

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: 01-31-2012 TIME: 09:04  
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 OUR LADY OF THE RESURRECTION (14-0251) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) \_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
\_\_\_\_\_  
TITLE  
\_\_\_\_\_  
DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1	HOSPITAL		318,218	96,684		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	3,933		-261		7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	322,151		96,423		200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 5645 WEST ADDISON STREET P.O.BOX: 1  
 2 CITY: CHICAGO STATE: IL ZIP CODE: 60634 COUNTY: COOK 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	14-0251	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	14-5548	16974		07/01/1985	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTG								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								21

INPATIENT PPS INFORMATION

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

		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 IPFS 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.	5,611	1,592					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
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 IIME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IIME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)	2.91			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
	ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
	PROGRAM NAME	PROGRAM CODE	1	2	3
	1	2	3	4	5
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))

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	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			N 70
71	ENTER 'Y' FOR YES OR 'N' FOR NO. IF LINE 70 YES:			71
	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.			
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			N 75
76	ENTER 'Y' FOR YES OR 'N' FOR NO. IF LINE 75 YES:			76
	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.			
<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 XIX 1 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

	1	2
115 IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N	115
116 IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117 IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	117
118 IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2	118
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.		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

	1	2
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

	1	2
140 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141 NAME: RESURRECTION HEALTH CARE	CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES	CONTRACTOR'S NUMBER: 00131	141
142 STREET: 100 NORTH RIVER ROAD	P.O. BOX: PO BOX 61		142
143 CITY: DES PLAINES	STATE: IN	ZIP CODE: 46206-6160	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.

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

MULTICAMPUS

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
2		Y/N	DATE	V/I	
1		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
1		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	11/18/2011	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.			5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
1		1		2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.			7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?			8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.			9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			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.			11	
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	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			15	
PS&R REPORT DATA		PART A		PART B	
Y/N	DATE	Y/N	DATE	Y/N	DATE
1	2	3	4	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		Y	11/18/2011
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	44,095,037	44,095,037	1,571,010.88	28.07	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A		229,459	229,459	1,520.00	150.96	4
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B		1,787,715	1,787,715	14,511.50	123.19	5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21		214,148	8,382.00	25.55	7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44	2,700,749	2,700,749	121,577.32	22.21	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		37,132	37,132	1,128.00	32.92	10
	OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)		1,278,744	1,278,744	22,639.00	56.48	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		7,164,620	7,164,620	233,323.00	30.71	14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		11,327,494	11,327,494			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		7,922	7,922			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A		10,749	10,749			22
23	PHYSICIAN PART B		129,344	129,344			23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)		58,830	58,830			25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS						26
27	ADMINISTRATIVE & GENERAL		2,042,802	2,042,802	65,299.85	31.28	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		1,362,981	1,362,981	68,708.76	19.84	30
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING		1,083,070	1,083,070	89,440.06	12.11	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		1,720,382	-610,038	1,110,344	100,138.54	11.09
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA			610,038	610,038	35,509.00	17.18
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		1,163,593	1,163,593	30,102.65	38.65	38
39	CENTRAL SERVICES AND SUPPLY		356,752	356,752	21,350.76	16.71	39
40	PHARMACY		1,614,860	1,614,860	42,800.99	37.73	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		2,314,796	2,314,796	92,136.26	25.12	41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	42,307,322	-214,148	42,093,174	1,548,117.3	27.19	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2,737,881		2,737,881	122,705.32	22.31	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	39,569,441	-214,148	39,355,293	1,425,412.0	27.61	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	8,443,364		8,443,364	255,962.00	32.99	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	11,338,243		11,338,243		28.81%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	59,351,048	-214,148	59,136,900	1,681,374.0	35.17	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	11,659,236		11,659,236	545,486.87	21.37	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	2,706,488	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)	4,299,865	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	140,286	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	65,696	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	200,692	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	590,529	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	3,287,626	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	116,493	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	87,682	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	11,495,357	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	38,982	25

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
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  
01/31/2012 09:04

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE				
		1	2	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
				1	2	3	4
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N	1				
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N	2				
3	RUX				7		7 3
4	RUL				130		130 4
5	RVX				381		381 5
6	RVL				1,457		1,457 6
7	RHX				9		9 7
8	RHL				97		97 8
9	RMX				761		761 9
10	RML				392		392 10
11	RLX						11
12	RUC				9		9 12
13	RUB				216		216 13
14	RUA				126		126 14
15	RVC				596		596 15
16	RVB				3,608		3,608 16
17	RVA				2,111		2,111 17
18	RHC				247		247 18
19	RHB				553		553 19
20	RHA				512		512 20
21	RMC				37		37 21
22	RMB				191		191 22
23	RMA				166		166 23
24	RLB						24
25	RLA				6		6 25
26	ES3						26
27	ES2						27
28	ES1				13		13 28
29	HE2				1		1 29
30	HE1				2		2 30
31	HD2				26		26 31
32	HD1				21		21 32
33	HC2						33
34	HC1				32		32 34
35	HB2						35
36	HB1				116		116 36
37	LE2						37
38	LE1						38
39	LD2						39
40	LD1				5		5 40
41	LC2						41
42	LC1				3		3 42
43	LB2						43
44	LB1				26		26 44
45	CE2						45
46	CE1						46
47	CD2				8		8 47
48	CD1				10		10 48
49	CC2						49
50	CC1				12		12 50
51	CB2						51
52	CB1				68		68 52
53	CA2				2		2 53
54	CA1				14		14 54
55	SE3				19		19 55
56	SE2						56
57	SE1				3		3 57
58	SSC						58
59	SSB						59
60	SSA				11		11 60
61	IB2						61
62	IB1						62
63	IA1						63
64	IA2						64
65	BB2						65
66	BB1						66
67	BA2						67
68	BA1						68

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
 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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PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1		2		2 74
75	PB2				75
76	PB1		12		12 76
77	PA2				77
78	PA1				78
199	AAA		53		53 199
200	TOTAL		12,071		12,071 200

		CBSA AT	CBSA	
		BEGINNING	ON/AFTER	
		OF COST	OF THE COST	
		REPORTING	REPORTING	
		PERIOD	PERIOD (IF	
		1	APPLICABLE)	
			2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	01600	01600	201

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

		EXPENSES	PERCENTAGE	ASSOCIATED
		1	2	WITH
				DIRECT
				PATIENT
				CARE AND
				RELATED
				EXPENSES?
				3
202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	10,351,557		207

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.218126	1																																																																																																									
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)																																																																																																															
2	NET REVENUE FROM MEDICAID				12,130,711	2																																																																																																									
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3																																																																																																									
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4																																																																																																									
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5																																																																																																									
6	MEDICAID CHARGES				111,193,121	6																																																																																																									
7	MEDICAID COST (LINE 1 TIMES LINE 6)				24,254,111	7																																																																																																									
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				12,123,400	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)				12,123,400	19																																																																																																									
<table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th></th> <th style="text-align: right;">UNINSURED</th> <th style="text-align: right;">INSURED</th> <th></th> <th></th> <th></th> </tr> <tr> <th></th> <th></th> <th style="text-align: right;">PATIENTS</th> <th style="text-align: right;">PATIENTS</th> <th style="text-align: right;">TOTAL</th> <th></th> <th></th> </tr> <tr> <th></th> <th></th> <th style="text-align: right;">1</th> <th style="text-align: right;">2</th> <th style="text-align: right;">3</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>20</td> <td>TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY</td> <td style="text-align: right;">16,720,233</td> <td></td> <td style="text-align: right;">16,720,233</td> <td></td> <td>20</td> </tr> <tr> <td>21</td> <td>COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)</td> <td style="text-align: right;">3,647,118</td> <td></td> <td style="text-align: right;">3,647,118</td> <td></td> <td>21</td> </tr> <tr> <td>22</td> <td>PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE</td> <td style="text-align: right;">1,932,382</td> <td></td> <td style="text-align: right;">1,932,382</td> <td></td> <td>22</td> </tr> <tr> <td>23</td> <td>COST OF CHARITY CARE</td> <td style="text-align: right;">1,714,736</td> <td></td> <td style="text-align: right;">1,714,736</td> <td></td> <td>23</td> </tr> <tr> <td>24</td> <td>DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM</td> <td></td> <td></td> <td></td> <td></td> <td>24</td> </tr> <tr> <td>25</td> <td>IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)</td> <td></td> <td></td> <td></td> <td></td> <td>25</td> </tr> <tr> <td>26</td> <td>TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)</td> <td></td> <td></td> <td style="text-align: right;">21,319,972</td> <td></td> <td>26</td> </tr> <tr> <td>27</td> <td>MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V</td> <td></td> <td></td> <td style="text-align: right;">1,285,113</td> <td></td> <td>27</td> </tr> <tr> <td>28</td> <td>NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)</td> <td></td> <td></td> <td style="text-align: right;">20,034,859</td> <td></td> <td>28</td> </tr> <tr> <td>29</td> <td>COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)</td> <td></td> <td></td> <td style="text-align: right;">4,370,124</td> <td></td> <td>29</td> </tr> <tr> <td>30</td> <td>COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)</td> <td></td> <td></td> <td style="text-align: right;">6,084,860</td> <td></td> <td>30</td> </tr> <tr> <td>31</td> <td>TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)</td> <td></td> <td></td> <td style="text-align: right;">18,208,260</td> <td></td> <td>31</td> </tr> </tbody> </table>									UNINSURED	INSURED						PATIENTS	PATIENTS	TOTAL					1	2	3			20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	16,720,233		16,720,233		20	21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	3,647,118		3,647,118		21	22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	1,932,382		1,932,382		22	23	COST OF CHARITY CARE	1,714,736		1,714,736		23	24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24	25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25	26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			21,319,972		26	27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			1,285,113		27	28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			20,034,859		28	29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			4,370,124		29	30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			6,084,860		30	31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			18,208,260		31
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100				3,948,723	1
2	00200				3,440,778	2
3	00300					3
4	00400		106,862	106,862	24,926	4
5	00500	2,042,802	27,502,059	29,544,861	-7,414,427	5
6	00600					6
7	00700	1,362,981	3,425,221	4,788,202		7
8	00800					8
9	00900	1,083,070	923,992	2,007,062		9
10	01000	1,720,382	1,518,375	3,238,757	-1,368,683	10
11	01100		621,096	621,096	1,368,683	11
12	01200					12
13	01300	1,163,593	357,510	1,521,103		13
14	01400	356,752	-176,518	180,234		14
15	01500	1,614,860	4,625,854	6,240,714	-4,263,252	15
16	01600	2,314,796	1,292,303	3,607,099		16
17	01700					17
17.01	01850		957,333	957,333		17.01
19	01900					19
20	02000					20
21	02100				214,148	21
22	02200				61,113	22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	9,278,897	3,321,095	12,599,992		30
34	03400	3,851,351	1,557,836	5,409,187		34
44	04400	2,700,749	962,271	3,663,020		44
ANCILLARY SERVICE COST CENTERS						
50	05000	2,141,705	5,983,562	8,125,267	-4,395,148	50
51	05100	448,434	106,603	555,037		51
53	05300	63,049	997,842	1,060,891		53
54	05400	1,141,211	412,685	1,553,896		54
55	05500	607,619	164,543	772,162		55
56	05600	222,220	265,847	488,067		56
57	05700	532,700	300,643	833,343		57
58	05800	201,355	78,412	279,767		58
59	05900	494,473	1,607,251	2,101,724	-615,868	59
60	06000	2,103,928	4,074,966	6,178,894		60
62.30	06250					62.30
65	06500	1,093,567	507,997	1,601,564		65
66	06600	1,461,228	436,864	1,898,092		66
67	06700	654,754	154,042	808,796		67
68	06800	170,362	72,175	242,537		68
69	06900	478,950	183,047	661,997		69
69.01	03160	278,547	64,062	342,609		69.01
70	07000	57,552	247,327	304,879		70
71	07100				2,078,311	71
72	07200				2,932,705	72
73	07300				4,263,252	73
75.01	03950	282,943	103,094	386,037		75.01
76	03040					76
76.01	03480					76.01
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	987,633	675,098	1,662,731		90
91	09100	3,145,442	5,822,971	8,968,413	-275,261	91
91.01	04950					91.01
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
118		44,057,905	69,254,320	113,312,225		118
NONREIMBURSABLE COST CENTERS						
190	19000	37,132	64,489	101,621		190
193.01	19301					193.01
193.02	19302					193.02
193.03	19303					193.03
200		44,095,037	69,318,809	113,413,846		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	3,948,723	1,040,223	4,988,946	1
2	00200	CAP REL COSTS-MVBLE EQUIP	3,440,778	493,295	3,934,073	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	131,788	617,842	749,630	4
5	00500	ADMINISTRATIVE & GENERAL	22,130,434	-587,302	21,543,132	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	4,788,202		4,788,202	7
8	00800	LAUNDRY & LINEN SERVICE				8
9	00900	HOUSEKEEPING	2,007,062		2,007,062	9
10	01000	DIETARY	1,870,074		1,870,074	10
11	01100	CAFETERIA	1,989,779	-383,176	1,606,603	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,521,103		1,521,103	13
14	01400	CENTRAL SERVICES & SUPPLY	180,234	719,370	899,604	14
15	01500	PHARMACY	1,977,462		1,977,462	15
16	01600	MEDICAL RECORDS & LIBRARY	3,607,099	-182	3,606,917	16
17	01700	SOCIAL SERVICE				17
17.01	01850	HOUSE STAFF PHYSICIANS	957,333	-957,333		17.01
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD	214,148		214,148	21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	61,113		61,113	22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	12,599,992		12,599,992	30
34	03400	SURGICAL INTENSIVE CARE UNIT	5,409,187	-45,600	5,363,587	34
44	04400	SKILLED NURSING FACILITY	3,663,020	-18,000	3,645,020	44
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	3,730,119		3,730,119	50
51	05100	RECOVERY ROOM	555,037		555,037	51
53	05300	ANESTHESIOLOGY	1,060,891	-872,668	188,223	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,553,896	-177,618	1,376,278	54
55	05500	RADIOLOGY-THERAPEUTIC	772,162		772,162	55
56	05600	RADIOISOTOPE	488,067		488,067	56
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	833,343		833,343	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	279,767		279,767	58
59	05900	CARDIAC CATHETERIZATION	1,485,856		1,485,856	59
60	06000	LABORATORY	6,178,894	-25,255	6,153,639	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	1,601,564	-25,585	1,575,979	65
66	06600	PHYSICAL THERAPY	1,898,092		1,898,092	66
67	06700	OCCUPATIONAL THERAPY	808,796		808,796	67
68	06800	SPEECH PATHOLOGY	242,537		242,537	68
69	06900	ELECTROCARDIOLOGY	661,997		661,997	69
69.01	03160	CARDIAC REHAB	342,609	-10,715	331,894	69.01
70	07000	ELECTROENCEPHALOGRAPHY	304,879		304,879	70
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	2,078,311		2,078,311	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	2,932,705		2,932,705	72
73	07300	DRUGS CHARGED TO PATIENTS	4,263,252		4,263,252	73
75.01	03950	ACUTE DIALYSIS	386,037		386,037	75.01
76	03040	AUDIO-VESTIBULAR LAB				76
76.01	03480	ONCOLOGY				76.01
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	1,662,731	-25,000	1,637,731	90
91	09100	EMERGENCY	8,693,152	-2,636,517	6,056,635	91
91.01	04950	LITHOTRIPSY				91.01
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						
118		SUBTOTALS (SUM OF LINES 1-117)	113,312,225	-2,894,221	110,418,004	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	101,621		101,621	190
193.01	19301	NON EMPLOYEE DAY CARE				193.01
193.02	19302	RESURRECTION HOME CARE OFFICES				193.02
193.03	19303	OCCUPATIONAL HEALTH NON-REIM				193.03
200		TOTAL (SUM OF LINES 118-199)	113,413,846	-2,894,221	110,519,625	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 SHARED FOOD COST F 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	CAFETERIA	11		610,038 610,038	758,645 758,645 1 500
1 CHARGEABLE MEDICAL SUPPLIES F 500 TOTAL RECLASSIFICATIONS CODE LETTER - B	B	MEDICAL SUPPLIES CHRGED TO PA	71			2,078,311 1 2,078,311 500
1 RECLASS DEPRECIATION F 2 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1 2			2,491,598 1 3,440,778 2 5,932,376 500
1 NON EMPLOYEE DAYCARE 500 TOTAL RECLASSIFICATIONS CODE LETTER - E	E					1 500
1 COST OF DRUGS SOLD F 500 TOTAL RECLASSIFICATIONS CODE LETTER - F	F	DRUGS CHARGED TO PATIENTS	73			4,263,252 1 4,263,252 500
1 WORKERS COMP RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - G	G	EMPLOYEE BENEFITS	4			24,926 1 24,926 500
1 IMPLANT MEDICAL SUPPLIES 2 500 TOTAL RECLASSIFICATIONS CODE LETTER - H	H	IMPL. DEV. CHARGED TO PATIENT	72			2,932,705 1 2,932,705 2 500
1 E/R RESIDENT PROGRAM F 500 TOTAL RECLASSIFICATIONS CODE LETTER - J	J	I&R SRVCES-SALARY & FRINGES A	21		214,148 214,148	1 500
1 PROPERTY INSURANCE F 500 TOTAL RECLASSIFICATIONS CODE LETTER - L	L	CAP REL COSTS-BLDG & FIXT	1			66,355 1 66,355 500
1 ER RESIDENCY PHYSICIANS F 500 TOTAL RECLASSIFICATIONS CODE LETTER - M	M	I&R SRVCES-OTHER PRGM COSTS A	22		61,113 61,113	1 500
1 SALARIED PHYSICIANS 500 TOTAL RECLASSIFICATIONS CODE LETTER - N	N	EMERGENCY	91		2,837,389 2,837,389	1 500
1 CAPITAL INTEREST RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - O GRAND TOTAL (INCREASES)	O	CAP REL COSTS-BLDG & FIXT	1			1,457,125 1 1,457,125 500 3,722,688 17,513,695

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 SHARED FOOD COST F	A	DIETARY	10	610,038	758,645	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				610,038	758,645	500
1 CHARGEABLE MEDICAL SUPPLIES F	B	OPERATING ROOM	50		2,078,311	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					2,078,311	500
1 RECLASS DEPRECIATION F	D	ADMINISTRATIVE & GENERAL	5		2,491,598	9 1
2		ADMINISTRATIVE & GENERAL	5		3,440,778	9 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					5,932,376	500
1 NON EMPLOYEE DAYCARE	E					1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E						500
1 COST OF DRUGS SOLD F	F	PHARMACY	15		4,263,252	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					4,263,252	500
1 WORKERS COMP RECLASS	G	ADMINISTRATIVE & GENERAL	5		24,926	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					24,926	500
1 IMPLANT MEDICAL SUPPLIES	H	OPERATING ROOM	50		2,316,837	1
2		CARDIAC CATHETERIZATION	59		615,868	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					2,932,705	500
1 E/R RESIDENT PROGRAM F	J	EMERGENCY	91	214,148		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				214,148		500
1 PROPERTY INSURANCE F	L	CAP REL COSTS-BLDG & FIXT	1		66,355	12 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - L					66,355	500
1 ER RESIDENCY PHYSICIANS F	M	EMERGENCY	91	61,113		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - M				61,113		500
1 SALARIED PHYSICIANS	N	EMERGENCY	91	2,837,389		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - N				2,837,389		500
1 CAPITAL INTEREST RECLASS	O	ADMINISTRATIVE & GENERAL	5		1,457,125	12 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - O					1,457,125	500
GRAND TOTAL (DECREASES)				3,722,688	17,513,695	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	1,760,349					1,760,349	1
2 LAND IMPROVEMENTS	2,253,847					2,253,847	2
3 BUILDINGS AND FIXTURES	75,656,645				967,357	74,689,288	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	49,936,432					49,936,432	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	129,607,273				967,357	128,639,916	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	129,607,273				967,357	128,639,916	10

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

----- SUMMARY OF CAPITAL -----

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	3,214,085		317,736	1,457,125			4,988,946 1
2 CAP REL COSTS-MVBLE EQUIP	3,934,073						3,934,073 2
3 TOTAL	7,148,158		317,736	1,457,125			8,923,019 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
			COST CENTER	LINE NO.	WKST A-7 REF
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	A	158,868	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	A		CAP REL COSTS-MVBLE EQUIP	2	11 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)	A	-9,032	ADMINISTRATIVE & GENERAL	5	9 7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-3,793	ADMINISTRATIVE & GENERAL	5	10 8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-3,832,357			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-41	RADIOLOGY-DIAGNOSTIC	54	11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST				
	A-8-1	-1,174,405			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-383,176	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-182	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	9 26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	9 27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 CPA ADJUSTMENT MEDICAID TAX	A	3,957,924	ADMINISTRATIVE & GENERAL	5	33
33.02 EMPLOYEE DAY CARE REVENUE	B	-44,008	EMPLOYEE BENEFITS	4	33.02
33.03 MISCELLANEOUS INCOME	B	-341,149	ADMINISTRATIVE & GENERAL	5	33.03
33.20 HOUSE STAFF PHYSICIANS	A	-957,333	HOUSE STAFF PHYSICIANS	17.01	33.20
33.34 MISCELLANEOUS REVENUE LAB	B	-5,255	LABORATORY	60	33.34
33.36 FITNESS CENTER REVENUE	B	-15,255	EMPLOYEE BENEFITS	4	33.36
33.42 PATIENT TRANSPORTATION	A	-3,270	ADMINISTRATIVE & GENERAL	5	33.42
33.43 GIFT SHOP REVENUE AND MISCELLANEOU	A	-78,793	ADMINISTRATIVE & GENERAL	5	33.43
33.45 CARDIAC REHAB MISC REVENUE	B	-10,715	CARDIAC REHAB	69.01	33.45
34 AHA AND MCHC DUES	A	-3,834	ADMINISTRATIVE & GENERAL	5	34
35 ER PHYSICAN MISC EXPENSE	A	-28,589	EMERGENCY	91	35
36 PROFESSIONAL BILLING	A	-119,826	ADMINISTRATIVE & GENERAL	5	36
37 PENSION EXPENSE					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,894,221			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	4,128,616	15,827,804	-11,699,188	1
2	14	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	719,370		719,370	2
3	4	EMPLOYEE BENEFITS	HUMAN RESOURCES	677,105		677,105	3
4	5	ADMINISTRATIVE & GENERAL	DATA PROCESSING	2,899,173		2,899,173	4
4.01	5	ADMINISTRATIVE & GENERAL	PURCHASING	387,660		387,660	4.01
4.02	5	ADMINISTRATIVE & GENERAL	CASHIERING	4,466,825		4,466,825	4.02
4.04	2	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION	493,295		493,295	9 4.04
4.05	1	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	722,487		722,487	9 4.05
4.06	1	CAP REL COSTS-BLDG & FIXT	INTEREST	158,868		158,868	11 4.06
5		TOTALS (SUM OF LINES 1-4)		14,653,399	15,827,804	-1,174,405	5
TRANSFER COL. 6, LINE 5 TO							
WKST A-8, COL. 2, LINE 12.							

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

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				TYPE OF BUSINESS	
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP			
3	4	5	6				
6	B		RESURRECTION HEALTH CARE		SOLE CORPORATE MEMBER		6
7							7
8							8
9							9
10							10

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9	
1	53	ANESTHESIOLOGY ANESTHES	872,668	872,668						1
2	44	SKILLED NURSING FACILITY SNF	18,000	18,000						2
3	65	RESPIRATORY THERAPY RESP THER	25,585	25,585						3
4	91	EMERGENCY EMER ROOM	2,837,389	2,607,830	229,559	314,000	1,520	229,461	11,473	4
5	90	CLINIC WOUND CARE	25,000	25,000						5
6	60	LABORATORY LABORATORY	20,000	20,000						6
8	34	SURGICAL INTENSIVE CARE ICU PHYSICAINS	45,600	45,600						8
10	54	RADIOLOGY-DIAGNOSTIC NEUROLOGY PHYSI	177,577	177,577						10
11	5	ADMINISTRATIVE & GENERAL CONTINUM OF CAR	39,999	39,999						11
200		TOTAL	4,061,818	3,832,259	229,559		1,520	229,461	11,473	200

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
 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  
 01/31/2012 09:04

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	53 ANESTHESIOLOGY	ANESTHES						872,668	1
2	44 SKILLED NURSING FACILITY	SNF						18,000	2
3	65 RESPIRATORY THERAPY	RESP THER						25,585	3
4	91 EMERGENCY	EMER ROOM				229,461	98	2,607,928	4
5	90 CLINIC	WOUND CARE						25,000	5
6	60 LABORATORY	LABORATORY						20,000	6
8	34 SURGICAL INTENSIVE CARE	ICU PHYSICAINS						45,600	8
10	54 RADIOLOGY-DIAGNOSTIC	NEUROLOGY PHYSI						177,577	10
11	5 ADMINISTRATIVE & GENERAL	CONTINUM OF CAR						39,999	11
200	TOTAL					229,461	98	3,832,357	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP- REL COSTS BLDG&FIXT 1	NEW CAP- REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	4,988,946	4,988,946				1
2 CAP REL COSTS-MVBLE EQUIP	3,934,073		3,934,073			2
4 EMPLOYEE BENEFITS	749,630	56,816	6,041	812,487		4
5 ADMINISTRATIVE & GENERAL	21,543,132	1,915,017	28,346	37,641	23,524,136	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4,788,202	207,060	230,708	25,114	5,251,084	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	2,007,062	93,627	9,001	19,957	2,129,647	9
10 DIETARY	1,870,074	118,245	14,330	20,459	2,023,108	10
11 CAFETERIA	1,606,603	122,089	2,907	11,241	1,742,840	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,521,103	39,564	3,156	21,440	1,585,263	13
14 CENTRAL SERVICES & SUPPLY	899,604	119,168	37,415	6,574	1,062,761	14
15 PHARMACY	1,977,462	41,809	11,578	29,755	2,060,604	15
16 MEDICAL RECORDS & LIBRARY	3,606,917	53,787	617	42,652	3,703,973	16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD	214,148			3,946	218,094	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	61,113			1,126	62,239	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,599,992	933,199	77,904	170,964	13,782,059	30
34 SURGICAL INTENSIVE CARE UNIT	5,363,587	112,525	30,407	70,965	5,577,484	34
44 SKILLED NURSING FACILITY	3,645,020	208,305	2,851	49,764	3,905,940	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,730,119	224,697	404,042	39,463	4,398,321	50
51 RECOVERY ROOM	555,037	21,589	2,482	8,263	587,371	51
53 ANESTHESIOLOGY	188,223	8,903	111,141	1,162	309,429	53
54 RADIOLOGY-DIAGNOSTIC	1,376,278	19,159	2,341,527	21,028	3,757,992	54
55 RADIOLOGY-THERAPEUTIC	772,162	38,318		11,196	821,676	55
56 RADIOISOTOPE	488,067	9,457		4,095	501,619	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	833,343	19,313		9,816	862,472	57
58 MAGNETIC RESONANCE IMAGING (MRI)	279,767	19,205		3,710	302,682	58
59 CARDIAC CATHETERIZATION	1,485,856	88,230	105,897	9,111	1,689,094	59
60 LABORATORY	6,153,639	148,737	16,624	38,767	6,357,767	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,575,979	31,230	66,431	20,150	1,693,790	65
66 PHYSICAL THERAPY	1,898,092	74,822	10,732	26,925	2,010,571	66
67 OCCUPATIONAL THERAPY	808,796	18,913	1,415	12,064	841,188	67
68 SPEECH PATHOLOGY	242,537	8,426	842	3,139	254,944	68
69 ELECTROCARDIOLOGY	661,997	22,665	2,352	8,825	695,839	69
69.01 CARDIAC REHAB	331,894	27,293	11,553	5,133	375,873	69.01
70 ELECTROENCEPHALOGRAPHY	304,879			1,060	305,939	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	2,078,311				2,078,311	71
72 IMPL. DEV. CHARGED TO PATIENT	2,932,705				2,932,705	72
73 DRUGS CHARGED TO PATIENTS	4,263,252				4,263,252	73
75.01 ACUTE DIALYSIS	386,037	10,933	10,833	5,214	413,017	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,637,731	23,172	285,336	18,198	1,964,437	90
91 EMERGENCY	6,056,635	130,608	107,605	52,886	6,347,734	91
91.01 LITHOTRIPSY						91.01
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)	110,418,004	4,966,881	3,934,073	811,803	110,395,255	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	101,621	22,065		684	124,370	190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	110,519,625	4,988,946	3,934,073	812,487	110,519,625	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL 5	OPERATION OF PLANT 7	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	23,524,136					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,419,925	6,671,009				7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	575,869	222,270	2,927,786			9
10 DIETARY	547,061	280,712	127,446	2,978,327		10
11 CAFETERIA	471,274	289,838	131,589		2,635,541	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	428,665	93,923	42,642		50,191	13
14 CENTRAL SERVICES & SUPPLY	287,377	282,902	128,440		28,157	14
15 PHARMACY	557,200	99,253	45,062		72,783	15
16 MEDICAL RECORDS & LIBRARY	1,001,577	127,689	57,972		149,675	16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD	58,974					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	16,830					22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,726,785	2,215,395	1,005,808	1,873,350	707,138	30
34 SURGICAL INTENSIVE CARE UNIT	1,508,185	267,132	121,281	332,421	216,447	34
44 SKILLED NURSING FACILITY	1,056,190	494,512	224,513	772,556	204,322	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,189,332	533,425	242,180		176,643	50
51 RECOVERY ROOM	158,829	51,251	23,268		33,713	51
53 ANESTHESIOLOGY	83,671	21,136	9,596		13,526	53
54 RADIOLOGY-DIAGNOSTIC	1,016,184	45,483	20,650		193,499	54
55 RADIOLOGY-THERAPEUTIC	222,186	90,967	41,300			55
56 RADIOISOTOPE	135,641	22,450	10,192			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	233,218	45,848	20,816			57
58 MAGNETIC RESONANCE IMAGING (MRI)	81,847	45,593	20,700			58
59 CARDIAC CATHETERIZATION	456,741	209,457	95,095		64,413	59
60 LABORATORY	1,719,178	353,098	160,310		158,820	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	458,011	74,139	33,660		75,695	65
66 PHYSICAL THERAPY	543,670	177,626	80,644		71,337	66
67 OCCUPATIONAL THERAPY	227,462	44,899	20,385		29,561	67
68 SPEECH PATHOLOGY	68,938	20,004	9,082		7,574	68
69 ELECTROCARDIOLOGY	188,159	53,806	24,428		57,744	69
69.01 CARDIAC REHAB	101,638	64,794	29,417			69.01
70 ELECTROENCEPHALOGRAPHY	82,728				3,582	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	561,988					71
72 IMPL. DEV. CHARGED TO PATIENT	793,021					72
73 DRUGS CHARGED TO PATIENTS	1,152,809					73
75.01 ACUTE DIALYSIS	111,682	25,954	11,783		23,461	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	531,196	55,011	24,975		60,820	90
91 EMERGENCY	1,716,465	310,060	140,770		234,501	91
91.01 LITHOTRIPSY						91.01
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)	23,490,506	6,618,627	2,904,004	2,978,327	2,633,602	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,630	52,382	23,782		1,939	190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	23,524,136	6,671,009	2,927,786	2,978,327	2,635,541	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	I/R-SALARY AND FRINGES 21	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,200,684					13
14 CENTRAL SERVICES & SUPPLY		1,789,637				14
15 PHARMACY			2,834,902			15
16 MEDICAL RECORDS & LIBRARY				5,040,886		16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD					277,068	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	709,259	576,783	51,712	715,515	69,267	30
34 SURGICAL INTENSIVE CARE UNIT			20,118	185,857	69,267	34
44 SKILLED NURSING FACILITY	222,675	181,083	6,197	101,362		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	142,627	115,987	26,261	150,149		50
51 RECOVERY ROOM	30,891	25,121	4,865	50,830		51
53 ANESTHESIOLOGY	15,438	12,555	2,508	69,765		53
54 RADIOLOGY-DIAGNOSTIC	207,385	168,650	4,028	120,267		54
55 RADIOLOGY-THERAPEUTIC				99,219		55
56 RADIOISOTOPE				40,086		56
57 COMPUTED TOMOGRAPHY (CT) SCAN				318,848		57
58 MAGNETIC RESONANCE IMAGING (MRI)				75,346		58
59 CARDIAC CATHETERIZATION	66,191	53,827	5,306	167,496		59
60 LABORATORY	171,600	139,549	9	802,894		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	87,689	71,311	13,989	224,999		65
66 PHYSICAL THERAPY	77,352	62,904	35	76,111		66
67 OCCUPATIONAL THERAPY	33,433	27,189	2	38,897		67
68 SPEECH PATHOLOGY	8,365	6,802		10,310		68
69 ELECTROCARDIOLOGY	59,251	48,184	2,406	150,567		69
69.01 CARDIAC REHAB	17,577	14,294		5,556		69.01
70 ELECTROENCEPHALOGRAPHY	4,436	3,607		3,229		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			21,246	191,571		71
72 IMPL. DEV. CHARGED TO PATIENT				125,363		72
73 DRUGS CHARGED TO PATIENTS			2,582,268	628,593		73
75.01 ACUTE DIALYSIS	25,893	21,056	5,864	29,304		75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	74,640	60,698	6,305	95,044		90
91 EMERGENCY	245,982	200,037	81,783	563,708	138,534	91
91.01 LITHOTRIPSY						91.01
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)	2,200,684	1,789,637	2,834,902	5,040,886	277,068	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,200,684	1,789,637	2,834,902	5,040,886	277,068	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
17.01 HOUSE STAFF PHYSICIANS					17.01
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	79,069				22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	19,767	25,452,838	-89,034	25,363,804	30
34 SURGICAL INTENSIVE CARE UNIT	19,767	8,317,959	-89,034	8,228,925	34
44 SKILLED NURSING FACILITY		7,169,350		7,169,350	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		6,974,925		6,974,925	50
51 RECOVERY ROOM		966,139		966,139	51
53 ANESTHESIOLOGY		537,624		537,624	53
54 RADIOLOGY-DIAGNOSTIC		5,534,138		5,534,138	54
55 RADIOLOGY-THERAPEUTIC		1,275,348		1,275,348	55
56 RADIOISOTOPE		709,988		709,988	56
57 COMPUTED TOMOGRAPHY (CT) SCAN		1,481,202		1,481,202	57
58 MAGNETIC RESONANCE IMAGING (MRI)		526,168		526,168	58
59 CARDIAC CATHETERIZATION		2,807,620		2,807,620	59
60 LABORATORY		9,863,225		9,863,225	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		2,733,283		2,733,283	65
66 PHYSICAL THERAPY		3,100,250		3,100,250	66
67 OCCUPATIONAL THERAPY		1,263,016		1,263,016	67
68 SPEECH PATHOLOGY		386,019		386,019	68
69 ELECTROCARDIOLOGY		1,280,384		1,280,384	69
69.01 CARDIAC REHAB		609,149		609,149	69.01
70 ELECTROENCEPHALOGRAPHY		403,521		403,521	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		2,853,116		2,853,116	71
72 IMPL. DEV. CHARGED TO PATIENT		3,851,089		3,851,089	72
73 DRUGS CHARGED TO PATIENTS		8,626,922		8,626,922	73
75.01 ACUTE DIALYSIS		668,014		668,014	75.01
76 AUDIO-VESTIBULAR LAB					76
76.01 ONCOLOGY					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		2,873,126		2,873,126	90
91 EMERGENCY	39,535	10,019,109	-178,069	9,841,040	91
91.01 LITHOTRIPSY					91.01
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)	79,069	110,283,522	-356,137	109,927,385	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		236,103		236,103	190
193.01 NON EMPLOYEE DAY CARE					193.01
193.02 RESURRECTION HOME CARE OFFICES					193.02
193.03 OCCUPATIONAL HEALTH NON-REIM					193.03
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	79,069	110,519,625	-356,137	110,163,488	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	1,644	56,816	6,041	64,501	64,501	4
5 ADMINISTRATIVE & GENERAL	11,845	1,915,017	28,346	1,955,208	2,989	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,461	207,060	230,708	440,229	1,994	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	272	93,627	9,001	102,900	1,585	9
10 DIETARY	4,269	118,245	14,330	136,844	1,624	10
11 CAFETERIA		122,089	2,907	124,996	892	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,273	39,564	3,156	45,993	1,702	13
14 CENTRAL SERVICES & SUPPLY	59,357	119,168	37,415	215,940	522	14
15 PHARMACY	510	41,809	11,578	53,897	2,363	15
16 MEDICAL RECORDS & LIBRARY	4,907	53,787	617	59,311	3,387	16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD					313	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					89	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,678	933,199	77,904	1,013,781	13,565	30
34 SURGICAL INTENSIVE CARE UNIT	989	112,525	30,407	143,921	5,635	34
44 SKILLED NURSING FACILITY	2,078	208,305	2,851	213,234	3,951	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	117,061	224,697	404,042	745,800	3,133	50
51 RECOVERY ROOM		21,589	2,482	24,071	656	51
53 ANESTHESIOLOGY		8,903	111,141	120,044	92	53
54 RADIOLOGY-DIAGNOSTIC		19,159	2,341,527	2,360,686	1,670	54
55 RADIOLOGY-THERAPEUTIC	3,286	38,318		41,604	889	55
56 RADIOISOTOPE		9,457		9,457	325	56
57 COMPUTED TOMOGRAPHY (CT) SCAN		19,313		19,313	779	57
58 MAGNETIC RESONANCE IMAGING (MRI)		19,205		19,205	295	58
59 CARDIAC CATHETERIZATION	561	88,230	105,897	194,688	723	59
60 LABORATORY	14,528	148,737	16,624	179,889	3,078	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	4,899	31,230	66,431	102,560	1,600	65
66 PHYSICAL THERAPY	13,004	74,822	10,732	98,558	2,138	66
67 OCCUPATIONAL THERAPY		18,913	1,415	20,328	958	67
68 SPEECH PATHOLOGY		8,426	842	9,268	249	68
69 ELECTROCARDIOLOGY	1,941	22,665	2,352	26,958	701	69
69.01 CARDIAC REHAB		27,293	11,553	38,846	408	69.01
70 ELECTROENCEPHALOGRAPHY					84	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75.01 ACUTE DIALYSIS		10,933	10,833	21,766	414	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,177	23,172	285,336	311,685	1,445	90
91 EMERGENCY	2,618	130,608	107,605	240,831	4,199	91
91.01 LITHOTRIPSY						91.01
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)	255,358	4,966,881	3,934,073	9,156,312	64,447	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		22,065		22,065	54	190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	255,358	4,988,946	3,934,073	9,178,377	64,501	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL	OPERATION OF PLANT	HOUSE- KEEPING	DIETARY	CAFETERIA	
	5	7	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	1,958,197					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	118,197	560,420				7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	47,936	18,672	171,093			9
10 DIETARY	45,538	23,582	7,448	215,036		10
11 CAFETERIA	39,230	24,349	7,690		197,157	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	35,683	7,890	2,492		3,755	13
14 CENTRAL SERVICES & SUPPLY	23,922	23,766	7,506		2,106	14
15 PHARMACY	46,382	8,338	2,633		5,445	15
16 MEDICAL RECORDS & LIBRARY	83,373	10,727	3,388		11,197	16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD	4,909					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	1,401					22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	310,232	186,114	58,775	135,256	52,897	30
34 SURGICAL INTENSIVE CARE UNIT	125,544	22,441	7,087	24,001	16,192	34
44 SKILLED NURSING FACILITY	87,919	41,543	13,120	55,779	15,285	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	99,002	44,812	14,152		13,214	50
51 RECOVERY ROOM	13,221	4,305	1,360		2,522	51
53 ANESTHESIOLOGY	6,965	1,776	561		1,012	53
54 RADIOLOGY-DIAGNOSTIC	84,589	3,821	1,207		14,475	54
55 RADIOLOGY-THERAPEUTIC	18,495	7,642	2,413			55
56 RADIOISOTOPE	11,291	1,886	596			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	19,413	3,852	1,216			57
58 MAGNETIC RESONANCE IMAGING (MRI)	6,813	3,830	1,210			58
59 CARDIAC CATHETERIZATION	38,020	17,596	5,557		4,819	59
60 LABORATORY	143,107	29,663	9,368		11,881	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	38,126	6,228	1,967		5,663	65
66 PHYSICAL THERAPY	45,256	14,922	4,713		5,336	66
67 OCCUPATIONAL THERAPY	18,934	3,772	1,191		2,211	67
68 SPEECH PATHOLOGY	5,739	1,680	531		567	68
69 ELECTROCARDIOLOGY	15,663	4,520	1,428		4,320	69
69.01 CARDIAC REHAB	8,461	5,443	1,719			69.01
70 ELECTROENCEPHALOGRAPHY	6,886				268	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	46,781					71
72 IMPL. DEV. CHARGED TO PATIENT	66,012					72
73 DRUGS CHARGED TO PATIENTS	95,962					73
75.01 ACUTE DIALYSIS	9,297	2,180	689		1,755	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	44,218	4,621	1,460		4,550	90
91 EMERGENCY	142,881	26,048	8,226		17,542	91
91.01 LITHOTRIPSY						91.01
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)	1,955,398	556,019	169,703	215,036	197,012	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,799	4,401	1,390		145	190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,958,197	560,420	171,093	215,036	197,157	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	I/R-SALARY AND FRINGES 21	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	97,515					13
14 CENTRAL SERVICES & SUPPLY		273,762				14
15 PHARMACY			119,058			15
16 MEDICAL RECORDS & LIBRARY				171,383		16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD					5,222	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	31,428	88,231	2,172	24,333		30
34 SURGICAL INTENSIVE CARE UNIT			845	6,321		34
44 SKILLED NURSING FACILITY	9,867	27,700	260	3,447		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,320	17,743	1,103	5,106		50
51 RECOVERY ROOM	1,369	3,843	204	1,729		51
53 ANESTHESIOLOGY	684	1,920	105	2,373		53
54 RADIOLOGY-DIAGNOSTIC	9,189	25,798	169	4,090		54
55 RADIOLOGY-THERAPEUTIC				3,374		55
56 RADIOISOTOPE				1,363		56
57 COMPUTED TOMOGRAPHY (CT) SCAN				10,843		57
58 MAGNETIC RESONANCE IMAGING (MRI)				2,562		58
59 CARDIAC CATHETERIZATION	2,933	8,234	223	5,696		59
60 LABORATORY	7,604	21,347		27,259		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,886	10,908	587	7,652		65
66 PHYSICAL THERAPY	3,428	9,622	1	2,588		66
67 OCCUPATIONAL THERAPY	1,481	4,159		1,323		67
68 SPEECH PATHOLOGY	371	1,041		351		68
69 ELECTROCARDIOLOGY	2,625	7,371	101	5,120		69
69.01 CARDIAC REHAB	779	2,187		189		69.01
70 ELECTROENCEPHALOGRAPHY	197	552		110		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			892	6,515		71
72 IMPL. DEV. CHARGED TO PATIENT				4,263		72
73 DRUGS CHARGED TO PATIENTS			108,450	21,377		73
75.01 ACUTE DIALYSIS	1,147	3,221	246	997		75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,307	9,285	265	3,232		90
91 EMERGENCY	10,900	30,600	3,435	19,170		91
91.01 LITHOTRIPSY						91.01
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)	97,515	273,762	119,058	171,383		118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03
200 CROSS FOOT ADJUSTMENTS					5,222	200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	97,515	273,762	119,058	171,383	5,222	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	I/R-OTHER	SUBTOTAL	I&R COST &	TOTAL	
	PROGRAM		POST STEP-		
	COSTS	24	DOWN ADJS	26	
	22		25		
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
17.01 HOUSE STAFF PHYSICIANS					17.01
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	1,490				22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		1,916,784		1,916,784	30
34 SURGICAL INTENSIVE CARE UNIT		351,987		351,987	34
44 SKILLED NURSING FACILITY		472,105		472,105	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		950,385		950,385	50
51 RECOVERY ROOM		53,280		53,280	51
53 ANESTHESIOLOGY		135,532		135,532	53
54 RADIOLOGY-DIAGNOSTIC		2,505,694		2,505,694	54
55 RADIOLOGY-THERAPEUTIC		74,417		74,417	55
56 RADIOISOTOPE		24,918		24,918	56
57 COMPUTED TOMOGRAPHY (CT) SCAN		55,416		55,416	57
58 MAGNETIC RESONANCE IMAGING (MRI)		33,915		33,915	58
59 CARDIAC CATHETERIZATION		278,489		278,489	59
60 LABORATORY		433,196		433,196	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		179,177		179,177	65
66 PHYSICAL THERAPY		186,562		186,562	66
67 OCCUPATIONAL THERAPY		54,357		54,357	67
68 SPEECH PATHOLOGY		19,797		19,797	68
69 ELECTROCARDIOLOGY		68,807		68,807	69
69.01 CARDIAC REHAB		58,032		58,032	69.01
70 ELECTROENCEPHALOGRAPHY		8,097		8,097	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		54,188		54,188	71
72 IMPL. DEV. CHARGED TO PATIENT		70,275		70,275	72
73 DRUGS CHARGED TO PATIENTS		225,789		225,789	73
75.01 ACUTE DIALYSIS		41,712		41,712	75.01
76 AUDIO-VESTIBULAR LAB					76
76.01 ONCOLOGY					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		384,068		384,068	90
91 EMERGENCY		503,832		503,832	91
91.01 LITHOTRIPSY					91.01
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)		9,140,811		9,140,811	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		30,854		30,854	190
193.01 NON EMPLOYEE DAY CARE					193.01
193.02 RESURRECTION HOME CARE OFFICES					193.02
193.03 OCCUPATIONAL HEALTH NON-REIM					193.03
200 CROSS FOOT ADJUSTMENTS	1,490	6,712		6,712	200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,490	9,178,377		9,178,377	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	ADMINI- STRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	324,453					1
2 CAP REL COSTS-MVBLE EQUIP		1,906,949				2
4 EMPLOYEE BENEFITS	3,695	2,928	44,095,037			4
5 ADMINISTRATIVE & GENERAL	124,542	13,740	2,042,802	-23,524,136	86,995,489	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	13,466	111,830	1,362,981		5,251,084	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	6,089	4,363	1,083,070		2,129,647	9
10 DIETARY	7,690	6,946	1,110,344		2,023,108	10
11 CAFETERIA	7,940	1,409	610,038		1,742,840	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,573	1,530	1,163,593		1,585,263	13
14 CENTRAL SERVICES & SUPPLY	7,750	18,136	356,752		1,062,761	14
15 PHARMACY	2,719	5,612	1,614,860		2,060,604	15
16 MEDICAL RECORDS & LIBRARY	3,498	299	2,314,796		3,703,973	16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD			214,148		218,094	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			61,113		62,239	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	60,690	37,762	9,278,897		13,782,059	30
34 SURGICAL INTENSIVE CARE UNIT	7,318	14,739	3,851,351		5,577,484	34
44 SKILLED NURSING FACILITY	13,547	1,382	2,700,749		3,905,940	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,613	195,850	2,141,705		4,398,321	50
51 RECOVERY ROOM	1,404	1,203	448,434		587,371	51
53 ANESTHESIOLOGY	579	53,873	63,049		309,429	53
54 RADIOLOGY-DIAGNOSTIC	1,246	1,135,001	1,141,211		3,757,992	54
55 RADIOLOGY-THERAPEUTIC	2,492		607,619		821,676	55
56 RADIOISOTOPE	615		222,220		501,619	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,256		532,700		862,472	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,249		201,355		302,682	58
59 CARDIAC CATHETERIZATION	5,738	51,331	494,473		1,689,094	59
60 LABORATORY	9,673	8,058	2,103,928		6,357,767	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,031	32,201	1,093,567		1,693,790	65
66 PHYSICAL THERAPY	4,866	5,202	1,461,228		2,010,571	66
67 OCCUPATIONAL THERAPY	1,230	686	654,754		841,188	67
68 SPEECH PATHOLOGY	548	408	170,362		254,944	68
69 ELECTROCARDIOLOGY	1,474	1,140	478,950		695,839	69
69.01 CARDIAC REHAB	1,775	5,600	278,547		375,873	69.01
70 ELECTROENCEPHALOGRAPHY			57,552		305,939	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					2,078,311	71
72 IMPL. DEV. CHARGED TO PATIENT					2,932,705	72
73 DRUGS CHARGED TO PATIENTS					4,263,252	73
75.01 ACUTE DIALYSIS	711	5,251	282,943		413,017	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,507	138,310	987,633		1,964,437	90
91 EMERGENCY	8,494	52,159	2,870,181		6,347,734	91
91.01 LITHOTRIPSY						91.01
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)	323,018	1,906,949	44,057,905	-23,524,136	86,871,119	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,435		37,132		124,370	190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
PERIOD FROM 07/01/2010 TO 06/30/2011

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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET 1	NEW CAP- REL COSTS MOV EQUIP (DOLLAR VALUE) 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINI- STRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	4,988,946	3,934,073	812,487		23,524,136	202
203 UNIT COST MULT-WS B PT I	15.376483	2.063020	0.018426		0.270406	203
204 COST TO BE ALLOC PER B PT II			64,501		1,958,197	204
205 UNIT COST MULT-WS B PT II			0.001463		0.022509	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT SQUARE FEET	AND LINEN SERVICE POUNDS OF LAUNDRY	KEEPING SQUARE FEET	(MEALS SERVED)	FTES SERVED	
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	182,750					7
8 LAUNDRY & LINEN SERVICE		1,197,699				8
9 HOUSEKEEPING	6,089	718	176,661			9
10 DIETARY	7,690		7,690	155,949		10
11 CAFETERIA	7,940		7,940		1,598,321	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,573		2,573		30,438	13
14 CENTRAL SERVICES & SUPPLY	7,750	173	7,750		17,076	14
15 PHARMACY	2,719		2,719		44,139	15
16 MEDICAL RECORDS & LIBRARY	3,498		3,498		90,770	16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS						17.01
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	60,690	562,028	60,690	98,091	428,845	30
34 SURGICAL INTENSIVE CARE UNIT	7,318	152,670	7,318	17,406	131,264	34
44 SKILLED NURSING FACILITY	13,547	139,195	13,547	40,452	123,911	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,613	45,765	14,613		107,125	50
51 RECOVERY ROOM	1,404		1,404		20,445	51
53 ANESTHESIOLOGY	579		579		8,203	53
54 RADIOLOGY-DIAGNOSTIC	1,246	88,664	1,246		117,347	54
55 RADIOLOGY-THERAPEUTIC	2,492		2,492			55
56 RADIOISOTOPE	615		615			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,256		1,256			57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,249		1,249			58
59 CARDIAC CATHETERIZATION	5,738	4,943	5,738		39,063	59
60 LABORATORY	9,673		9,673		96,316	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,031		2,031		45,905	65
66 PHYSICAL THERAPY	4,866	20,315	4,866		43,262	66
67 OCCUPATIONAL THERAPY	1,230	1,988	1,230		17,927	67
68 SPEECH PATHOLOGY	548		548		4,593	68
69 ELECTROCARDIOLOGY	1,474	4,912	1,474		35,019	69
69.01 CARDIAC REHAB	1,775		1,775			69.01
70 ELECTROENCEPHALOGRAPHY		117			2,172	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75.01 ACUTE DIALYSIS	711	3,004	711		14,228	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,507	14,846	1,507		36,884	90
91 EMERGENCY	8,494	158,361	8,494		142,213	91
91.01 LITHOTRIPSY						91.01
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)	181,315	1,197,699	175,226	155,949	1,597,145	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,435		1,435		1,176	190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING  SQUARE FEET	DIETARY  (MEALS SERVED)	CAFETERIA  FTES SERVED	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	6,671,009		2,927,786	2,978,327	2,635,541	202
203	UNIT COST MULT-WS B PT I	36.503469		16.572905	19.098083	1.648943	203
204	COST TO BE ALLOC PER B PT II	560,420		171,093	215,036	197,157	204
205	UNIT COST MULT-WS B PT II	3.066594		0.968482	1.378887	0.123353	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (DIRECT NRSG HRS) 14	PHARMACY  (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	HOUSE STAFF PHYSICIAN ASSIGNED TIME 17.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,201,538					13
14 CENTRAL SERVICES & SUPPLY		1,201,538				14
15 PHARMACY			5,176,081			15
16 MEDICAL RECORDS & LIBRARY				514,819,321		16
17 SOCIAL SERVICE						17
17.01 HOUSE STAFF PHYSICIANS					100	17.01
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	387,244	387,244	94,417	73,071,370	100	30
34 SURGICAL INTENSIVE CARE UNIT			36,732	18,980,492		34
44 SKILLED NURSING FACILITY	121,577	121,577	11,315	10,351,557		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	77,872	77,872	47,949	15,333,884		50
51 RECOVERY ROOM	16,866	16,866	8,883	5,190,953		51
53 ANESTHESIOLOGY	8,429	8,429	4,579	7,124,721		53
54 RADIOLOGY-DIAGNOSTIC	113,229	113,229	7,354	12,282,176		54
55 RADIOLOGY-THERAPEUTIC				10,132,637		55
56 RADIOISOTOPE				4,093,742		56
57 COMPUTED TOMOGRAPHY (CT) SCAN				32,562,131		57
58 MAGNETIC RESONANCE IMAGING (MRI)				7,694,675		58
59 CARDIAC CATHETERIZATION	36,139	36,139	9,687	17,105,378		59
60 LABORATORY	93,691	93,691	17	82,017,713		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	47,877	47,877	25,541	22,977,831		65
66 PHYSICAL THERAPY	42,233	42,233	63	7,772,812		66
67 OCCUPATIONAL THERAPY	18,254	18,254	3	3,972,366		67
68 SPEECH PATHOLOGY	4,567	4,567		1,052,900		68
69 ELECTROCARDIOLOGY	32,350	32,350	4,393	15,376,503		69
69.01 CARDIAC REHAB	9,597	9,597		567,398		69.01
70 ELECTROENCEPHALOGRAPHY	2,422	2,422		329,736		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			38,792	19,564,078		71
72 IMPL. DEV. CHARGED TO PATIENT				12,802,582		72
73 DRUGS CHARGED TO PATIENTS			4,714,816	64,194,534		73
75.01 ACUTE DIALYSIS	14,137	14,137	10,706	2,992,682		75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	40,752	40,752	11,512	9,706,276		90
91 EMERGENCY	134,302	134,302	149,322	57,568,194		91
91.01 LITHOTRIPSY						91.01
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)	1,201,538	1,201,538	5,176,081	514,819,321	100	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
193.01 NON EMPLOYEE DAY CARE						193.01
193.02 RESURRECTION HOME CARE OFFICES						193.02
193.03 OCCUPATIONAL HEALTH NON-REIM						193.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (DIRECT NRSG HRS) 14	PHARMACY  (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	HOUSE STAFF PHYSICIAN ASSIGNED TIME 17.01	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,200,684	1,789,637	2,834,902	5,040,886		202
203 UNIT COST MULT-WS B PT I	1.831556	1.489455	0.547693	0.009792		203
204 COST TO BE ALLOC PER B PT II	97,515	273,762	119,058	171,383		204
205 UNIT COST MULT-WS B PT II	0.081158	0.227843	0.023002	0.000333		205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	
	21	22	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
17.01 HOUSE STAFF PHYSICIANS			17.01
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD	200		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD		200	22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	50	50	30
34 SURGICAL INTENSIVE CARE UNIT	50	50	34
44 SKILLED NURSING FACILITY			44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
51 RECOVERY ROOM			51
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC			54
55 RADIOLOGY-THERAPEUTIC			55
56 RADIOISOTOPE			56
57 COMPUTED TOMOGRAPHY (CT) SCAN			57
58 MAGNETIC RESONANCE IMAGING (MRI)			58
59 CARDIAC CATHETERIZATION			59
60 LABORATORY			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
69 ELECTROCARDIOLOGY			69
69.01 CARDIAC REHAB			69.01
70 ELECTROENCEPHALOGRAPHY			70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS			73
75.01 ACUTE DIALYSIS			75.01
76 AUDIO-VESTIBULAR LAB			76
76.01 ONCOLOGY			76.01
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	100	100	91
91.01 LITHOTRIPSY			91.01
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)	200	200	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
193.01 NON EMPLOYEE DAY CARE			193.01
193.02 RESURRECTION HOME CARE OFFICES			193.02
193.03 OCCUPATIONAL HEALTH NON-REIM			193.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	I/R-SALARY AND FRINGES (ASSIGNED TIME) 21	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	277,068	79,069	202
203 UNIT COST MULT-WS B PT I	1,385.340000	395.345000	203
204 COST TO BE ALLOC PER B PT II	5,222	1,490	204
205 UNIT COST MULT-WS B PT II	26.110000	7.450000	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	25,363,804		25,363,804		25,363,804	30
34 SURGICAL INTENSIVE CARE UNI	8,228,925		8,228,925		8,228,925	34
44 SKILLED NURSING FACILITY	7,169,350		7,169,350		7,169,350	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,974,925		6,974,925		6,974,925	50
51 RECOVERY ROOM	966,139		966,139		966,139	51
53 ANESTHESIOLOGY	537,624		537,624		537,624	53
54 RADIOLOGY-DIAGNOSTIC	5,534,138		5,534,138		5,534,138	54
55 RADIOLOGY-THERAPEUTIC	1,275,348		1,275,348		1,275,348	55
56 RADIOISOTOPE	709,988		709,988		709,988	56
57 COMPUTED TOMOGRAPHY (CT) SC	1,481,202		1,481,202		1,481,202	57
58 MAGNETIC RESONANCE IMAGING	526,168		526,168		526,168	58
59 CARDIAC CATHETERIZATION	2,807,620		2,807,620		2,807,620	59
60 LABORATORY	9,863,225		9,863,225		9,863,225	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,733,283		2,733,283		2,733,283	65
66 PHYSICAL THERAPY	3,100,250		3,100,250		3,100,250	66
67 OCCUPATIONAL THERAPY	1,263,016		1,263,016		1,263,016	67
68 SPEECH PATHOLOGY	386,019		386,019		386,019	68
69 ELECTROCARDIOLOGY	1,280,384		1,280,384		1,280,384	69
69.01 CARDIAC REHAB	609,149		609,149		609,149	69.01
70 ELECTROENCEPHALOGRAPHY	403,521		403,521		403,521	70
71 MEDICAL SUPPLIES CHRGED TO	2,853,116		2,853,116		2,853,116	71
72 IMPL. DEV. CHARGED TO PATIE	3,851,089		3,851,089		3,851,089	72
73 DRUGS CHARGED TO PATIENTS	8,626,922		8,626,922		8,626,922	73
75.01 ACUTE DIALYSIS	668,014		668,014		668,014	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,873,126		2,873,126		2,873,126	90
91 EMERGENCY	9,841,040		9,841,040	98	9,841,138	91
91.01 LITHOTRIPSY						91.01
92 OBSERVATION BEDS	2,368,273		2,368,273		2,368,273	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
200 SUBTOTAL (SEE INSTRUCTIONS)	112,295,658		112,295,658	98	112,295,756	200
201 LESS OBSERVATION BEDS	2,368,273		2,368,273		2,368,273	201
202 TOTAL (SEE INSTRUCTIONS)	109,927,385		109,927,385	98	109,927,483	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	67,487,627		67,487,627			30
34 SURGICAL INTENSIVE CARE UNI	18,980,492		18,980,492			34
44 SKILLED NURSING FACILITY	10,351,557		10,351,557			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,901,825	10,432,059	15,333,884	0.454870	0.454870	0.454870 50
51 RECOVERY ROOM	2,976,850	2,214,103	5,190,953	0.186120	0.186120	0.186120 51
53 ANESTHESIOLOGY	3,549,340	3,575,381	7,124,721	0.075459	0.075459	0.075459 53
54 RADIOLOGY-DIAGNOSTIC	5,062,262	7,219,914	12,282,176	0.450583	0.450583	0.450583 54
55 RADIOLOGY-THERAPEUTIC	3,705,513	6,427,124	10,132,637	0.125865	0.125865	0.125865 55
56 RADIOISOTOPE	1,464,553	2,629,189	4,093,742	0.173433	0.173433	0.173433 56
57 COMPUTED TOMOGRAPHY (CT) SC	11,982,416	20,579,715	32,562,131	0.045488	0.045488	0.045488 57
58 MAGNETIC RESONANCE IMAGING	2,847,543	4,847,132	7,694,675	0.068381	0.068381	0.068381 58
59 CARDIAC CATHETERIZATION	13,263,927	3,841,451	17,105,378	0.164137	0.164137	0.164137 59
60 LABORATORY	44,155,272	37,862,441	82,017,713	0.120257	0.120257	0.120257 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	21,917,248	1,060,583	22,977,831	0.118953	0.118953	0.118953 65
66 PHYSICAL THERAPY	5,379,675	2,393,137	7,772,812	0.398858	0.398858	0.398858 66
67 OCCUPATIONAL THERAPY	3,118,633	853,733	3,972,366	0.317951	0.317951	0.317951 67
68 SPEECH PATHOLOGY	882,876	170,024	1,052,900	0.366625	0.366625	0.366625 68
69 ELECTROCARDIOLOGY	8,529,495	6,847,008	15,376,503	0.083269	0.083269	0.083269 69
69.01 CARDIAC REHAB	333,749	233,649	567,398	1.073583	1.073583	1.073583 69.01
70 ELECTROENCEPHALOGRAPHY	247,476	82,260	329,736	1.223770	1.223770	1.223770 70
71 MEDICAL SUPPLIES CHRGD TO	15,789,871	3,774,207	19,564,078	0.145834	0.145834	0.145834 71
72 IMPL. DEV. CHARGED TO PATIE	9,783,132	3,019,450	12,802,582	0.300806	0.300806	0.300806 72
73 DRUGS CHARGED TO PATIENTS	53,743,584	10,450,950	64,194,534	0.134387	0.134387	0.134387 73
75.01 ACUTE DIALYSIS	2,836,774	155,908	2,992,682	0.223216	0.223216	0.223216 75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,642,198	7,064,078	9,706,276	0.296007	0.296007	0.296007 90
91 EMERGENCY	17,368,842	40,199,352	57,568,194	0.170946	0.170946	0.170946 91
91.01 LITHOTRIPSY						91.01
92 OBSERVATION BEDS	1,340,098	4,243,645	5,583,743	0.424137	0.424137	0.424137 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
200 SUBTOTAL (SEE INSTRUCTIONS)	334,642,828	180,176,493	514,819,321			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	334,642,828	180,176,493	514,819,321			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 CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	(COL.1 MINUS COL.2) 3	(COL.3 ÷ COL.4) 5	(COL.5 x COL.6) 7		
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,916,784		1,916,784	32,697	58.62	17,323	1,015,474
31 INTENSIVE CARE UNIT							30
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT	351,987		351,987	5,802	60.67	3,191	193,598
35 OTHER SPECIAL CARE (SPECIFY)							34
40 SUBPROVIDER - IPF							35
41 SUBPROVIDER - IRF							40
42 SUBPROVIDER I							41
43 NURSERY							42
44 SKILLED NURSING FACILITY	472,105		472,105	13,484	35.01	12,071	422,606
45 NURSING FACILITY							43
200 TOTAL (LINES 30-199)	2,740,876		2,740,876	51,983		32,585	1,631,678

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0251) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF

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	950,385	15,333,884	0.061979	2,926,985	181,412	50
51 RECOVERY ROOM	53,280	5,190,953	0.010264	1,478,317	15,173	51
53 ANESTHESIOLOGY	135,532	7,124,721	0.019023	1,517,127	28,860	53
54 RADIOLOGY-DIAGNOSTIC	2,505,694	12,282,176	0.204011	4,682,227	955,226	54
55 RADIOLOGY-THERAPEUTIC	74,417	10,132,637	0.007344	837,218	6,149	55
56 RADIOISOTOPE	24,918	4,093,742	0.006087	865,882	5,271	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	55,416	32,562,131	0.001702	6,766,987	11,517	57
58 MAGNETIC RESONANCE IMAGING (M	33,915	7,694,675	0.004408	1,444,207	6,366	58
59 CARDIAC CATHETERIZATION	278,489	17,105,378	0.016281	5,589,553	91,004	59
60 LABORATORY	433,196	82,017,713	0.005282	23,734,736	125,367	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	179,177	22,977,831	0.007798	7,527,530	58,700	65
66 PHYSICAL THERAPY	186,562	7,772,812	0.024002	1,018,890	24,455	66
67 OCCUPATIONAL THERAPY	54,357	3,972,366	0.013684	330,315	4,520	67
68 SPEECH PATHOLOGY	19,797	1,052,900	0.018802	468,775	8,814	68
69 ELECTROCARDIOLOGY	68,807	15,376,503	0.004475	6,079,859	27,207	69
69.01 CARDIAC REHAB	58,032	567,398	0.102277	86,076	8,804	69.01
70 ELECTROENCEPHALOGRAPHY	8,097	329,736	0.024556	167,393	4,111	70
71 MEDICAL SUPPLIES CHRGD TO PA	54,188	19,564,078	0.002770	7,962,278	22,056	71
72 IMPL. DEV. CHARGED TO PATIENT	70,275	12,802,582	0.005489	4,390,478	24,099	72
73 DRUGS CHARGED TO PATIENTS	225,789	64,194,534	0.003517	30,583,631	107,563	73
75.01 ACUTE DIALYSIS	41,712	2,992,682	0.013938	1,835,388	25,582	75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	384,068	9,706,276	0.039569	1,005,302	39,779	90
91 EMERGENCY	503,832	57,568,194	0.008752	8,640,474	75,621	91
91.01 LITHOTRIPSY						91.01
92 OBSERVATION BEDS	178,975	5,583,743	0.032053	1,181,438	37,869	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	6,578,910	417,999,645	417,999,645	121,121,066	1,895,525	200

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

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

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

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

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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	32,697		17,323		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT	5,802		3,191		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	13,484		12,071		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	51,983		32,585		200

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
 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  
 01/31/2012 09:04

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0251) [ ] 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			HEALTH	MEDICAL	COST
	ANESTHETIST	SCHOOL	EDUCATION	EDUCATION	(SUM OF	(SUM OF
	COST		HEALTH	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
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75.01 ACUTE DIALYSIS						75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
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
91.01 LITHOTRIPSY						91.01
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 (14-0251) [ ] 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	15,333,884			2,926,985		5,702,199	50
51 RECOVERY ROOM	5,190,953			1,478,317		1,803,738	51
53 ANESTHESIOLOGY	7,124,721			1,517,127		1,421,715	53
54 RADIOLOGY-DIAGNOSTIC	12,282,176			4,682,227		3,272,278	54
55 RADIOLOGY-THERAPEUTIC	10,132,637			837,218		730,280	55
56 RADIOISOTOPE	4,093,742			865,882		1,164,829	56
57 COMPUTED TOMOGRAPHY (CT) SCA	32,562,131			6,766,987		5,458,472	57
58 MAGNETIC RESONANCE IMAGING (	7,694,675			1,444,207		1,705,068	58
59 CARDIAC CATHETERIZATION	17,105,378			5,589,553		1,649,997	59
60 LABORATORY	82,017,713			23,734,736		1,274,114	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	22,977,831			7,527,530		179,734	65
66 PHYSICAL THERAPY	7,772,812			1,018,890		328	66
67 OCCUPATIONAL THERAPY	3,972,366			330,315		4,856	67
68 SPEECH PATHOLOGY	1,052,900			468,775			68
69 ELECTROCARDIOLOGY	15,376,503			6,079,859		2,582,851	69
69.01 CARDIAC REHAB	567,398			86,076		80,000	69.01
70 ELECTROENCEPHALOGRAPHY	329,736			167,393		39,778	70
71 MEDICAL SUPPLIES CHRGED TO P	19,564,078			7,962,278		2,010,266	71
72 IMPL. DEV. CHARGED TO PATIEN	12,802,582			4,390,478			72
73 DRUGS CHARGED TO PATIENTS	64,194,534			30,583,631		6,701,832	73
75.01 ACUTE DIALYSIS	2,992,682			1,835,388			75.01
76 AUDIO-VESTIBULAR LAB							76
76.01 ONCOLOGY							76.01
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	9,706,276			1,005,302		4,965,406	90
91 EMERGENCY	57,568,194			8,640,474		5,774,600	91
91.01 LITHOTRIPSY							91.01
92 OBSERVATION BEDS	5,583,743			1,181,438			92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	417,999,645			121,121,066		46,522,341	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0251) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES 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	0.454870	5,702,199			2,593,759			50
51 RECOVERY ROOM	0.186120	1,803,738			335,712			51
53 ANESTHESIOLOGY	0.075459	1,421,715			107,281			53
54 RADIOLOGY-DIAGNOSTIC	0.450583	3,272,278			1,474,433			54
55 RADIOLOGY-THERAPEUTIC	0.125865	730,280			91,917			55
56 RADIOISOTOPE	0.173433	1,164,829			202,020			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.045488	5,458,472			248,295			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.068381	1,705,068			116,594			58
59 CARDIAC CATHETERIZATION	0.164137	1,649,997			270,826			59
60 LABORATORY	0.120257	1,274,114			153,221			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.118953	179,734			21,380			65
66 PHYSICAL THERAPY	0.398858	328			131			66
67 OCCUPATIONAL THERAPY	0.317951	4,856			1,544			67
68 SPEECH PATHOLOGY	0.366625							68
69 ELECTROCARDIOLOGY	0.083269	2,582,851			215,071			69
69.01 CARDIAC REHAB	1.073583	80,000			85,887			69.01
70 ELECTROENCEPHALOGRAPHY	1.223770	39,778			48,679			70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.145834	2,010,266			293,165			71
72 IMPL. DEV. CHARGED TO PATIENT	0.300806							72
73 DRUGS CHARGED TO PATIENTS	0.134387	6,701,832		136,512	900,639		18,345	73
75.01 ACUTE DIALYSIS	0.223216							75.01
76 AUDIO-VESTIBULAR LAB								76
76.01 ONCOLOGY								76.01
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	0.296007	4,965,406			1,469,795			90
91 EMERGENCY	0.170946	5,774,600			987,145			91
91.01 LITHOTRIPSY								91.01
92 OBSERVATION BEDS	0.424137							92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)		46,522,341		136,512	9,617,494		18,345	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		46,522,341		136,512	9,617,494		18,345	202

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
 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 [ ] IPF [XX] SNF (14-5548) [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75.01 ACUTE DIALYSIS						75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
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
91.01 LITHOTRIPSY						91.01
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[ ] HOSPITAL [ ] IPF [ ] IRF	[ ] SUB (OTHER) [XX] SNF (14-5548) [ ] NF	[ ] ICF/MR	[ ] PPS [ ] TEFRA						
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	15,333,884			4,305						50
51	RECOVERY ROOM	5,190,953									51
53	ANESTHESIOLOGY	7,124,721			239						53
54	RADIOLOGY-DIAGNOSTIC	12,282,176			380,035						54
55	RADIOLOGY-THERAPEUTIC	10,132,637									55
56	RADIOISOTOPE	4,093,742									56
57	COMPUTED TOMOGRAPHY (CT) SCA	32,562,131									57
58	MAGNETIC RESONANCE IMAGING (	7,694,675									58
59	CARDIAC CATHETERIZATION	17,105,378									59
60	LABORATORY	82,017,713			2,425,332						60
62.30	BLOOD CLOTTING FOR HEMOPHILI										62.30
65	RESPIRATORY THERAPY	22,977,831			1,356,181						65
66	PHYSICAL THERAPY	7,772,812			3,290,575						66
67	OCCUPATIONAL THERAPY	3,972,366			2,334,042						67
68	SPEECH PATHOLOGY	1,052,900			167,499						68
69	ELECTROCARDIOLOGY	15,376,503			53,216						69
69.01	CARDIAC REHAB	567,398			384						69.01
70	ELECTROENCEPHALOGRAPHY	329,736			476						70
71	MEDICAL SUPPLIES CHRGED TO P	19,564,078			1,426,460						71
72	IMPL. DEV. CHARGED TO PATIEN	12,802,582									72
73	DRUGS CHARGED TO PATIENTS	64,194,534			5,817,575						73
75.01	ACUTE DIALYSIS	2,992,682									75.01
76	AUDIO-VESTIBULAR LAB										76
76.01	ONCOLOGY										76.01
76.97	CARDIAC REHABILITATION										76.97
76.98	HYPERBARIC OXYGEN THERAPY										76.98
76.99	LITHOTRIPSY										76.99
OUTPATIENT SERVICE COST CENTERS											
90	CLINIC	9,706,276			765						90
91	EMERGENCY	57,568,194									91
91.01	LITHOTRIPSY										91.01
92	OBSERVATION BEDS	5,583,743									92
OTHER REIMBURSABLE COST CENTERS											
200	TOTAL (SUM OF LINES 50-199)	417,999,645			17,257,084						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [XX] SNF (14-5548) [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES 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	0.454870							50
51 RECOVERY ROOM	0.186120							51
53 ANESTHESIOLOGY	0.075459							53
54 RADIOLOGY-DIAGNOSTIC	0.450583							54
55 RADIOLOGY-THERAPEUTIC	0.125865							55
56 RADIOISOTOPE	0.173433							56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.045488							57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.068381							58
59 CARDIAC CATHETERIZATION	0.164137							59
60 LABORATORY	0.120257							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.118953							65
66 PHYSICAL THERAPY	0.398858							66
67 OCCUPATIONAL THERAPY	0.317951							67
68 SPEECH PATHOLOGY	0.366625							68
69 ELECTROCARDIOLOGY	0.083269							69
69.01 CARDIAC REHAB	1.073583							69.01
70 ELECTROENCEPHALOGRAPHY	1.223770							70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.145834							71
72 IMPL. DEV. CHARGED TO PATIENT	0.300806							72
73 DRUGS CHARGED TO PATIENTS	0.134387				16,769		2,254	73
75.01 ACUTE DIALYSIS	0.223216							75.01
76 AUDIO-VESTIBULAR LAB								76
76.01 ONCOLOGY								76.01
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	0.296007							90
91 EMERGENCY	0.170946							91
91.01 LITHOTRIPSY								91.01
92 OBSERVATION BEDS	0.424137							92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)					16,769		2,254	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)					16,769		2,254	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	REDUCED	TOTAL	PER	INPAT	INPAT PGM	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)	PATIENT DAYS	DIEM (COL.3 ÷ COL.4)	PGM DAYS	CAP COST (COL.5 x COL.6)
	1	2	3	4	5	6	7
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 (LINES 30-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0251) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
55 RADIOLOGY-THERAPEUTIC					55
56 RADIOISOTOPE					56
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (M					58
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
69.01 CARDIAC REHAB					69.01
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGED TO PA					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
75.01 ACUTE DIALYSIS					75.01
76 AUDIO-VESTIBULAR LAB					76
76.01 ONCOLOGY					76.01
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
91.01 LITHOTRIPSY					91.01
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
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  
01/31/2012 09:04

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

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

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

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
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  
01/31/2012 09:04

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					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-0251) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [XX] OTHER

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75.01 ACUTE DIALYSIS						75.01
76 AUDIO-VESTIBULAR LAB						76
76.01 ONCOLOGY						76.01
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
91.01 LITHOTRIPSY						91.01
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 (14-0251) [ ] 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) 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	15,333,884						50
51 RECOVERY ROOM	5,190,953						51
53 ANESTHESIOLOGY	7,124,721						53
54 RADIOLOGY-DIAGNOSTIC	12,282,176						54
55 RADIOLOGY-THERAPEUTIC	10,132,637						55
56 RADIOISOTOPE	4,093,742						56
57 COMPUTED TOMOGRAPHY (CT) SCA	32,562,131						57
58 MAGNETIC RESONANCE IMAGING (	7,694,675						58
59 CARDIAC CATHETERIZATION	17,105,378						59
60 LABORATORY	82,017,713						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	22,977,831						65
66 PHYSICAL THERAPY	7,772,812						66
67 OCCUPATIONAL THERAPY	3,972,366						67
68 SPEECH PATHOLOGY	1,052,900						68
69 ELECTROCARDIOLOGY	15,376,503						69
69.01 CARDIAC REHAB	567,398						69.01
70 ELECTROENCEPHALOGRAPHY	329,736						70
71 MEDICAL SUPPLIES CHRGED TO P	19,564,078						71
72 IMPL. DEV. CHARGED TO PATIEN	12,802,582						72
73 DRUGS CHARGED TO PATIENTS	64,194,534						73
75.01 ACUTE DIALYSIS	2,992,682						75.01
76 AUDIO-VESTIBULAR LAB							76
76.01 ONCOLOGY							76.01
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	9,706,276						90
91 EMERGENCY	57,568,194						91
91.01 LITHOTRIPSY							91.01
92 OBSERVATION BEDS	5,583,743						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	417,999,645						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0251) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [ ] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.454870						50
51 RECOVERY ROOM	0.186120						51
53 ANESTHESIOLOGY	0.075459						53
54 RADIOLOGY-DIAGNOSTIC	0.450583						54
55 RADIOLOGY-THERAPEUTIC	0.125865						55
56 RADIOISOTOPE	0.173433						56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.045488						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.068381						58
59 CARDIAC CATHETERIZATION	0.164137						59
60 LABORATORY	0.120257						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.118953						65
66 PHYSICAL THERAPY	0.398858						66
67 OCCUPATIONAL THERAPY	0.317951						67
68 SPEECH PATHOLOGY	0.366625						68
69 ELECTROCARDIOLOGY	0.083269						69
69.01 CARDIAC REHAB	1.073583						69.01
70 ELECTROENCEPHALOGRAPHY	1.223770						70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.145834						71
72 IMPL. DEV. CHARGED TO PATIENT	0.300806						72
73 DRUGS CHARGED TO PATIENTS	0.134387						73
75.01 ACUTE DIALYSIS	0.223216						75.01
76 AUDIO-VESTIBULAR LAB							76
76.01 ONCOLOGY							76.01
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.296007						90
91 EMERGENCY	0.170946						91
91.01 LITHOTRIPSY							91.01
92 OBSERVATION BEDS	0.424137						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

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0251) [ ] 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)	32,697	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	32,697	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	32,697	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)	17,323	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	25,363,804	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	25,363,804	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	25,363,804	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0251)	[ ]	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)							775.72	38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)							13,437,798	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)							13,437,798	41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT	8,228,925	5,802	1,418.29	3,191	4,525,763	46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					19,924,139	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					37,887,700	49

PASS-THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					1,209,072	50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					1,895,525	51
52 TOTAL PROGRAM EXCLUDABLE COST					3,104,597	52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					34,783,103	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)					3,053	87
88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)					775.72	88
89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)					2,368,273	89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	1,916,784	25,363,804	0.075572	2,368,273	178,975	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [XX] SNF (14-5548) [ ] 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)	13,484	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	13,484	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,484	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	12,071	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	7,169,350	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,169,350	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	7,169,350	37

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
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  
01/31/2012 09:04

WORKSHEET D-1  
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [XX] SNF (14-5548) [ ] TEFRA  
BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [ ] OTHER

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	7,169,350	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	531.69	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	6,418,030	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	6,418,030	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	6,418,030	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	3,737,674	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	10,155,704	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0251) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	32,697	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	32,697	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	32,697	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)	7,203	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)	25,363,804	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	25,363,804	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	25,363,804	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0251)	[ ]	SUB (OTHER)	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF			[XX]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)					775.72 38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)					5,587,511 39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)					40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)					5,587,511 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT	8,228,925	5,802	1,418.29		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)					5,587,511 49

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

TARGET AMOUNT AND LIMIT COMPUTATION					
54 PROGRAM DISCHARGES					54
55 TARGET AMOUNT PER DISCHARGE					55
56 TARGET AMOUNT (LINE 54 x LINE 55)					56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					57
58 BONUS PAYMENT (SEE INSTRUCTIONS)					58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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)					3,053 87
88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)					88
89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)					89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0251) [ ] 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		36,209,001			30
34 SURGICAL INTENSIVE CARE UNIT		9,474,220			34
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.454870	2,926,985	1,331,398		50
51 RECOVERY ROOM	0.186120	1,478,317	275,144		51
53 ANESTHESIOLOGY	0.075459	1,517,127	114,481		53
54 RADIOLOGY-DIAGNOSTIC	0.450583	4,682,227	2,109,732		54
55 RADIOLOGY-THERAPEUTIC	0.125865	837,218	105,376		55
56 RADIOISOTOPE	0.173433	865,882	150,173		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.045488	6,766,987	307,817		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.068381	1,444,207	98,756		58
59 CARDIAC CATHETERIZATION	0.164137	5,589,553	917,452		59
60 LABORATORY	0.120257	23,734,736	2,854,268		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.118953	7,527,530	895,422		65
66 PHYSICAL THERAPY	0.398858	1,018,890	406,392		66
67 OCCUPATIONAL THERAPY	0.317951	330,315	105,024		67
68 SPEECH PATHOLOGY	0.366625	468,775	171,865		68
69 ELECTROCARDIOLOGY	0.083269	6,079,859	506,264		69
69.01 CARDIAC REHAB	1.073583	86,076	92,410		69.01
70 ELECTROENCEPHALOGRAPHY	1.223770	167,393	204,851		70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.145834	7,962,278	1,161,171		71
72 IMPL. DEV. CHARGED TO PATIENT	0.300806	4,390,478	1,320,682		72
73 DRUGS CHARGED TO PATIENTS	0.134387	30,583,631	4,110,042		73
75.01 ACUTE DIALYSIS	0.223216	1,835,388	409,688		75.01
76 AUDIO-VESTIBULAR LAB					76
76.01 ONCOLOGY					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.296007	1,005,302	297,576		90
91 EMERGENCY	0.170947	8,640,474	1,477,063		91
91.01 LITHOTRIPSY					91.01
92 OBSERVATION BEDS	0.424137	1,181,438	501,092		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		121,121,066	19,924,139		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		121,121,066			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B SNF [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [XX] SNF (14-5548) [ ] 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
34 SURGICAL INTENSIVE CARE UNIT					34
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.454870	4,305	1,958		50
51 RECOVERY ROOM	0.186120				51
53 ANESTHESIOLOGY	0.075459	239	18		53
54 RADIOLOGY-DIAGNOSTIC	0.450583	380,035	171,237		54
55 RADIOLOGY-THERAPEUTIC	0.125865				55
56 RADIOISOTOPE	0.173433				56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.045488				57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.068381				58
59 CARDIAC CATHETERIZATION	0.164137				59
60 LABORATORY	0.120257	2,425,332	291,663		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.118953	1,356,181	161,322		65
66 PHYSICAL THERAPY	0.398858	3,290,575	1,312,472		66
67 OCCUPATIONAL THERAPY	0.317951	2,334,042	742,111		67
68 SPEECH PATHOLOGY	0.366625	167,499	61,409		68
69 ELECTROCARDIOLOGY	0.083269	53,216	4,431		69
69.01 CARDIAC REHAB	1.073583	384	412		69.01
70 ELECTROENCEPHALOGRAPHY	1.223770	476	583		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.145834	1,426,460	208,026		71
72 IMPL. DEV. CHARGED TO PATIENT	0.300806				72
73 DRUGS CHARGED TO PATIENTS	0.134387	5,817,575	781,806		73
75.01 ACUTE DIALYSIS	0.223216				75.01
76 AUDIO-VESTIBULAR LAB					76
76.01 ONCOLOGY					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.296007	765	226		90
91 EMERGENCY	0.170946				91
91.01 LITHOTRIPSY					91.01
92 OBSERVATION BEDS	0.424137				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		17,257,084	3,737,674		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		17,257,084			202

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
 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  
 01/31/2012 09:04

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-0251) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
34 SURGICAL INTENSIVE CARE UNIT				34
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.454870			50
51 RECOVERY ROOM	0.186120			51
53 ANESTHESIOLOGY	0.075459			53
54 RADIOLOGY-DIAGNOSTIC	0.450583			54
55 RADIOLOGY-THERAPEUTIC	0.125865			55
56 RADIOISOTOPE	0.173433			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.045488			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.068381			58
59 CARDIAC CATHETERIZATION	0.164137			59
60 LABORATORY	0.120257			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.118953			65
66 PHYSICAL THERAPY	0.398858			66
67 OCCUPATIONAL THERAPY	0.317951			67
68 SPEECH PATHOLOGY	0.366625			68
69 ELECTROCARDIOLOGY	0.083269			69
69.01 CARDIAC REHAB	1.073583			69.01
70 ELECTROENCEPHALOGRAPHY	1.223770			70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.145834			71
72 IMPL. DEV. CHARGED TO PATIENT	0.300806			72
73 DRUGS CHARGED TO PATIENTS	0.134387			73
75.01 ACUTE DIALYSIS	0.223216			75.01
76 AUDIO-VESTIBULAR LAB				76
76.01 ONCOLOGY				76.01
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.296007			90
91 EMERGENCY	0.170946			91
91.01 LITHOTRIPSY				91.01
92 OBSERVATION BEDS	0.424137			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 (14-0251)  
 APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	32,394,742	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	335,194	2
3	MANAGED CARE SIMULATED PAYMENTS	2,087,057	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	184.64	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)	4.56	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)	4.56	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	2.91	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	2.91	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	2.89	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	4.35	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	3.38	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	3.38	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.018306	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.020248	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.018306	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	343,266	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)	-1.65	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)	343,266	29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0793	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.2032	31
32	SUM OF LINES 30 AND 31	0.2825	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1252	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	4,055,822	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)	37,129,024	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)	37,129,024	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	2,836,297	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 (14-0251)  
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)	192,361	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)	40,157,682	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	40,157,682	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	3,005,148	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	186,695	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	1,012,553	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	708,787	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	855,165	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	37,674,626	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)	37,674,626	71
72	INTERIM PAYMENTS	37,356,408	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	318,218	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	644,655	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96



CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:         HOSPITAL                                 IPF                                 IRF  
    SUB (OTHER)                                 SNF (14-5548)

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,254	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)	2,254	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	16,769	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)	16,769	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)	16,769	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	14,515	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)	2,254	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)	2,254	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)	2,254	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,254	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)	2,254	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)	2,254	40
41	INTERIM PAYMENTS	2,515	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-261	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (14-0251) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT			
	1	2	3	4			
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		36,304,468		6,168,220	1		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		963,053		434,667	2		
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.							
		.01			3.01		
		.02	01/28/2011	156,259	01/28/2011	82,217	3.02
PROGRAM		.03				3.03	
TO		.04				3.04	
PROVIDER		.05				3.05	
		.06				3.06	
		.07				3.07	
		.08				3.08	
		.09				3.09	
		.50	06/24/2011	67,372	06/24/2011	3,902	3.50
		.51				3.51	
PROVIDER		.52				3.52	
TO		.53				3.53	
PROGRAM		.54				3.54	
		.55				3.55	
		.56				3.56	
		.57				3.57	
		.58				3.58	
		.59				3.59	
		.99		88,887		78,315	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)							
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				37,356,408		6,681,202	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						
		PROGRAM	.01	NONE	NONE	5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50	NONE	NONE	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
			.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		PROGRAM	.01		96,684	6.01
		TO	.02			
		PROVIDER				
		PROVIDER				
		TO	.02	-37,356,408		6.02
		PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					6,777,886	7

8 NAME OF CONTRACTOR:

CONTRACTOR NUMBER:

DATE:

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [ ] HOSPITAL [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [XX] SNF (14-5548)  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		5,575,961		2,515	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		5,575,961		2,515	4
TO BE COMPLETED BY CONTRACTOR					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01	3,933			6.01
	PROVIDER PROVIDER TO .02			-261	6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		5,579,894		2,254	7
8 NAME OF CONTRACTOR:	CONTRACTOR NUMBER:		DATE:		

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
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  
01/31/2012 09:04

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-0251) [ ] 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	7,521 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	20,514 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,444 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	35,446 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	514,819,321 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	16,720,233 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 VI

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

PROSPECTIVE PAYMENT AMOUNT		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	5,800,507 1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS	2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS	3
4	SUBTOTAL (SUM OF LINES 1-3)	5,800,507 4
COMPUTATION OF NET COST OF COVERED SERVICES		
5	MEDICAL AND OTHER SERVICES	5
6	DEDUCTIBLES	6
7	COINSURANCE	224,546 7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	5,618 8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	3,933 10
11	UTILIZATION REVIEW	11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	5,579,894 12
13	INPATIENT PRIMARY PAYER PAYMENTS	13
14	OTHER ADJUSTMENTS (ADJ. PENDING CORRECT SNF PS & R)	14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	5,579,894 15
16	INTERIM PAYMENTS	5,575,961 16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)	3,933 18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-0251) [ ] SNF [ ] PPS  
APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
[ ] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	5,587,511 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	5,587,511 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	5,587,511 7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	5,587,511 18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LINE 7)	5,587,511 21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22-26 PLUS LINE 3 MINUS LINES 5 AND 6)	27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	28
29	TITLE V OR XIX PPS, ENTER AMOUNT FROM LINE 27, NON-PPS ENTER AMOUNT FROM LINE 21	5,587,511 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	5,587,511 30
31	SUBTOTAL (SUM OF LINES 19-20 PLUS 29 MINUS 30)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996		1	
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)	1.56	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))	2.05	4	
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.01	
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.02	
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)	3.61	5	
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)	2.91	6	
7	ENTER THE LESSER OF LINE 5 OR LINE 6	2.91	7	
		PRIMARY CARE 1	OTHER 2	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.08	2.83	2.91
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.08	2.83	2.91
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		2.53	10
11	TOTAL WEIGHTED FTE COUNT	0.08	5.36	11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)		2.89	12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)		4.35	13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	0.03	4.20	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	0.03	4.20	17
18	PER RESIDENT AMOUNT	88,349.94	88,349.94	18
19	APPROVED AMOUNT FOR RESIDENT COSTS	2,650	371,070	373,720
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			1.45
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)			373,720
COMPUTATION OF PROGRAM PATIENT LOAD				
		INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS	20,514	1,444	26
27	TOTAL INPATIENT DAYS	35,446	35,446	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.578739	0.040738	28
29	PROGRAM DIRECT GME AMOUNT	216,286	15,225	29
30	REDUCTION FOR NURSING/ALLIED HEALTH		2,151	30
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
31	NET PROGRAM DIRECT GME AMOUNT			229,360
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)			50,106,237
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)			50,106,237
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			9,638,093
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			729
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			9,637,364
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			59,743,601
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.838688
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.161312
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			229,360
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			192,361
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			36,999

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	7,203		26
27	TOTAL INPATIENT DAYS	35,446		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.203211		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	5,954			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	50,537,180			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-35,659,950			6
7	INVENTORY	1,103,753			7
8	PREPAID EXPENSES	221,940			8
9	OTHER CURRENT ASSETS	381,453			9
10	DUE FROM OTHER FUNDS	-3,653,026			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	12,937,304			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS				15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	122,284,095			19
20	ACCUMULATED DEPRECIATION	-94,887,165			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)	27,396,930			30
OTHER ASSETS					
31	INVESTMENTS	32,943,283			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	32,943,283			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	73,277,517			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,286,118			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				43
44	OTHER CURRENT LIABILITIES	4,786,509			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,072,627			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	17,917,824			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	17,917,824			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	23,990,451			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	49,287,066			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)	49,287,066			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	73,277,517			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		57,596,490							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		-8,309,424							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		49,287,066							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									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)		49,287,066							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 TRANSFERS TO AFFILIATES									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		49,287,066							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	299,223,918		299,223,918	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	10,351,557		10,351,557	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	309,575,475		309,575,475	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT	18,980,492		18,980,492	14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	18,980,492		18,980,492	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	328,555,967		328,555,967	18
19 ANCILLARY SERVICES				19
20 OUTPATIENT SERVICES		186,277,544	186,277,544	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	328,555,967	186,277,544	514,833,511	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		113,413,846	29
30 TRIAL BALANCE VARIANCE WITH KPMG			30
31			31
32			32
33			33
34			34
35 IMMATERIAL VARIANCE			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		113,413,846	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	514,833,511	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	410,610,931	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	104,222,580	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	113,413,846	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-9,191,266	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	735	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	374,424	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	78,793	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS	39,034	23
24			24
24.01	OTHER (NUTRITION CONSULTING)		24.01
24.02	OTHER (MISCELLANEOUS - NET ASSETS RELEASED)	182,380	24.02
24.03	OTHER (MISCELLANEOUS - CARDIAC REHAB, ETC.)	206,476	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	881,842	25
26	TOTAL (LINE 5 PLUS LINE 25)	-8,309,424	26
27	OTHER EXPENSES (OTHER EXPENSE)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-8,309,424	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((14-025) [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	2,641,322	1
2	CAPITAL DRG OUTLIER PAYMENTS	13,252	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	97.11	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	3.38	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0099	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	26,149	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0793	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.2032	8
9	SUM OF LINES 7 AND 8	0.2825	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0589	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	155,574	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	2,836,297	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	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
17.01 HOUSE STAFF PHYSICIANS					17.01
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
34 SURGICAL INTENSIVE CARE UNIT					34
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
55 RADIOLOGY-THERAPEUTIC					55
56 RADIOISOTOPE					56
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR)					58
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
69.01 CARDIAC REHAB					69.01
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
75.01 ACUTE DIALYSIS					75.01
76 AUDIO-VESTIBULAR LAB					76
76.01 ONCOLOGY					76.01
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
91.01 LITHOTRIPSY					91.01
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					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
193.01 NON EMPLOYEE DAY CARE					193.01
193.02 RESURRECTION HOME CARE OFFICES					193.02
193.03 OCCUPATIONAL HEALTH NON-REIM					193.03

PROVIDER CCN: 14-0251 OUR LADY OF THE RESURRECTION  
PERIOD FROM 07/01/2010 TO 06/30/2011

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

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ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4) 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