IMPL. DEV. CHARGED TO PATIENT	0.527368			72
73 DRUGS CHARGED TO PATIENTS	0.195979			73
75 ASC (NON-DISTINCT PART)	0.402907			75
76 HEMODIALYSIS	0.393559			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	0.625852			90
91 EMERGENCY	0.187801			91
92 OBSERVATION BEDS	0.011792			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

PROVIDER CCN: 14-0095 ST ANTHONY 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  
 01/26/2012 15:47

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	S/B SNF	<input type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input checked="" type="checkbox"/>	IPF (14-S095)	<input type="checkbox"/>	SNF	<input type="checkbox"/>	S/B NF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.371208			50
51 RECOVERY ROOM	0.463286			51
52 DELIVERY ROOM & LABOR ROOM	0.583963			52
53 ANESTHESIOLOGY	0.193513			53
54 RADIOLOGY-DIAGNOSTIC	0.276893			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.044125			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089414			58
60 LABORATORY	0.214954			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.248935			63
65 RESPIRATORY THERAPY	0.147413			65
66 PHYSICAL THERAPY	0.332792			66
69 ELECTROCARDIOLOGY	0.171351			69
70 ELECTROENCEPHALOGRAPHY	0.180523			70
72 IMPL. DEV. CHARGED TO PATIENT	0.527368			72
73 DRUGS CHARGED TO PATIENTS	0.195979			73
75 ASC (NON-DISTINCT PART)	0.402907			75
76 HEMODIALYSIS	0.393559			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	0.625852			90
91 EMERGENCY	0.187801			91
92 OBSERVATION BEDS	0.011792			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 (14-0095)  
 APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	9,447,431	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	316,293	2
3	MANAGED CARE SIMULATED PAYMENTS	1,123	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	108.88	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)	5.59	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)	5.59	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	1.78	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	1.78	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	2.13	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	0.75	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	1.55	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	1.55	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.014236	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.016945	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.014236	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	73,226	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)	-3.81	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)	73,226	29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.1594	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.5471	31
32	SUM OF LINES 30 AND 31	0.7065	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.4750	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	4,487,530	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)	14,324,480	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	14,324,480	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	915,578	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 (14-0095)  
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)	46,867	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)	15,286,925	59
60	PRIMARY PAYER PAYMENTS	1,454	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	15,285,471	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	900,640	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	206,842	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	411,109	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	287,776	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	383,739	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	14,465,765	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)	14,465,765	71
72	INTERIM PAYMENTS	14,474,541	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-8,776	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	451,124	75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:             HOSPITAL (14-0095)             IPF             IRF  
    SUB (OTHER)                             SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,449	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)	4,821,541	2
3	PPS PAYMENTS	4,204,818	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	3,922	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)	2,449	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	12,497	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)	12,497	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)	12,497	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	10,048	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)	2,449	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)	4,208,740	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	967,951	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,243,238	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)	13,674	28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	3,256,912	30
31	PRIMARY PAYER PAYMENTS	1,516	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,255,396	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)	388,680	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	272,076	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	380,458	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	3,527,472	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	4,236	38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	3,523,236	40
41	INTERIM PAYMENTS	3,385,910	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	137,326	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	11,756	44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:             HOSPITAL                             IPF (14-S095)             IRF  
    SUB (OTHER)                             SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

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





PROVIDER CCN: 14-0095 ST ANTHONY 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  
01/26/2012 15:47

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-0095) [ ] CAH  
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	7,826	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	8,091	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	167	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	20,494	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	271,696,138	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	24,050,472	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART II

CHECK [ ] HOSPITAL  
APPLICABLE BOX: [XX] IPF (14-S095)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	2,031,058	1
2	NET IPF PPS OUTLIER PAYMENT	44,486	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN PTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	25.394521	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8}/\text{LINE 9}))\}$ RAISED TO THE POWER OF .5150 -1}		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	2,075,544	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	2,075,544	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	2,075,544	18
19	DEDUCTIBLES	83,620	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	1,991,924	20
21	COINSURANCE	62,432	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	1,929,492	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	1,929,492	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	1,929,492	31
32	INTERIM PAYMENTS	1,929,492	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)		34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35
TO BE COMPLETED BY CONTRACTOR			
50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-0095) [ ] 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 4 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART VII

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SNF [XX] PPS  
APPLICABLE [XX] TITLE XIX [XX] IPF (14-S095) [ ] 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 4 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996	5.59		1	
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2	
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA	-3.26		3	
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01	
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4	
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01	
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02	
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)	8.85		5	
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)	1.78		6	
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7	
			PRIMARY CARE	OTHER	TOTAL
			1	2	3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	1.22	0.52		1.74
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	1.22	0.52		1.74
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10
11	TOTAL WEIGHTED FTE COUNT				11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	0.87	0.44		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	0.74	0.19		13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	0.94	0.38		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.94	0.38		17
18	PER RESIDENT AMOUNT	122,474.36	130,103.93		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	115,126	49,439		164,565
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)				164,565
	COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT	MANAGED	
			PART A	CARE	
26	INPATIENT DAYS		10,806	167	26
27	TOTAL INPATIENT DAYS		29,763	29,763	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.363068		0.005611	28
29	PROGRAM DIRECT GME AMOUNT	59,748		923	29
30	REDUCTION FOR NURSING/ALLIED HEALTH			130	30
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
31	NET PROGRAM DIRECT GME AMOUNT				60,541
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)				16,530,482
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)				38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)				39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				1,454
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)				16,529,028
	PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)				4,823,990
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				1,516
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)				4,822,474
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)				21,351,502
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)				0.774139
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)				0.225861
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)				60,541
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				46,867
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				13,674

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
		PRIMARY CARE	OTHER	TOTAL
		1	2	3
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)			12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)			14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT			17
18	PER RESIDENT AMOUNT			18
19	APPROVED AMOUNT FOR RESIDENT COSTS			19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT	MANAGED	
		PART A	CARE	
26	INPATIENT DAYS	15,774	785	26
27	TOTAL INPATIENT DAYS	29,763	29,763	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.529987	0.026375	28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR NURSING/ALLIED HEALTH			30
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
31	NET PROGRAM DIRECT GME AMOUNT			31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			50

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	22,489,659			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	13,896,895			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	1,047,378			7
8 PREPAID EXPENSES				8
9 OTHER CURRENT ASSETS	1,500,454			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	38,934,386			11
FIXED ASSETS				
12 LAND	803,709			12
13 LAND IMPROVEMENTS				13
14 ACCUMULATED DEPRECIATION				14
15 BUILDINGS	53,462,387			15
16 ACCUMULATED DEPRECIATION	-36,609,024			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT				23
24 ACCUMULATED DEPRECIATION				24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	17,657,072			30
OTHER ASSETS				
31 INVESTMENTS				31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	22,138,391			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	22,138,391			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	78,729,849			36
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	7,517,378			37
38 SALARIES, WAGES & FEES PAYABLE				38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)				40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS	-45,488			43
44 OTHER CURRENT LIABILITIES	4,377,570			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	11,849,460			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE				47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	6,293,054			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	6,293,054			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	18,142,514			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	60,587,335			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)	60,587,335			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	78,729,849			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	3	5	7	
	2	4	6	8	
1 FUND BALANCES AT BEGINNING OF PERIOD	60,250,477				1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)	944,997				2
3 TOTAL (SUM OF LINE 1 AND LINE 2)	61,195,474				3
4 ADDITIONS (CREDIT ADJUSTMENTS)					4
5 UNRESTRICTED ASSETS					5
6					6
7					7
8					8
9					9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)					10
11 SUBTOTAL (LINE 3 PLUS LINE 10)	61,195,474				11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13 UNRESTRICTED ASSETS	608,139				13
14					14
15					15
16					16
17					17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)	608,139				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	60,587,335				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	30,257,395		30,257,395	1
2 SUBPROVIDER IPF	13,683,345		13,683,345	2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	43,940,740		43,940,740	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT	11,090,884		11,090,884	11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	11,090,884		11,090,884	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	55,031,624		55,031,624	17
18 ANCILLARY SERVICES	94,117,552	122,430,128	216,547,680	18
19 OUTPATIENT SERVICES				19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	149,149,176	122,430,128	271,579,304	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		95,289,866	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38 PHYSICIAN PRACTICE REVENUE	-20,035,118		38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)	-20,035,118		42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		75,254,748	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	271,579,304	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	197,830,567	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	73,748,737	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	75,254,748	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,506,011	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING REVENUE)	2,764,939	24
24.01	OTHER (PHYSICIAN REVENUE)		24.01
24.02	OTHER (RECONCILING ITEM)		24.02
24.03	OTHER (RENTAL INCOME FROM OUTSIDE CLINICS)		24.03
24.04	OTHER (STUDENT MENTORING PROGRAM)		24.04
24.05	OTHER (HOUSE STAFF/PEDS& MED STUDENT PROGR)		24.05
24.06	OTHER (FINANCIAL CENTER ,ADMINISTRATION &)		24.06
24.07	OTHER (ADMINISTRATION FHN CONTRIBUTION)		24.07
24.08	OTHER (FINANCE DEPT.)		24.08
24.09	OTHER (FQHC CLINIC SOUTH LAWNDALE)		24.09
24.10	OTHER (FQHC CLINIC LOWER WESTSIDE)		24.10
24.11	OTHER (MIDWIFERY CITY OF CHGO GRANT)		24.11
24.12	OTHER (SURGERY CAPITAL GRANT)		24.12
24.13	OTHER (QUALITY ASSURANCE)		24.13
24.14	OTHER (PROGRAM CIELO)		24.14
24.15	OTHER (51ST STREET CLINIC GRANT)		24.15
24.16	OTHER (59 TH STREET CLINIC GRANT)		24.16
24.17	OTHER (VENDING MACHINES COMMISSIONS)		24.17
24.18	OTHER (LAB ADMINISTRATION)		24.18
24.19	OTHER (RADIOLOGY)		24.19
24.20	OTHER (EMERGENCY DEPARTMENT)		24.20
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	2,764,939	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,258,928	26
27	OTHER EXPENSES (NON-OPERATING INCOME)	313,931	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	313,931	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	944,997	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((14-009) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
 BOXES [ ] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	770,721	1
2	CAPITAL DRG OUTLIER PAYMENTS	20,308	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	56.15	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	1.55	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0078	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6,012	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.1594	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.5471	8
9	SUM OF LINES 7 AND 8	0.7065	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1538	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	118,537	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	915,578	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 ((14-009) [XX] PPS  
APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT		
2	CAPITAL DRG OTHER THAN OUTLIER		1
3	CAPITAL DRG OUTLIER PAYMENTS		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		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)		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 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 COMMUNICATIONS					5.01
5.02 PURCHASING, RECEIVING					5.02
5.03 ADMITTING					5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 DATA PROCESSING					5.05
5.06 ADMINISTRATIVE & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
40 SUBPROVIDER - IPF					40
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR)					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
63 BLOOD STORING, PROCESSING & TR					63
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
75 ASC (NON-DISTINCT PART)					75
76 HEMODIALYSIS					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
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 THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 FUND DEVELOPMENT					192.01

PROVIDER CCN: 14-0095 ST ANTHONY 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  
01/26/2012 15:47

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	
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	38.51		49.96				88.47 30
31 INTENSIVE CARE UNIT	43.70		54.72				98.42 31
43 NURSERY			54.71				54.71 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	11.14	9.02					20.16 50
51 RECOVERY ROOM	8.16	19.29					27.45 51
52 DELIVERY ROOM & LABOR ROOM	0.09	0.03					0.12 52
53 ANESTHESIOLOGY	6.78	12.23					19.01 53
54 RADIOLOGY-DIAGNOSTIC	9.14	9.79					18.93 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	9.05	11.79					20.84 57
58 MAGNETIC RESONANCE IMAGING (MRI)	4.77	15.26					20.03 58
60 LABORATORY	17.07	1.02					18.09 60
63 BLOOD STORING, PROCESSING & TRA	26.52	1.86					28.38 63
65 RESPIRATORY THERAPY	45.90	2.85					48.75 65
66 PHYSICAL THERAPY	6.95	0.57					7.52 66
69 ELECTROCARDIOLOGY	19.53	16.65					36.18 69
70 ELECTROENCEPHALOGRAPHY	12.79	18.27					31.06 70
72 IMPL. DEV. CHARGED TO PATIENT	14.32	8.54					22.86 72
73 DRUGS CHARGED TO PATIENTS	19.79	14.06					33.85 73
75 ASC (NON-DISTINCT PART)	1.22	15.50					16.72 75
76 HEMODIALYSIS	45.82	1.57					47.39 76
90 CLINIC	0.01	39.84					39.85 90
91 EMERGENCY	5.09	4.95					10.04 91
92 OBSERVATION BEDS	1.12	20.14					21.26 92
200 TOTAL CHARGES	12.94	9.09					22.03 200

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

SUBPROVIDER-IPF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
40 SUBPROVIDER - IPF	29.29		57.69				86.98 40
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	0.06						0.06 50
51 RECOVERY ROOM	0.06						0.06 51
53 ANESTHESIOLOGY	0.04						0.04 53
54 RADIOLOGY-DIAGNOSTIC	0.20						0.20 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.19						0.19 57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.17						0.17 58
60 LABORATORY	1.23						1.23 60
63 BLOOD STORING, PROCESSING & TRA	0.50						0.50 63
65 RESPIRATORY THERAPY	1.67						1.67 65
66 PHYSICAL THERAPY	0.25						0.25 66
69 ELECTROCARDIOLOGY	0.60						0.60 69
70 ELECTROENCEPHALOGRAPHY	1.45						1.45 70
73 DRUGS CHARGED TO PATIENTS	2.47						2.47 73
75 ASC (NON-DISTINCT PART)	0.01						0.01 75
76 HEMODIALYSIS	1.16						1.16 76
91 EMERGENCY	0.35						0.35 91
200 TOTAL CHARGES	0.76						0.76 200

COST CENTER		---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	4,868,771	5.19	-4,868,771	-10.24			1
2	CAP REL COSTS-MVBLE EQUIP	358,369	0.38	-358,369	-0.75			2
3	OTHER CAPITAL RELATED COSTS							3
4	EMPLOYEE BENEFITS	6,724,410	7.17	-6,724,410	-14.14			4
5.01	COMMUNICATIONS							5.01
5.02	PURCHASING, RECEIVING							5.02
5.03	ADMITTING							5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE							5.04
5.05	DATA PROCESSING							5.05
5.06	ADMINISTRATIVE & GENERAL	23,162,679	24.70	-23,162,679	-48.72			5.06
6	MAINTENANCE & REPAIRS	1,613,144	1.72	-1,613,144	-3.39			6
7	OPERATION OF PLANT	2,601,140	2.77	-2,601,140	-5.47			7
8	LAUNDRY & LINEN SERVICE	493,741	0.53	-493,741	-1.04			8
9	HOUSEKEEPING	1,366,004	1.46	-1,366,004	-2.87			9
10	DIETARY	928,562	0.99	-928,562	-1.95			10
11	CAFETERIA	487,209	0.52	-487,209	-1.02			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	981,055	1.05	-981,055	-2.06			13
14	CENTRAL SERVICES & SUPPLY	530,945	0.57	-530,945	-1.12			14
15	PHARMACY	711,599	0.76	-711,599	-1.50			15
16	MEDICAL RECORDS & LIBRARY	734,409	0.78	-734,409	-1.54			16
17	SOCIAL SERVICE	640,233	0.68	-640,233	-1.35			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SRVCES-SALARY & FRINGES APP							21
22	I&R SRVCES-OTHER PRGM COSTS APP	1,342,305	1.43	-1,342,305	-2.82			22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	6,474,322	6.90	11,726,895	24.67	18,201,217	19.41	30
31	INTENSIVE CARE UNIT	2,250,842	2.40	2,457,071	5.17	4,707,913	5.02	31
40	SUBPROVIDER - IPF	2,156,625	2.30	3,796,757	7.99	5,953,382	6.35	40
43	NURSERY	981,985	1.05	1,074,832	2.26	2,056,817	2.19	43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	3,671,453	3.92	3,824,000	8.04	7,495,453	7.99	50
51	RECOVERY ROOM	359,751	0.38	240,194	0.51	599,945	0.64	51
52	DELIVERY ROOM & LABOR ROOM	3,214,012	3.43	3,028,796	6.37	6,242,808	6.66	52
53	ANESTHESIOLOGY	1,082,314	1.15	492,380	1.04	1,574,694	1.68	53
54	RADIOLOGY-DIAGNOSTIC	3,150,854	3.36	3,026,985	6.37	6,177,839	6.59	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	466,328	0.50	334,885	0.70	801,213	0.85	57
58	MAGNETIC RESONANCE IMAGING (MRI)	185,720	0.20	118,061	0.25	303,781	0.32	58
60	LABORATORY	3,024,959	3.23	2,208,094	4.64	5,233,053	5.58	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRA	558,126	0.60	225,440	0.47	783,566	0.84	63
65	RESPIRATORY THERAPY	958,413	1.02	677,049	1.42	1,635,462	1.74	65
66	PHYSICAL THERAPY	768,547	0.82	596,608	1.25	1,365,155	1.46	66
69	ELECTROCARDIOLOGY	605,843	0.65	449,658	0.95	1,055,501	1.13	69
70	ELECTROENCEPHALOGRAPHY	63,195	0.07	93,328	0.20	156,523	0.17	70
72	IMPL. DEV. CHARGED TO PATIENT	782,142	0.83	291,241	0.61	1,073,383	1.14	72
73	DRUGS CHARGED TO PATIENTS	3,607,360	3.85	2,897,751	6.09	6,505,111	6.94	73
75	ASC (NON-DISTINCT PART)	365,292	0.39	242,555	0.51	607,847	0.65	75
76	HEMODIALYSIS	295,764	0.32	111,523	0.23	407,287	0.43	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
90	CLINIC	1,832,011	1.95	2,037,828	4.29	3,869,839	4.13	90
91	EMERGENCY	3,221,907	3.44	3,554,686	7.48	6,776,593	7.23	91
92	OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS								
OUTPATIENT SERVICE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CAN	99,991	0.11	105,691	0.22	205,682	0.22	190
192	PHYSICIANS' PRIVATE OFFICES	6,052,921	6.45	3,932,267	8.27	9,985,188	10.65	192
192.01	FUND DEVELOPMENT							192.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	93,775,252	100.00			93,775,252	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	440,281	20,192,075	0.021805	2,249,767	49,056	50
51 RECOVERY ROOM	6,680	1,294,978	0.005158	105,681	545	51
52 DELIVERY ROOM & LABOR ROOM	197,306	10,730,695	0.018387	9,524	175	52
53 ANESTHESIOLOGY	36,049	8,137,390	0.004430	551,712	2,444	53
54 RADIOLOGY-DIAGNOSTIC	546,898	22,311,298	0.024512	2,040,368	50,014	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	12,930	18,157,651	0.000712	1,643,163	1,170	57
58 MAGNETIC RESONANCE IMAGING (MRI)	3,480	3,397,483	0.001024	162,139	166	58
60 LABORATORY	280,012	24,344,991	0.011502	4,155,167	47,793	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRA	6,514	3,147,667	0.002069	834,878	1,727	63
65 RESPIRATORY THERAPY	60,857	11,094,403	0.005485	5,092,485	27,932	65
66 PHYSICAL THERAPY	62,853	4,102,132	0.015322	285,260	4,371	66
69 ELECTROCARDIOLOGY	42,049	6,159,863	0.006826	1,203,053	8,212	69
70 ELECTROENCEPHALOGRAPHY	21,258	867,052	0.024518	110,884	2,719	70
72 IMPL. DEV. CHARGED TO PATIENT	7,966	2,035,357	0.003914	291,374	1,140	72
73 DRUGS CHARGED TO PATIENTS	144,456	33,192,872	0.004352	6,569,026	28,588	73
75 ASC (NON-DISTINCT PART)	6,764	1,508,653	0.004483	18,425	83	75
76 HEMODIALYSIS	3,131	1,034,882	0.003025	474,227	1,435	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	208,197	5,445,760	0.038231	308	12	90
91 EMERGENCY	188,670	31,168,151	0.006053	1,585,387	9,596	91
92 OBSERVATION BEDS	4,115	3,618,983	0.001137	40,486	46	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	2,280,466	211,942,336		27,423,314	237,224	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	1,666,016		1,666,016	17,005	97.97	6,548	641,508 30
31	INTENSIVE CARE UNIT	269,720		269,720	3,531	76.39	1,543	117,870 31
200	TOTAL	1,935,736		1,935,736	20,536		8,091	759,378 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								759,378
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								237,224
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								996,602
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								1,300
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								8,091
PER DISCHARGE CAPITAL COSTS								766.62
PER DIEM CAPITAL COSTS								123.17

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)	13,468,550
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	44,665,519
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.302

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINE 41 + WKST D PART IV COL 11 LINE 200))	2,065,330
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	5,564,751
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.371

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)	996,602
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.022

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	4,813,739
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	19,252,468
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.250