

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

- PROVIDER USE ONLY
1. ELECTRONICALLY FILED COST REPORT
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
- DATE: _____ TIME: _____
- CONTRACTOR USE ONLY
5. COST REPORT STATUS
 6. DATE RECEIVED: _____
 7. CONTRACTOR NO: _____
 8. INITIAL REPORT FOR THIS PROVIDER CCN
 9. FINAL REPORT FOR THIS PROVIDER CCN
 10. NPR DATE: _____
 11. CONTRACTOR'S VENDOR CODE: _____
 12. IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.
- 1 - AS SUBMITTED
 - 2 - SETTLED WITHOUT AUDIT
 - 3 - SETTLED WITH AUDIT
 - 4 - REOPENED
 - 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. MARY'S HOSPITAL (14-0026) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

TITLE

DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		114,916	56,852			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		1,250				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		116,166	56,852			200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

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

STATE: IL

P.O.BOX:
 ZIP CODE: 61364

COUNTY: LASALLE

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM			3
							(P, T, O, OR N)	V	XVIII	
3	HOSPITAL	ST. MARY'S HOSPITAL	14-0026	99914	1	05/23/1966	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	ST. MARY'S EXTENDED CARE FACIL	14-5594	99914		08/23/1988	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	ST. MARY'S HOME HEALTH	14-7173	99914		12/03/1979	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 07/01/2011 TO: 06/30/2012									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	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO PAID DAYS	OTHER MEDICAID PAID DAYS	2
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1,010	44			43	24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			1			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING: 07/01/2011		ENDING: 06/30/2012	38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	56
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL 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))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	2	3	4	5	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N 2 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES. 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.			106
107	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 41,406 PAID LOSSES: 23,750 SELF INSURANCE: 216,095			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

141	NAME: HOSPITAL SISTERS HEALTH SYSTEM CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET: 4936 LAVERNA RD. P.O. BOX: 19456		142
143	CITY: STPRINGFIELD STATE: IL	ZIP CODE: 62794	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149

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

	TITLE XVIII	TITLE	TITLE	
	PART A	PART B	V	
	1	2	3	
			XIX	
			4	
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	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			169

(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N		2 6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 Y	2 10/15/2012	3 Y	4 10/15/2012
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

	Y/N	DATE	
	1	2	
36			WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? 36
37			IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 37
38	N		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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: ANDREW	LAST NAME: MATSKO	TITLE: ACCOUNTANT	41
42	EMPLOYER: ST. MARY'S HOSPITAL			42
43	PHONE NUMBER: 815-673-2311 EXT 3387	E-MAIL ADDRESS: ANDY.MATSKO@HSHS.ORG		43

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	17,050,616	17,050,616	777,072.00	21.94	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44	78,233	78,233	5,530.00	14.15	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		858,071	-166,132	691,939	26,682.00	25.93
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		463,004	463,004	7,197.00	64.33	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		503,595	503,595	3,718.00	135.45	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,181,442	1,181,442	14,162.00	83.42	14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		6,459,684	6,459,684			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		293,352	293,352			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS		208,849	208,849	8,345.00	25.03	26
27	ADMINISTRATIVE & GENERAL		3,236,845	29,260	3,266,105	141,740.00	23.04
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		85,339	85,339	750.00	113.79	28
29	MAINTENANCE & REPAIRS		490,232	490,232	21,777.00	22.51	29
30	OPERATION OF PLANT		138,258	138,258	9,971.00	13.87	30
31	LAUNDRY & LINEN SERVICE		24,749	24,749	2,885.00	8.58	31
32	HOUSEKEEPING		486,148	486,148	43,958.00	11.06	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		378,651	378,651	29,196.00	12.97	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA		48,719	48,719	4,160.00	11.71	36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		837,315	837,315	29,523.00	28.36	38
39	CENTRAL SERVICES AND SUPPLY		105,317	105,317	6,965.00	15.12	39
40	PHARMACY		512,826	512,826	13,380.00	38.33	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		435,400	435,400	27,619.00	15.76	41
42	SOCIAL SERVICE			19,327	19,327	867.00	22.29
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	17,135,955		17,135,955	777,822.00	22.03	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	936,304	-166,132	770,172	32,212.00	23.91	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	16,199,651	166,132	16,365,783	745,610.00	21.95	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	2,148,041		2,148,041	25,077.00	85.66	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	6,459,684		6,459,684		39.47%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	24,807,376	166,132	24,973,508	770,687.00	32.40	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	6,988,648	48,587	7,037,235	341,136.00	20.63	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	1,583,888 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	13,383 7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	3,358,615 8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	120,281 10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	20,623 11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	29,357 13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	59,669 14
15 WORKERS' COMPENSATION INSURANCE	86,939 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	949,300 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	331,446 18
19 UNEMPLOYMENT INSURANCE	194,544 19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	4,991 23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	6,753,036 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
11/26/2012 10:53

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	463,004	2
3	SUBPROVIDER - IPF	463,004	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7173

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: LASALLE

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		473			473	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		315.00		88.00	403.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL 3	
	STAFF 1	CONTRACT 2			
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)					3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			1.03	1.03	4
5 OTHER ADMINISTRATIVE PERSONNEL			2.59	2.59	5
6 DIRECT NURSING SERVICE			4.69	4.69	6
7 NURSING SUPERVISOR			1.66	1.66	7
8 PHYSICAL THERAPY SERVICE			1.32	1.32	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE			0.15	0.15	10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE			0.01	0.01	12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE			0.42	0.42	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE			0.23	0.23	16
17 HOME HEALTH AIDE SUPERVISOR					17
18 OTHER (SPECIFY)					18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2				
21 SKILLED NURSING VISITS	2,642		133	48	2,823	21
22 SKILLED NURSING VISIT CHARGES	526,630		26,585	9,555	562,770	22
23 PHYSICAL THERAPY VISITS	1,060			9	1,069	23
24 PHYSICAL THERAPY VISIT CHARGES	211,685			1,800	213,485	24
25 OCCUPATIONAL THERAPY VISITS	141				141	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	28,185				28,185	26
27 SPEECH PATHOLOGY VISITS	74				74	27
28 SPEECH PATHOLOGY VISIT CHARGES	14,800				14,800	28
29 MEDICAL SOCIAL SERVICE VISITS	118		5	4	127	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	31,060		1,325	1,060	33,445	30
31 HOME HEALTH AIDE VISITS	247		2	3	252	31
32 HOME HEALTH AIDE VISIT CHARGES	29,625		240	360	30,225	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	4,282		140	64	4,486	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	841,985		28,150	12,775	882,910	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	320		28	7	355	36
37 TOTAL NUMBER OF OUTLIER EPISODES						37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	22,530		2,879	88	25,497	38

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
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PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL	255		255 200

	CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF 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).	99914	201

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

	EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3	
202	STAFFING		N	202
203	RECRUITMENT		N	203
204	RETENTION OF EMPLOYEES		N	204
205	TRAINING		N	205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	107,950		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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.302351	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,744,053	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				16,879,944	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				5,103,668	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				3,359,615	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				37,427	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				3,359,615	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	6,947,378	730,386	7,677,764		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	2,100,547	220,833	2,321,380		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	55,811	22,088	77,899		22
23	COST OF CHARITY CARE	2,044,736	198,745	2,243,481		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 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					N 24
25	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				1,936,778	25
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				258,765	26
27	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				1,678,013	27
28	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				507,349	28
29	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				2,750,830	29
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				6,110,445	30
31						31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,677,100	1,677,100	-118,678	1
2	00200		3,144,402	3,144,402	18,430	2
3	00300		58,276	58,276	-58,276	3
4	00400	208,849	6,532,526	6,741,375		4
5	00500	3,236,845	8,424,917	11,661,762	-1,072,724	5
6	00600	490,232	485,471	975,703		6
7	00700	138,258	1,052,029	1,190,287		7
8	00800	24,749	167,911	192,660		8
9	00900	486,148	237,126	723,274		9
10	01000	378,651	211,922	590,573		10
11	01100	48,719	-4,027	44,692		11
12	01200					12
13	01300	837,315	5,256	842,571		13
14	01400	105,317	234,129	339,446	-218,621	14
15	01500	512,826	1,004,309	1,517,135	-964,850	15
16	01600	435,400	149,537	584,937		16
17	01700				19,327	17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,058,040	95,743	2,153,783		30
31	03100	639,179	23,523	662,702		31
43	04300	111,466	11,336	122,802		43
44	04400	78,233	5,849	84,082		44
ANCILLARY SERVICE COST CENTERS						
50	05000	1,234,945	2,067,385	3,302,330	-1,831,812	50
52	05200	111,466	26,928	138,394		52
53	05300		124,537	124,537	1,101,984	53
54	05400	1,092,555	1,057,493	2,150,048		54
57	05700	134,911	177,980	312,891		57
58	05800	121,763	178,700	300,463		58
60	06000	907,924	1,636,874	2,544,798		60
62.30	06250					62.30
65	06500	373,452	84,592	458,044	-66,293	65
66	06600	546,886	325,195	872,081	105,516	66
67	06700	130,548	103,060	233,608	7,536	67
68	06800	40,862	176	41,038	1,139	68
68.01	03040	2,410	-12,956	-10,546		68.01
69	06900	27,184	47,924	75,108		69
69.01	03951					69.01
70	07000	1,020	145,887	146,907		70
71	07100				1,149,115	71
72	07200				1,021,953	72
73	07300				964,850	73
73.01	03480					73.01
76	03950					76
76.97	07697	70,661	3,962	74,623		76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	196,385	9,018	205,403		90
90.01	09001	568,614	1,406,477	1,975,091	79,983	90.01
91	09100	840,732	1,702,385	2,543,117	-43,969	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	724,455	54,044	778,499	-173,151	101
113	11300		241,131	241,131		113
118		16,917,000	32,898,127	49,815,127	-78,541	118
NONREIMBURSABLE COST CENTERS						
190	19000		32,310	32,310		190
192	19200		3,696,501	3,696,501	78,541	192
194	07950	133,616	107,947	241,563		194
200		17,050,616	36,734,885	53,785,501		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,558,422	-8,506	1,549,916	1
2	00200	3,162,832	-157,589	3,005,243	2
3	00300				3
4	00400	6,741,375	-1,882,359	4,859,016	4
5	00500	10,589,038	-1,922,311	8,666,727	5
6	00600	975,703		975,703	6
7	00700	1,190,287	-65	1,190,222	7
8	00800	192,660		192,660	8
9	00900	723,274		723,274	9
10	01000	590,573	-23,421	567,152	10
11	01100	44,692	-15	44,677	11
12	01200				12
13	01300	842,571	-300	842,271	13
14	01400	120,825		120,825	14
15	01500	552,285	-1,441	550,844	15
16	01600	584,937	-21,765	563,172	16
17	01700	19,327		19,327	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,153,783		2,153,783	30
31	03100	662,702		662,702	31
43	04300	122,802		122,802	43
44	04400	84,082		84,082	44
ANCILLARY SERVICE COST CENTERS					
50	05000	1,470,518		1,470,518	50
52	05200	138,394		138,394	52
53	05300	1,226,521	-1,101,984	124,537	53
54	05400	2,150,048	-2,095	2,147,953	54
57	05700	312,891		312,891	57
58	05800	300,463		300,463	58
60	06000	2,544,798		2,544,798	60
62.30	06250				62.30
65	06500	391,751		391,751	65
66	06600	977,597		977,597	66
67	06700	241,144		241,144	67
68	06800	42,177		42,177	68
68.01	03040	-10,546		-10,546	68.01
69	06900	75,108	-38,174	36,934	69
69.01	03951				69.01
70	07000	146,907		146,907	70
71	07100	1,149,115	-1,650	1,147,465	71
72	07200	1,021,953		1,021,953	72
73	07300	964,850		964,850	73
73.01	03480				73.01
76	03950				76
76.97	07697	74,623		74,623	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	205,403		205,403	90
90.01	09001	2,055,074	-992,988	1,062,086	90.01
91	09100	2,499,148	-1,518,375	980,773	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
101	10100	605,348		605,348	101
SPECIAL PURPOSE COST CENTERS					
113	11300	241,131	-241,131		113
118		49,736,586	-7,914,169	41,822,417	118
NONREIMBURSABLE COST CENTERS					
190	19000	32,310		32,310	190
192	19200	3,775,042	-2,797,267	977,775	192
194	07950	241,563		241,563	194
200		53,785,501	-10,711,436	43,074,065	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 SUPPLY CHARGED TO PATIENTS	A	MEDICAL SUPPLIES CHRGED TO PA	71			218,621 1
500 TOTAL RECLASSIFICATIONS						218,621 500
CODE LETTER - A						
1 DRUGS CHARGED TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73			964,850 1
500 TOTAL RECLASSIFICATIONS						964,850 500
CODE LETTER - B						
1 MED/SURG ER RECLASS	C	MEDICAL SUPPLIES CHRGED TO PA	71			43,969 1
500 TOTAL RECLASSIFICATIONS						43,969 500
CODE LETTER - C						
1 MED/SURG SURGERY RECLASS	D	MEDICAL SUPPLIES CHRGED TO PA	71			809,859 1
500 TOTAL RECLASSIFICATIONS						809,859 500
CODE LETTER - D						
1 MED/SURG RESP THER RECLASS	E	MEDICAL SUPPLIES CHRGED TO PA	71			66,293 1
500 TOTAL RECLASSIFICATIONS						66,293 500
CODE LETTER - E						
1 MED/SURG P.T. RECLASS	F	MEDICAL SUPPLIES CHRGED TO PA	71			2,031 1
500 TOTAL RECLASSIFICATIONS						2,031 500
CODE LETTER - F						
1 MED/SURG O.T. RECLASS	G	MEDICAL SUPPLIES CHRGED TO PA	71			1,323 1
500 TOTAL RECLASSIFICATIONS						1,323 500
CODE LETTER - G						
1 PHY PRIV OFC DIRECT DEPR	H	PHYSICIANS' PRIVATE OFFICES	192			76,419 1
500 TOTAL RECLASSIFICATIONS						76,419 500
CODE LETTER - H						
1 P.T. SALARY	I	PHYSICAL THERAPY	66		107,547	1
500 TOTAL RECLASSIFICATIONS					107,547	500
CODE LETTER - I						
1 MSW SALARY	K	SOCIAL SERVICE	17		19,327	1
500 TOTAL RECLASSIFICATIONS					19,327	500
CODE LETTER - K						
1 O.T. SALARY	L	OCCUPATIONAL THERAPY	67		8,859	1
500 TOTAL RECLASSIFICATIONS					8,859	500
CODE LETTER - L						
1 HHA COST BILLERS	M	ADMINISTRATIVE & GENERAL	5		29,260	1
500 TOTAL RECLASSIFICATIONS					29,260	500
CODE LETTER - M						
1 MED SURG HH RECLASS	O	MEDICAL SUPPLIES CHRGED TO PA	71			7,019 1
500 TOTAL RECLASSIFICATIONS						7,019 500
CODE LETTER - O						
1 ANESTHESIA PHY	P	ANESTHESIOLOGY	53			1,101,984 1
500 TOTAL RECLASSIFICATIONS						1,101,984 500
CODE LETTER - P						
1 PHY PRIV OFC DIRECT DEPT	Q	PHYSICIANS' PRIVATE OFFICES	192			2,122 1
500 TOTAL RECLASSIFICATIONS						2,122 500
CODE LETTER - Q						

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----			
		COST CENTER	LINE #	SALARY	OTHER
	1	2	3	4	5
1 OTTAWA CLINIC DIRECT DEPT	R	OTTAWA CLINIC	90.01		79,983 1
500 TOTAL RECLASSIFICATIONS					79,983 500
1 MED/SURG SURGERY RELACC	S	IMPL. DEV. CHARGED TO PATIENT	72		1,021,953 1
500 TOTAL RECLASSIFICATIONS					1,021,953 500
1 S.T. SALARY	T	SPEECH PATHOLOGY	68	1,139	1
500 TOTAL RECLASSIFICATIONS				1,139	500
GRAND TOTAL (INCREASES)				166,132	4,396,426

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 SUPPLY CHARGED TO PATIENTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	CENTRAL SERVICES & SUPPLY	14		218,621	1 500
1 DRUGS CHARGED TO PATIENTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - B	B	PHARMACY	15		964,850	1 500
1 MED/SURG ER RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - C	C	EMERGENCY	91		43,969	1 500
1 MED/SURG SURGERY RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	OPERATING ROOM	50		809,859	1 500
1 MED/SURG RESP THER RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - E	E	RESPIRATORY THERAPY	65		66,293	1 500
1 MED/SURG P.T. RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - F	F	PHYSICAL THERAPY	66		2,031	1 500
1 MED/SURG O.T. RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - G	G	OCCUPATIONAL THERAPY	67		1,323	1 500
1 PHY PRIV OFC DIRECT DEPR 500 TOTAL RECLASSIFICATIONS CODE LETTER - H	H	CAP REL COSTS-BLDG & FIXT	1		76,419	9 1 500
1 P.T. SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - I	I	HOME HEALTH AGENCY	101	107,547		1 500
1 MSW SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - K	K	HOME HEALTH AGENCY	101	19,327		1 500
1 O.T. SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - L	L	HOME HEALTH AGENCY	101	8,859		1 500
1 HHA COST BILLERS 500 TOTAL RECLASSIFICATIONS CODE LETTER - M	M	HOME HEALTH AGENCY	101	29,260		1 500
1 MED SURG HH RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - O	O	HOME HEALTH AGENCY	101		7,019	1 500
1 ANESTHESIA PHY 500 TOTAL RECLASSIFICATIONS CODE LETTER - P	P	ADMINISTRATIVE & GENERAL	5		1,101,984	1 500
1 PHY PRIV OFC DIRECT DEPT 500 TOTAL RECLASSIFICATIONS CODE LETTER - Q	Q	CAP REL COSTS-BLDG & FIXT	1		2,122	9 1 500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7	
			LINE #	SALARY		REF.	
	1	6	7	8	9	10	
1 OTTAWA CLINIC DIRECT DEPT	R	CAP REL COSTS-BLDG & FIXT	1		79,983		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - R					79,983		500
1 MED/SURG SURGERY RELACC	S	OPERATING ROOM	50		1,021,953		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - S					1,021,953		500
1 S.T. SALARY	T	HOME HEALTH AGENCY	101	1,139			1
500 TOTAL RECLASSIFICATIONS CODE LETTER - T				1,139			500
GRAND TOTAL (DECREASES)				166,132	4,396,426		

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	1,234,900				73	1,234,827	1
2 LAND IMPROVEMENTS	979,977					979,977	2
3 BUILDINGS AND FIXTURES	51,394,088	253,588		253,588	20,284	51,627,392	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	25,258,325	942,527		942,527	515,631	25,685,221	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	78,867,290	1,196,115		1,196,115	535,988	79,527,417	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	78,867,290	1,196,115		1,196,115	535,988	79,527,417	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	1,677,100						1,677,100 1
2 CAP REL COSTS-MVBLE EQUIP	3,144,402						3,144,402 2
3 TOTAL (SUM OF LINES 1-2)	4,821,502						4,821,502 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	54,608,965		54,608,965	0.683746	39,846			39,846 1
2 CAP REL COSTS-MVBLE EQUIP	25,258,325		25,258,325	0.316254	18,430			18,430 2
3 TOTAL (SUM OF LINES 1-2)	79,867,290		79,867,290	1.000000	58,276			58,276 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	1,510,070			39,846			1,549,916 1
2 CAP REL COSTS-MVBLE EQUIP	2,986,813			18,430			3,005,243 2
3 TOTAL	4,496,883			58,276			4,555,159 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-5,202	ADMINISTRATIVE & GENERAL	5	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,619,564			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-740,297			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-15	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-21,765	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		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT	B	19,420	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		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
33.01 OTHER INCOME	B	-300	NURSING ADMINISTRATION	13	33.01
33.02 OTHER INCOME DIETARY	B	-23,346	DIETARY	10	33.02
33.03 DIETARY INC	B	-75	DIETARY	10	33.03
33.04 X-RAY DEPT INC	B	-261	RADIOLOGY-DIAGNOSTIC	54	33.04
33.08 EDUCATION	B	-3,972	ADMINISTRATIVE & GENERAL	5	33.08
33.11 OTHER INCOME	B	-20	EMPLOYEE BENEFITS	4	33.11
33.12 OTHER INCOME	B	-1,650	MEDICAL SUPPLIES CHRGD TO PATI	71	33.12
33.17 OTHER INCOME	B	-65	OPERATION OF PLANT	7	33.17
33.19 OTHER INCOME	B	-4,957	ADMINISTRATIVE & GENERAL	5	33.19
33.20 OTHER INCOME	B	-510	OTTAWA CLINIC	90.01	33.20
33.21 NON ALLOW ADVER	A	-33,281	OTTAWA CLINIC	90.01	33.21
33.23 OTHER INCOME	B	-74,139	ADMINISTRATIVE & GENERAL	5	33.23
33.25 ASSOC DUE LOBBY	A	-17,862	ADMINISTRATIVE & GENERAL	5	33.25
33.26 OTHER INCOME	B	-89	ADMINISTRATIVE & GENERAL	5	33.26
33.28 OTHER INCOME	B	-34,498	ADMINISTRATIVE & GENERAL	5	33.28
33.30 INTEREST EXPENSE	B	-241,131	INTEREST EXPENSE	113	33.30
33.33 HSHS SELF IND EXP OFFSET	B	-1,882,339	EMPLOYEE BENEFITS	4	33.33
33.35 OTHER INCOME	B	-58,563	ADMINISTRATIVE & GENERAL	5	33.35
33.38 A&G NON ALLOWABLE	A	-1,159,097	ADMINISTRATIVE & GENERAL	5	33.38
33.39 OTHER INCOME	B	-1,441	PHARMACY	15	33.39
33.42 OTHER INCOME	B	-9,150	ADMINISTRATIVE & GENERAL	5	33.42
33.43 MEDICAL GROUP ASSESSMENT	B	-2,797,267	PHYSICIANS' PRIVATE OFFICES	192	33.43
34					34
35					35
36					36
37					37
38					38
39					39

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
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) TRANSFER TO WKST A, COL. 6, LINE 200)	-10,711,436			50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJUSTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL				
		CENTRAL MGMT SERVICE	2,051,342	2,606,124	-554,782	1
2						2
3		HOME OFFICE				3
4	1	CAP REL COSTS-BLDG & FIXT	31,452	39,958	-8,506	9 4
4.01	2	CAP REL COSTS-MVBLE EQUIP	654,509	831,518	-177,009	9 4.01
5		TOTALS (SUM OF LINES 1-4)	2,737,303	3,477,600	-740,297	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9	
2	69	ELECTROCARDIOLOGY	AGGREGATE	38,174	38,174		159,800			2
3	91	EMERGENCY	AGGREGATE	1,634,845	1,354,262	280,583	159,800	1,516	116,470	5,824
4	60	LABORATORY		25,000		25,000	208,000	1,132	113,200	5,660
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	1,834	1,834		217,600			
6	53	ANESTHESIOLOGY	AGGREGATE	1,101,984	1,101,984		162,500			
7	90.01	OTTAWA CLINIC	AGGREGATE	1,041,402	843,390	198,012	159,800	1,070	82,205	4,110
200		TOTAL		3,843,239	3,339,644	503,595		3,718	311,875	15,594

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT		
LINE NO.	11		12	13	14	15	16	17	18		
2	69	ELECTROCARDIOLOGY	AGGREGATE							38,174	2
3	91	EMERGENCY	AGGREGATE								
4	60	LABORATORY					116,470	164,113	1,518,375		3
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE				113,200			1,834	4
6	53	ANESTHESIOLOGY	AGGREGATE							1,101,984	5
7	90.01	OTTAWA CLINIC	AGGREGATE				82,205	115,807	959,197		6
200		TOTAL					311,875	279,920	3,619,564		7

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP-REL COSTS BLDG&FIXT 1	NEW CAP-REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,549,916	1,549,916				1
2 CAP REL COSTS-MVBLE EQUIP	3,005,243		3,005,243			2
4 EMPLOYEE BENEFITS	4,859,016	6,418	340	4,865,774		4
5 ADMINISTRATIVE & GENERAL	8,666,727	394,276	381,011	942,962	10,384,976	5
6 MAINTENANCE & REPAIRS	975,703	37,238	14,491	141,536	1,168,968	6
7 OPERATION OF PLANT	1,190,222	326,071	4,056	39,917	1,560,266	7
8 LAUNDRY & LINEN SERVICE	192,660	13,275		7,145	213,080	8
9 HOUSEKEEPING	723,274	18,261	1,820	140,357	883,712	9
10 DIETARY	567,152	48,734	28,106	109,321	753,313	10
11 CAFETERIA	44,677	12,022	506	14,066	71,271	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	842,271	10,384		241,744	1,094,399	13
14 CENTRAL SERVICES & SUPPLY	120,825	20,735	120,688	30,406	292,654	14
15 PHARMACY	550,844	15,917	105,288	148,060	820,109	15
16 MEDICAL RECORDS & LIBRARY	563,172	20,724	2,472	125,706	712,074	16
17 SOCIAL SERVICE	19,327			5,580	24,907	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,153,783	152,744	91,739	594,183	2,992,449	30
31 INTENSIVE CARE UNIT	662,702	27,820	30,725	184,539	905,786	31
43 NURSERY	122,802	19,704	18,812	32,182	193,500	43
44 SKILLED NURSING FACILITY	84,082	10,319	7,954	22,587	124,942	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,470,518	96,996	358,094	356,545	2,282,153	50
52 DELIVERY ROOM & LABOR ROOM	138,394	24,337	37,159	32,182	232,072	52
53 ANESTHESIOLOGY	124,537	2,799	33,080		160,416	53
54 RADIOLOGY-DIAGNOSTIC	2,147,953	79,033	738,554	315,435	3,280,975	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	312,891	6,966	335,128	38,951	693,936	57
58 MAGNETIC RESONANCE IMAGING (MRI)	300,463	8,111	317,861	35,155	661,590	58
60 LABORATORY	2,544,798	42,967	69,935	262,129	2,919,829	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	391,751	8,523	18,058	107,820	526,152	65
66 PHYSICAL THERAPY	977,597	26,860	6,590	188,943	1,199,990	66
67 OCCUPATIONAL THERAPY	241,144	22,102	1,258	40,249	304,753	67
68 SPEECH PATHOLOGY	42,177	3,798	49	12,126	58,150	68
68.01 AUDIOLOGY	-10,546		1,055	696	-8,795	68.01
69 ELECTROCARDIOLOGY	36,934	2,317	28,017	7,848	75,116	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	146,907	608		294	147,809	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,147,465				1,147,465	71
72 IMPL. DEV. CHARGED TO PATIENT	1,021,953				1,021,953	72
73 DRUGS CHARGED TO PATIENTS	964,850				964,850	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	74,623	14,328	6,357	20,401	115,709	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	205,403	8,800	631	56,699	271,533	90
90.01 OTTAWA CLINIC	1,062,086		85,715	164,166	1,311,967	90.01
91 EMERGENCY	980,773	42,934	24,475	242,730	1,290,912	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	605,348	20,127		161,195	786,670	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	41,822,417	1,546,248	2,870,024	4,823,855	41,641,611	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,310	2,040	153		34,503	190
192 PHYSICIANS' PRIVATE OFFICES	977,775		84,973	3,342	1,066,090	192
194 OTHER NONREIMBURSABLE COST	241,563	1,628	50,093	38,577	331,861	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	43,074,065	1,549,916	3,005,243	4,865,774	43,074,065	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL 5	MAINTEN- ANCE AND REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	10,384,976					5
6 MAINTENANCE & REPAIRS	371,269	1,540,237				6
7 OPERATION OF PLANT	495,547	652,233	2,708,046			7
8 LAUNDRY & LINEN SERVICE	67,675	908	45,743	327,406		8
9 HOUSEKEEPING	280,670	27,537	62,923		1,254,842	9
10 DIETARY	239,255	63,767	167,924	3,644	4,300	10
11 CAFETERIA	22,636	11,547	41,425		19,641	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	347,585	12,666	35,780			13
14 CENTRAL SERVICES & SUPPLY	92,948	96,267	71,447	4,352	13,637	14
15 PHARMACY	260,470	8,303	54,847		14,876	15
16 MEDICAL RECORDS & LIBRARY	226,158	3,827	71,409		9,375	16
17 SOCIAL SERVICE	7,911					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	950,414	80,325	526,316	113,758	380,238	30
31 INTENSIVE CARE UNIT	287,681	42,960	95,861	27,627	64,542	31
43 NURSERY	61,456	3,081	67,895	4,092	22,857	43
44 SKILLED NURSING FACILITY	39,682	5,011	35,555	6,340	21,733	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	724,821	159,791	334,223	46,422	80,658	50
52 DELIVERY ROOM & LABOR ROOM	73,707	39,652	83,859	4,658	10,344	52
53 ANESTHESIOLOGY	50,949	1,087	9,646			53
54 RADIOLOGY-DIAGNOSTIC	1,042,048	41,598	272,328	27,077	74,304	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	220,397	1,476	24,003	1,702	8,445	57
58 MAGNETIC RESONANCE IMAGING (MRI)	210,124	3,746	27,947	1,784		58
60 LABORATORY	927,349	43,820	148,053	413	55,438	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	167,108	17,839	29,368		10,886	65
66 PHYSICAL THERAPY	381,122	8,368	92,552	10,412	15,225	66
67 OCCUPATIONAL THERAPY	96,791	20,710	76,158	7,160	14,528	67
68 SPEECH PATHOLOGY	18,469	2,838	13,086			68
68.01 AUDIOLOGY		3,146			775	68.01
69 ELECTROCARDIOLOGY	23,857	3,341	7,982	2,467	2,324	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	46,945	795	2,094	2,314	5,307	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	364,439					71
72 IMPL. DEV. CHARGED TO PATIENT	324,576					72
73 DRUGS CHARGED TO PATIENTS	306,440					73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	36,750	18,537	49,370	2,008	18,014	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	86,240	5,060	30,321	9,729	24,445	90
90.01 OTTAWA CLINIC	416,686	34,543		6,788	76,900	90.01
91 EMERGENCY	409,999	52,642	147,941	44,659	134,972	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	249,850	6,487	69,353			101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	9,930,024	1,473,908	2,695,409	327,406	1,083,764	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,958	324	7,029		1,550	190
192 PHYSICIANS' PRIVATE OFFICES	338,594	65,259			163,330	192
194 OTHER NONREIMBURSABLE COST	105,400	746	5,608		6,198	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	10,384,976	1,540,237	2,708,046	327,406	1,254,842	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	1,232,203					10
11 CAFETERIA		166,520				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		10,013	1,500,443			13
14 CENTRAL SERVICES & SUPPLY		2,343	33,845	607,493		14
15 PHARMACY		4,545	65,638	746	1,229,534	15
16 MEDICAL RECORDS & LIBRARY		9,373		1		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,010,666	33,307	481,002	26,699		30
31 INTENSIVE CARE UNIT	125,823	9,302	134,353	5,435		31
43 NURSERY		1,420	20,512	754		43
44 SKILLED NURSING FACILITY	34,367	1,846	26,665			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	50,181	17,611	254,347	272,309		50
52 DELIVERY ROOM & LABOR ROOM		1,420	20,512	1,181		52
53 ANESTHESIOLOGY				29,555		53
54 RADIOLOGY-DIAGNOSTIC		15,338		160,956		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		1,633		70		57
58 MAGNETIC RESONANCE IMAGING (MRI)		1,420		91		58
60 LABORATORY		15,622		1,974		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		4,971	71,792	133		65
66 PHYSICAL THERAPY		6,320		29		66
67 OCCUPATIONAL THERAPY		1,846		13		67
68 SPEECH PATHOLOGY		284				68
68.01 AUDIOLOGY		71				68.01
69 ELECTROCARDIOLOGY		639	9,230	20		69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				86,180		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					1,225,153	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION		923	13,333	313		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	5,214	2,343	33,845	3,390		90
90.01 OTTAWA CLINIC				3,568	4,381	90.01
91 EMERGENCY	5,952	12,853	185,632	11,715		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		8,592	124,097	2,293		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,232,203	164,035	1,474,803	607,425	1,229,534	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES				14		192
194 OTHER NONREIMBURSABLE COST		2,485	25,640	54		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,232,203	166,520	1,500,443	607,493	1,229,534	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,032,217					16
17 SOCIAL SERVICE		32,818				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	485,142		7,080,316		7,080,316	30
31 INTENSIVE CARE UNIT	51,611		1,750,981		1,750,981	31
43 NURSERY	10,322		385,889		385,889	43
44 SKILLED NURSING FACILITY	10,322		306,463		306,463	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	165,155		4,387,671		4,387,671	50
52 DELIVERY ROOM & LABOR ROOM			467,405		467,405	52
53 ANESTHESIOLOGY			251,653		251,653	53
54 RADIOLOGY-DIAGNOSTIC			4,914,624		4,914,624	54
57 COMPUTED TOMOGRAPHY (CT) SCAN			951,662		951,662	57
58 MAGNETIC RESONANCE IMAGING (MRI)			906,702		906,702	58
60 LABORATORY			4,112,498		4,112,498	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			828,249		828,249	65
66 PHYSICAL THERAPY			1,714,018		1,714,018	66
67 OCCUPATIONAL THERAPY			521,959		521,959	67
68 SPEECH PATHOLOGY			92,827		92,827	68
68.01 AUDIOLOGY			-4,803		-4,803	68.01
69 ELECTROCARDIOLOGY			124,976		124,976	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY			205,264		205,264	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,598,084		1,598,084	71
72 IMPL. DEV. CHARGED TO PATIENT			1,346,529		1,346,529	72
73 DRUGS CHARGED TO PATIENTS			2,496,443		2,496,443	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION			254,957		254,957	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			472,120		472,120	90
90.01 OTTAWA CLINIC			1,854,833		1,854,833	90.01
91 EMERGENCY	309,665		2,606,942		2,606,942	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		32,780	1,280,122		1,280,122	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,032,217	32,780	40,908,384		40,908,384	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			54,364		54,364	190
192 PHYSICIANS' PRIVATE OFFICES			1,633,287		1,633,287	192
194 OTHER NONREIMBURSABLE COST		38	478,030		478,030	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,032,217	32,818	43,074,065		43,074,065	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		6,418	340	6,758	6,758	4
5 ADMINISTRATIVE & GENERAL	685,961	394,276	381,011	1,461,248	1,308	5
6 MAINTENANCE & REPAIRS		37,238	14,491	51,729	197	6
7 OPERATION OF PLANT		326,071	4,056	330,127	55	7
8 LAUNDRY & LINEN SERVICE		13,275		13,275	10	8
9 HOUSEKEEPING		18,261	1,820	20,081	195	9
10 DIETARY		48,734	28,106	76,840	152	10
11 CAFETERIA		12,022	506	12,528	20	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		10,384		10,384	336	13
14 CENTRAL SERVICES & SUPPLY		20,735	120,688	141,423	42	14
15 PHARMACY		15,917	105,288	121,205	206	15
16 MEDICAL RECORDS & LIBRARY		20,724	2,472	23,196	175	16
17 SOCIAL SERVICE					8	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		152,744	91,739	244,483	825	30
31 INTENSIVE CARE UNIT		27,820	30,725	58,545	256	31
43 NURSERY		19,704	18,812	38,516	45	43
44 SKILLED NURSING FACILITY		10,319	7,954	18,273	31	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		96,996	358,094	455,090	495	50
52 DELIVERY ROOM & LABOR ROOM		24,337	37,159	61,496	45	52
53 ANESTHESIOLOGY		2,799	33,080	35,879		53
54 RADIOLOGY-DIAGNOSTIC		79,033	738,554	817,587	438	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		6,966	335,128	342,094	54	57
58 MAGNETIC RESONANCE IMAGING (MRI)		8,111	317,861	325,972	49	58
60 LABORATORY		42,967	69,935	112,902	364	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		8,523	18,058	26,581	150	65
66 PHYSICAL THERAPY		26,860	6,590	33,450	262	66
67 OCCUPATIONAL THERAPY		22,102	1,258	23,360	56	67
68 SPEECH PATHOLOGY		3,798	49	3,847	17	68
68.01 AUDIOLOGY			1,055	1,055	1	68.01
69 ELECTROCARDIOLOGY		2,317	28,017	30,334	11	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY		608		608		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION		14,328	6,357	20,685	28	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		8,800	631	9,431	79	90
90.01 OTTAWA CLINIC			85,715	85,715	228	90.01
91 EMERGENCY		42,934	24,475	67,409	337	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		20,127		20,127	224	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	685,961	1,546,248	2,870,024	5,102,233	6,699	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,040	153	2,193		190
192 PHYSICIANS' PRIVATE OFFICES			84,973	84,973	5	192
194 OTHER NONREIMBURSABLE COST		1,628	50,093	51,721	54	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	685,961	1,549,916	3,005,243	5,241,120	6,758	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINI- STRATIVE & GENERAL 5	MAINTEN- ANCE AND REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	1,462,556					5
6 MAINTENANCE & REPAIRS	52,287	104,213				6
7 OPERATION OF PLANT	69,789	44,132	444,103			7
8 LAUNDRY & LINEN SERVICE	9,531	61	7,502	30,379		8
9 HOUSEKEEPING	39,528	1,863	10,319		71,986	9
10 DIETARY	33,695	4,315	27,539	338	247	10
11 CAFETERIA	3,188	781	6,793		1,127	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	48,951	857	5,868			13
14 CENTRAL SERVICES & SUPPLY	13,090	6,513	11,717	404	782	14
15 PHARMACY	36,683	562	8,995		853	15
16 MEDICAL RECORDS & LIBRARY	31,850	259	11,711		538	16
17 SOCIAL SERVICE	1,114					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	133,849	5,435	86,313	10,556	21,816	30
31 INTENSIVE CARE UNIT	40,515	2,907	15,721	2,563	3,703	31
43 NURSERY	8,655	208	11,134	380	1,311	43
44 SKILLED NURSING FACILITY	5,589	339	5,831	588	1,247	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	102,078	10,811	54,810	4,307	4,627	50
52 DELIVERY ROOM & LABOR ROOM	10,380	2,683	13,752	432	593	52
53 ANESTHESIOLOGY	7,175	74	1,582			53
54 RADIOLOGY-DIAGNOSTIC	146,769	2,815	44,660	2,512	4,263	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	31,039	100	3,936	158	484	57
58 MAGNETIC RESONANCE IMAGING (MRI)	29,592	253	4,583	166		58
60 LABORATORY	130,601	2,965	24,280	38	3,180	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	23,534	1,207	4,816		624	65
66 PHYSICAL THERAPY	53,674	566	15,178	966	873	66
67 OCCUPATIONAL THERAPY	13,631	1,401	12,489	664	833	67
68 SPEECH PATHOLOGY	2,601	192	2,146			68
68.01 AUDIOLOGY		213			44	68.01
69 ELECTROCARDIOLOGY	3,360	226	1,309	229	133	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	6,611	54	343	215	304	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	51,325					71
72 IMPL. DEV. CHARGED TO PATIENT	45,711					72
73 DRUGS CHARGED TO PATIENTS	43,157					73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	5,176	1,254	8,096	186	1,033	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	12,145	342	4,972	903	1,402	90
90.01 OTTAWA CLINIC	58,683	2,337		630	4,411	90.01
91 EMERGENCY	57,741	3,562	24,261	4,144	7,743	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	35,187	439	11,374			101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,398,484	99,726	442,030	30,379	62,171	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,543	22	1,153		89	190
192 PHYSICIANS' PRIVATE OFFICES	47,685	4,415			9,370	192
194 OTHER NONREIMBURSABLE COST	14,844	50	920		356	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,462,556	104,213	444,103	30,379	71,986	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	143,126					10
11 CAFETERIA		24,437				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		1,469	67,865			13
14 CENTRAL SERVICES & SUPPLY		344	1,531	175,846		14
15 PHARMACY		667	2,969	216	172,356	15
16 MEDICAL RECORDS & LIBRARY		1,376				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	117,393	4,889	21,755	7,728		30
31 INTENSIVE CARE UNIT	14,615	1,365	6,077	1,573		31
43 NURSERY		208	928	218		43
44 SKILLED NURSING FACILITY	3,992	271	1,206			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,829	2,584	11,504	78,829		50
52 DELIVERY ROOM & LABOR ROOM		208	928	342		52
53 ANESTHESIOLOGY				8,555		53
54 RADIOLOGY-DIAGNOSTIC		2,251		46,588		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		240		20		57
58 MAGNETIC RESONANCE IMAGING (MRI)		208		26		58
60 LABORATORY		2,293		571		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		729	3,247	38		65
66 PHYSICAL THERAPY		927		8		66
67 OCCUPATIONAL THERAPY		271		4		67
68 SPEECH PATHOLOGY		42				68
68.01 AUDIOLOGY		10				68.01
69 ELECTROCARDIOLOGY		94	417	6		69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				24,945		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					171,742	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION		135	603	90		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	606	344	1,531	981		90
90.01 OTTAWA CLINIC				1,033	614	90.01
91 EMERGENCY	691	1,886	8,396	3,391		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		1,261	5,613	664		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	143,126	24,072	66,705	175,826	172,356	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES				4		192
194 OTHER NONREIMBURSABLE COST		365	1,160	16		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	143,126	24,437	67,865	175,846	172,356	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	69,105				16
17 SOCIAL SERVICE		1,122			17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	32,479		687,521		687,521 30
31 INTENSIVE CARE UNIT	3,455		151,295		151,295 31
43 NURSERY	691		62,294		62,294 43
44 SKILLED NURSING FACILITY	691		38,058		38,058 44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	11,057		742,021		742,021 50
52 DELIVERY ROOM & LABOR ROOM			90,859		90,859 52
53 ANESTHESIOLOGY			53,265		53,265 53
54 RADIOLOGY-DIAGNOSTIC			1,067,883		1,067,883 54
57 COMPUTED TOMOGRAPHY (CT) SCAN			378,125		378,125 57
58 MAGNETIC RESONANCE IMAGING (MRI)			360,849		360,849 58
60 LABORATORY			277,194		277,194 60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY			60,926		60,926 65
66 PHYSICAL THERAPY			105,904		105,904 66
67 OCCUPATIONAL THERAPY			52,709		52,709 67
68 SPEECH PATHOLOGY			8,845		8,845 68
68.01 AUDIOLOGY			1,323		1,323 68.01
69 ELECTROCARDIOLOGY			36,119		36,119 69
69.01 CARDIAC REHAB					69.01
70 ELECTROENCEPHALOGRAPHY			8,135		8,135 70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			76,270		76,270 71
72 IMPL. DEV. CHARGED TO PATIENT			45,711		45,711 72
73 DRUGS CHARGED TO PATIENTS			214,899		214,899 73
73.01 ONCOLOGY					73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY					76
76.97 CARDIAC REHABILITATION			37,286		37,286 76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC			32,736		32,736 90
90.01 OTTAWA CLINIC			153,651		153,651 90.01
91 EMERGENCY	20,732		200,293		200,293 91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		1,121	76,010		76,010 101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	69,105	1,121	5,020,181		5,020,181 118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			5,000		5,000 190
192 PHYSICIANS' PRIVATE OFFICES			146,452		146,452 192
194 OTHER NONREIMBURSABLE COST		1	69,487		69,487 194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	69,105	1,122	5,241,120		5,241,120 202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET 1	NEW CAP- REL COSTS MOV EQUIP DOLLAR VA OR SQ. FEE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINI- STRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	285,693					1
2 CAP REL COSTS-MVBLE EQUIP		2,474,707				2
4 EMPLOYEE BENEFITS	1,183	280	16,853,344			4
5 ADMINISTRATIVE & GENERAL	72,677	313,749	3,266,105	-10,384,976	32,697,884	5
6 MAINTENANCE & REPAIRS	6,864	11,933	490,232		1,168,968	6
7 OPERATION OF PLANT	60,104	3,340	138,258		1,560,266	7
8 LAUNDRY & LINEN SERVICE	2,447		24,749		213,080	8
9 HOUSEKEEPING	3,366	1,499	486,148		883,712	9
10 DIETARY	8,983	23,144	378,651		753,313	10
11 CAFETERIA	2,216	417	48,719		71,271	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,914		837,315		1,094,399	13
14 CENTRAL SERVICES & SUPPLY	3,822	99,382	105,317		292,654	14
15 PHARMACY	2,934	86,701	512,826		820,109	15
16 MEDICAL RECORDS & LIBRARY	3,820	2,036	435,400		712,074	16
17 SOCIAL SERVICE			19,327		24,907	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	28,155	75,544	2,058,040		2,992,449	30
31 INTENSIVE CARE UNIT	5,128	25,301	639,179		905,786	31
43 NURSERY	3,632	15,491	111,466		193,500	43
44 SKILLED NURSING FACILITY	1,902	6,550	78,233		124,942	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	17,879	294,877	1,234,945		2,282,153	50
52 DELIVERY ROOM & LABOR ROOM	4,486	30,599	111,466		232,072	52
53 ANESTHESIOLOGY	516	27,240			160,416	53
54 RADIOLOGY-DIAGNOSTIC	14,568	608,169	1,092,555		3,280,975	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,284	275,966	134,911		693,936	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,495	261,747	121,763		661,590	58
60 LABORATORY	7,920	57,589	907,924		2,919,829	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,571	14,870	373,452		526,152	65
66 PHYSICAL THERAPY	4,951	5,427	654,433		1,199,990	66
67 OCCUPATIONAL THERAPY	4,074	1,036	139,407		304,753	67
68 SPEECH PATHOLOGY	700	40	42,001		58,150	68
68.01 AUDIOLOGY		869	2,410	8,795		68.01
69 ELECTROCARDIOLOGY	427	23,071	27,184		75,116	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	112		1,020		147,809	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					1,147,465	71
72 IMPL. DEV. CHARGED TO PATIENT					1,021,953	72
73 DRUGS CHARGED TO PATIENTS					964,850	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	2,641	5,235	70,661		115,709	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,622	520	196,385		271,533	90
90.01 OTTAWA CLINIC		70,583	568,614		1,311,967	90.01
91 EMERGENCY	7,914	20,154	840,732		1,290,912	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	3,710		558,323		786,670	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	285,017	2,363,359	16,708,151	-10,376,181	31,265,430	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	376	126			34,503	190
192 PHYSICIANS' PRIVATE OFFICES		69,972	11,577		1,066,090	192
194 OTHER NONREIMBURSABLE COST	300	41,250	133,616		331,861	194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET 1	NEW CAP- REL COSTS MOV EQUIP DOLLAR VA OR SQ. FEE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINI- STRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,549,916	3,005,243	4,865,774		10,384,976	202
203	UNIT COST MULT-WS B PT I	5.425110	1.214383	0.288713		0.317604	203
204	COST TO BE ALLOC PER B PT II			6,758		1,462,556	204
205	UNIT COST MULT-WS B PT II			0.000401		0.044729	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTEN- ANCE AND REPAIRS MAINTENANC HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	94,974					6
7 OPERATION OF PLANT	40,218	144,865				7
8 LAUNDRY & LINEN SERVICE	56	2,447	64,244			8
9 HOUSEKEEPING	1,698	3,366		32,391		9
10 DIETARY	3,932	8,983	715	111	28,361	10
11 CAFETERIA	712	2,216		507		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	781	1,914				13
14 CENTRAL SERVICES & SUPPLY	5,936	3,822	854	352		14
15 PHARMACY	512	2,934		384		15
16 MEDICAL RECORDS & LIBRARY	236	3,820		242		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,953	28,155	22,322	9,815	23,262	30
31 INTENSIVE CARE UNIT	2,649	5,128	5,421	1,666	2,896	31
43 NURSERY	190	3,632	803	590		43
44 SKILLED NURSING FACILITY	309	1,902	1,244	561	791	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	9,853	17,879	9,109	2,082	1,155	50
52 DELIVERY ROOM & LABOR ROOM	2,445	4,486	914	267		52
53 ANESTHESIOLOGY	67	516				53
54 RADIOLOGY-DIAGNOSTIC	2,565	14,568	5,313	1,918		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	91	1,284	334	218		57
58 MAGNETIC RESONANCE IMAGING (MRI)	231	1,495	350			58
60 LABORATORY	2,702	7,920	81	1,431		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,100	1,571		281		65
66 PHYSICAL THERAPY	516	4,951	2,043	393		66
67 OCCUPATIONAL THERAPY	1,277	4,074	1,405	375		67
68 SPEECH PATHOLOGY	175	700				68
68.01 AUDIOLOGY	194			20		68.01
69 ELECTROCARDIOLOGY	206	427	484	60		69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	49	112	454	137		70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY						76
76.97 CARDIAC REHABILITATION	1,143	2,641	394	465		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	312	1,622	1,909	631	120	90
90.01 OTTAWA CLINIC	2,130		1,332	1,985		90.01
91 EMERGENCY	3,246	7,914	8,763	3,484	137	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	400	3,710				101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	90,884	144,189	64,244	27,975	28,361	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20	376		40		190
192 PHYSICIANS' PRIVATE OFFICES	4,024			4,216		192
194 OTHER NONREIMBURSABLE COST	46	300		160		194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAINTEN- ANCE AND REPAIRS MAINTENANC HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,540,237	2,708,046	327,406	1,254,842	1,232,203	202
203	UNIT COST MULT-WS B PT I	16.217460	18.693584	5.096289	38.740453	43.447093	203
204	COST TO BE ALLOC PER B PT II	104,213	444,103	30,379	71,986	143,126	204
205	UNIT COST MULT-WS B PT II	1.097279	3.065634	0.472869	2.222407	5.046578	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL
	DIRECT HO OF SERVICE 11	ADMINI- STRATION (DIRECT NRSG HRS) 13	& SUPPLY (COSTED REQUIS) 14	(COSTED REQUIS) 15	RECORDS & LIBRARY (TIME SPENT) 16
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA	2,345				11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	141	1,463			13
14 CENTRAL SERVICES & SUPPLY	33	33	154,091,446		14
15 PHARMACY	64	64	189,347	96,829,965	15
16 MEDICAL RECORDS & LIBRARY	132		202		100
17 SOCIAL SERVICE					16
19 NONPHYSICIAN ANESTHETISTS					17
20 NURSING SCHOOL					19
21 I&R SRVCES-SALARY & FRINGES APPRVD					20
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					21
23 PARAMED ED PRGM-(SPECIFY)					22
INPATIENT ROUTINE SERV COST CENTERS					23
30 ADULTS & PEDIATRICS	469	469	6,773,061		47
31 INTENSIVE CARE UNIT	131	131	1,378,802		5
43 NURSERY	20	20	191,309		1
44 SKILLED NURSING FACILITY	26	26			1
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	248	248	69,062,010		16
52 DELIVERY ROOM & LABOR ROOM	20	20	299,666		52
53 ANESTHESIOLOGY			7,497,564		53
54 RADIOLOGY-DIAGNOSTIC	216		40,831,134		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	23		17,795		57
58 MAGNETIC RESONANCE IMAGING (MRI)	20		22,973		58
60 LABORATORY	220		500,734		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	70	70	33,624		65
66 PHYSICAL THERAPY	89		7,354		66
67 OCCUPATIONAL THERAPY	26		3,354		67
68 SPEECH PATHOLOGY	4				68
68.01 AUDIOLOGY	1				68.01
69 ELECTROCARDIOLOGY	9	9	5,044		69
69.01 CARDIAC REHAB					69.01
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			21,862,092		71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS				96,484,965	73
73.01 ONCOLOGY					73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY					76
76.97 CARDIAC REHABILITATION	13	13	79,315		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	33	33	859,970		90
90.01 OTTAWA CLINIC			905,107	345,000	90.01
91 EMERGENCY	181	181	2,971,895		91
92 OBSERVATION BEDS					30
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY	121	121	581,721		101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	2,310	1,438	154,074,073	96,829,965	100
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
192 PHYSICIANS' PRIVATE OFFICES			3,591		192
194 OTHER NONREIMBURSABLE COST	35	25	13,782		194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAFETERIA DIRECT HO OF SERVICE 11	NURSING ADMINI- STRATION (DIRECT NRSG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	166,520	1,500,443	607,493	1,229,534	1,032,217	202
203	UNIT COST MULT-WS B PT I	71.010661	1,025.593301	0.003942	0.012698	10,322.170000	203
204	COST TO BE ALLOC PER B PT II	24,437	67,865	175,846	172,356	69,105	204
205	UNIT COST MULT-WS B PT II	10.420896	46.387560	0.001141	0.001780	691.050000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	(TIME SPENT)
		17
GENERAL SERVICE COST CENTERS		
1 CAP REL COSTS-BLDG & FIXT		1
2 CAP REL COSTS-MVBLE EQUIP		2
4 EMPLOYEE BENEFITS		4
5 ADMINISTRATIVE & GENERAL		5
6 MAINTENANCE & REPAIRS		6
7 OPERATION OF PLANT		7
8 LAUNDRY & LINEN SERVICE		8
9 HOUSEKEEPING		9
10 DIETARY		10
11 CAFETERIA		11
12 MAINTENANCE OF PERSONNEL		12
13 NURSING ADMINISTRATION		13
14 CENTRAL SERVICES & SUPPLY		14
15 PHARMACY		15
16 MEDICAL RECORDS & LIBRARY		16
17 SOCIAL SERVICE	868	17
19 NONPHYSICIAN ANESTHETISTS		19
20 NURSING SCHOOL		20
21 I&R SRVCES-SALARY & FRINGES APPRVD		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23 PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS		
30 ADULTS & PEDIATRICS		30
31 INTENSIVE CARE UNIT		31
43 NURSERY		43
44 SKILLED NURSING FACILITY		44
ANCILLARY SERVICE COST CENTERS		
50 OPERATING ROOM		50
52 DELIVERY ROOM & LABOR ROOM		52
53 ANESTHESIOLOGY		53
54 RADIOLOGY-DIAGNOSTIC		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		57
58 MAGNETIC RESONANCE IMAGING (MRI)		58
60 LABORATORY		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65 RESPIRATORY THERAPY		65
66 PHYSICAL THERAPY		66
67 OCCUPATIONAL THERAPY		67
68 SPEECH PATHOLOGY		68
68.01 AUDIOLOGY		68.01
69 ELECTROCARDIOLOGY		69
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
73.01 ONCOLOGY		73.01
76 OTHER ANCILLARY CHEMICAL DEPENDENCY		76
76.97 CARDIAC REHABILITATION		76.97
76.98 HYPERBARIC OXYGEN THERAPY		76.98
76.99 LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS		
90 CLINIC		90
90.01 OTTAWA CLINIC		90.01
91 EMERGENCY		91
92 OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS		
99.10 CORF		99.10
99.20 OUTPATIENT PHYSICAL THERAPY		99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40 OUTPATIENT SPEECH PATHOLOGY		99.40
101 HOME HEALTH AGENCY	867	101
SPECIAL PURPOSE COST CENTERS		
118 SUBTOTALS (SUM OF LINES 1-117)	867	118
NONREIMBURSABLE COST CENTERS		
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192 PHYSICIANS' PRIVATE OFFICES		192
194 OTHER NONREIMBURSABLE COST	1	194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		SOCIAL SERVICE	
		(TIME SPENT)	
		17	
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	32,818	202
203	UNIT COST MULT-WS B PT I	37.808756	203
204	COST TO BE ALLOC PER B PT II	1,122	204
205	UNIT COST MULT-WS B PT II	1.292627	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,080,316		7,080,316		7,080,316	30
31 INTENSIVE CARE UNIT	1,750,981		1,750,981		1,750,981	31
43 NURSERY	385,889		385,889		385,889	43
44 SKILLED NURSING FACILITY	306,463		306,463		306,463	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,387,671		4,387,671		4,387,671	50
52 DELIVERY ROOM & LABOR ROOM	467,405		467,405		467,405	52
53 ANESTHESIOLOGY	251,653		251,653		251,653	53
54 RADIOLOGY-DIAGNOSTIC	4,914,624		4,914,624		4,914,624	54
57 COMPUTED TOMOGRAPHY (CT) SC	951,662		951,662		951,662	57
58 MAGNETIC RESONANCE IMAGING	906,702		906,702		906,702	58
60 LABORATORY	4,112,498		4,112,498		4,112,498	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	828,249		828,249		828,249	65
66 PHYSICAL THERAPY	1,714,018		1,714,018		1,714,018	66
67 OCCUPATIONAL THERAPY	521,959		521,959		521,959	67
68 SPEECH PATHOLOGY	92,827		92,827		92,827	68
68.01 AUDIOLOGY						68.01
69 ELECTROCARDIOLOGY	124,976		124,976		124,976	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	205,264		205,264		205,264	70
71 MEDICAL SUPPLIES CHRGD TO	1,598,084		1,598,084		1,598,084	71
72 IMPL. DEV. CHARGED TO PATIE	1,346,529		1,346,529		1,346,529	72
73 DRUGS CHARGED TO PATIENTS	2,496,443		2,496,443		2,496,443	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DE						76
76.97 CARDIAC REHABILITATION	254,957		254,957		254,957	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	472,120		472,120		472,120	90
90.01 OTTAWA CLINIC	1,854,833		1,854,833	115,807	1,970,640	90.01
91 EMERGENCY	2,606,942		2,606,942	164,113	2,771,055	91
92 OBSERVATION BEDS	1,149,963		1,149,963		1,149,963	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,280,122		1,280,122		1,280,122	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	42,063,150		42,063,150	279,920	42,343,070	200
201 LESS OBSERVATION BEDS	1,149,963		1,149,963		1,149,963	201
202 TOTAL (SEE INSTRUCTIONS)	40,913,187		40,913,187		41,193,107	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	6,887,793		6,887,793			30
31 INTENSIVE CARE UNIT	2,701,488		2,701,488			31
43 NURSERY	448,670		448,670			43
44 SKILLED NURSING FACILITY	107,950		107,950			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,269,243	12,508,499	16,777,742	0.261517	0.261517	0.261517 50
52 DELIVERY ROOM & LABOR ROOM	240,228	199,331	439,559	1.063350	1.063350	1.063350 52
53 ANESTHESIOLOGY	1,339,507	2,569,434	3,908,941	0.064379	0.064379	0.064379 53
54 RADIOLOGY-DIAGNOSTIC	2,996,256	18,211,778	21,208,034	0.231734	0.231734	0.231734 54
57 COMPUTED TOMOGRAPHY (CT) SC	2,052,166	10,337,309	12,389,475	0.076812	0.076812	0.076812 57
58 MAGNETIC RESONANCE IMAGING	102,417	4,296,153	4,398,570	0.206136	0.206136	0.206136 58
60 LABORATORY	5,264,343	15,622,214	20,886,557	0.196897	0.196897	0.196897 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,509,132	306,429	1,815,561	0.456195	0.456195	0.456195 65
66 PHYSICAL THERAPY	552,733	3,155,983	3,708,716	0.462159	0.462159	0.462159 66
67 OCCUPATIONAL THERAPY	123,735	1,466,350	1,590,085	0.328259	0.328259	0.328259 67
68 SPEECH PATHOLOGY	32,020	159,880	191,900	0.483726	0.483726	0.483726 68
68.01 AUDIOLOGY		7,472	7,472			68.01
69 ELECTROCARDIOLOGY	452,155	1,111,319	1,563,474	0.079935	0.079935	0.079935 69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	754	633,168	633,922	0.323800	0.323800	0.323800 70
71 MEDICAL SUPPLIES CHRGED TO	2,636,618	3,091,537	5,728,155	0.278988	0.278988	0.278988 71
72 IMPL. DEV. CHARGED TO PATIE	1,891,983	713,690	2,605,673	0.516768	0.516768	0.516768 72
73 DRUGS CHARGED TO PATIENTS	5,858,733	3,319,640	9,178,373	0.271992	0.271992	0.271992 73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DE						76
76.97 CARDIAC REHABILITATION	1,121	671,955	673,076	0.378794	0.378794	0.378794 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	259,794	2,553,876	2,813,670	0.167795	0.167795	0.167795 90
90.01 OTTAWA CLINIC		1,669,574	1,669,574	1.110962	1.110962	1.180325 90.01
91 EMERGENCY	1,680,315	7,223,086	8,903,401	0.292803	0.292803	0.311236 91
92 OBSERVATION BEDS	223,370	2,943,039	3,166,409	0.363176	0.363176	0.363176 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		912,470	912,470			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	41,632,524	93,684,186	135,316,710			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	41,632,524	93,684,186	135,316,710			202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	687,521		687,521	7,844	87.65	4,899	429,397	30
31 INTENSIVE CARE UNIT	151,295		151,295	984	153.76	512	78,725	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	62,294		62,294	408	152.68			43
44 SKILLED NURSING FACILITY	38,058		38,058	255	149.25	255	38,059	44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	939,168		939,168	9,491		5,666	546,181	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

COST CENTER DESCRIPTION	CAP-REL COST (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	742,021	16,777,742	0.044227	2,761,398	122,128	50
52 DELIVERY ROOM & LABOR ROOM	90,859	439,559	0.206705			52
53 ANESTHESIOLOGY	53,265	3,908,941	0.013626	736,219	10,032	53
54 RADIOLOGY-DIAGNOSTIC	1,067,883	21,208,034	0.050353	2,475,129	124,630	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	378,125	12,389,475	0.030520	1,598,250	48,779	57
58 MAGNETIC RESONANCE IMAGING (M	360,849	4,398,570	0.082038	72,862	5,977	58
60 LABORATORY	277,194	20,886,557	0.013271	3,938,663	52,270	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	60,926	1,815,561	0.033558	1,209,713	40,596	65
66 PHYSICAL THERAPY	105,904	3,708,716	0.028555	419,145	11,969	66
67 OCCUPATIONAL THERAPY	52,709	1,590,085	0.033149	89,685	2,973	67
68 SPEECH PATHOLOGY	8,845	191,900	0.046092	22,240	1,025	68
68.01 AUDIOLOGY						68.01
69 ELECTROCARDIOLOGY	36,119	1,563,474	0.023102	358,985	8,293	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	8,135	633,922	0.012833	754	10	70
71 MEDICAL SUPPLIES CHRGD TO PA	76,270	5,728,155	0.013315	1,786,694	23,790	71
72 IMPL. DEV. CHARGED TO PATIENT	45,711	2,605,673	0.017543	1,309,988	22,981	72
73 DRUGS CHARGED TO PATIENTS	214,899	9,178,373	0.023414	4,536,364	106,214	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPE						76
76.97 CARDIAC REHABILITATION	37,286	673,076	0.055396			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	32,736	2,813,670	0.011635	25,832	301	90
90.01 OTTAWA CLINIC	153,651	1,669,574	0.092030			90.01
91 EMERGENCY	200,293	8,903,401	0.022496	1,564,188	35,188	91
92 OBSERVATION BEDS	111,665	3,166,409	0.035266	223,370	7,877	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	4,115,345	124,250,867		23,129,479	625,033	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
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

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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	7,844		4,899		30
31 INTENSIVE CARE UNIT	984		512		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	408				43
44 SKILLED NURSING FACILITY	255		255		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	9,491		5,666		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-0026)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>		<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>			

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN				COST	MEDICAL
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	COLS. 1-4)	(SUM OF
	COST			COST		COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
52	DELIVERY ROOM & LABOR ROOM					52
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
57	COMPUTED TOMOGRAPHY (CT) SCAN					57
58	MAGNETIC RESONANCE IMAGING (M					58
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
68.01	AUDIOLOGY					68.01
69	ELECTROCARDIOLOGY					69
69.01	CARDIAC REHAB					69.01
70	ELECTROENCEPHALOGRAPHY					70
71	MEDICAL SUPPLIES CHRGED TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
73.01	ONCOLOGY					73.01
76	OTHER ANCILLARY CHEMICAL DEPE					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC					90
90.01	OTTAWA CLINIC					90.01
91	EMERGENCY					91
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] [] []	HOSPITAL (14-0026) IPF IRF	[] [] []	SUB (OTHER) SNF NF	[] [] []	ICF/WR	[XX] []	PPS TEFRA
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)		
	7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	16,777,742		2,761,398		5,560,716		50	
52	DELIVERY ROOM & LABOR ROOM	439,559				1,020		52	
53	ANESTHESIOLOGY	3,908,941		736,219		942,865		53	
54	RADIOLOGY-DIAGNOSTIC	21,208,034		2,475,129		6,318,823		54	
57	COMPUTED TOMOGRAPHY (CT) SCA	12,389,475		1,598,250		4,085,366		57	
58	MAGNETIC RESONANCE IMAGING (4,398,570		72,862		1,338,674		58	
60	LABORATORY	20,886,557		3,938,663		599,852		60	
62.30	BLOOD CLOTTING FOR HEMOPHILI							62.30	
65	RESPIRATORY THERAPY	1,815,561		1,209,713		103,883		65	
66	PHYSICAL THERAPY	3,708,716		419,145		300		66	
67	OCCUPATIONAL THERAPY	1,590,085		89,685				67	
68	SPEECH PATHOLOGY	191,900		22,240				68	
68.01	AUDIOLOGY							68.01	
69	ELECTROCARDIOLOGY	1,563,474		358,985		599,435		69	
69.01	CARDIAC REHAB							69.01	
70	ELECTROENCEPHALOGRAPHY	633,922		754		195,581		70	
71	MEDICAL SUPPLIES CHRGED TO P	5,728,155		1,786,694		1,382,153		71	
72	IMPL. DEV. CHARGED TO PATIEN	2,605,673		1,309,988		415,516		72	
73	DRUGS CHARGED TO PATIENTS	9,178,373		4,536,364		2,714,938		73	
73.01	ONCOLOGY							73.01	
76	OTHER ANCILLARY CHEMICAL DEP							76	
76.97	CARDIAC REHABILITATION	673,076				402,053		76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
90	CLINIC	2,813,670		25,832		786,186		90	
90.01	OTTAWA CLINIC	1,669,574				82,324		90.01	
91	EMERGENCY	8,903,401		1,564,188		1,565,122		91	
92	OBSERVATION BEDS	3,166,409		223,370		622,245		92	
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (SUM OF LINES 50-199)	124,250,867		23,129,479		27,717,052		200	

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO	PPS REIMBURSED	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	FROM WKST C, PT I, COL. 9 1	SERVICES 2	3	4	PPS SERVICES 5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.261517	5,560,716			1,454,222		50
52 DELIVERY ROOM & LABOR ROOM	1.063350	1,020			1,085		52
53 ANESTHESIOLOGY	0.064379	942,865			60,701		53
54 RADIOLOGY-DIAGNOSTIC	0.231734	6,318,823			1,464,286		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076812	4,085,366	850		313,805	65	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206136	1,338,674			275,949		58
60 LABORATORY	0.196897	599,852			118,109		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.456195	103,883			47,391		65
66 PHYSICAL THERAPY	0.462159	300			139		66
67 OCCUPATIONAL THERAPY	0.328259						67
68 SPEECH PATHOLOGY	0.483726						68
68.01 AUDIOLOGY		744					68.01
69 ELECTROCARDIOLOGY	0.079935	599,435			47,916		69
69.01 CARDIAC REHAB							69.01
70 ELECTROENCEPHALOGRAPHY	0.323800	195,581			63,329		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.278988	1,382,153	33,567		385,604	9,365	71
72 IMPL. DEV. CHARGED TO PATIENT	0.516768	415,516			214,725		72
73 DRUGS CHARGED TO PATIENTS	0.271992	2,714,938	25	19,584	738,441	7	5,327 73
73.01 ONCOLOGY							73.01
76 OTHER ANCILLARY CHEMICAL DEPEND							76
76.97 CARDIAC REHABILITATION	0.378794	402,053			152,295		76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.167795	786,186			131,918		90
90.01 OTTAWA CLINIC	1.110962	82,324			91,459		90.01
91 EMERGENCY	0.292803	1,565,122			458,272		91
92 OBSERVATION BEDS	0.363176	622,245			225,984		92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		27,717,796	34,442	19,584	6,245,630	9,437	5,327 200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		27,717,796	34,442	19,584	6,245,630	9,437	5,327 202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input checked="" type="checkbox"/>	SNF (14-5594)			<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF				

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN				COST	MEDICAL
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
52	DELIVERY ROOM & LABOR ROOM					52
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
57	COMPUTED TOMOGRAPHY (CT) SCAN					57
58	MAGNETIC RESONANCE IMAGING (M					58
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
68.01	AUDIOLOGY					68.01
69	ELECTROCARDIOLOGY					69
69.01	CARDIAC REHAB					69.01
70	ELECTROENCEPHALOGRAPHY					70
71	MEDICAL SUPPLIES CHRGED TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
73.01	ONCOLOGY					73.01
76	OTHER ANCILLARY CHEMICAL DEPE					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC					90
90.01	OTTAWA CLINIC					90.01
91	EMERGENCY					91
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[XX] SNF (14-5594)		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 + COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 + COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	16,777,742					50
52	DELIVERY ROOM & LABOR ROOM	439,559					52
53	ANESTHESIOLOGY	3,908,941					53
54	RADIOLOGY-DIAGNOSTIC	21,208,034			2,457		54
57	COMPUTED TOMOGRAPHY (CT) SCA	12,389,475					57
58	MAGNETIC RESONANCE IMAGING (4,398,570					58
60	LABORATORY	20,886,557			32,857		60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	1,815,561			23,252		65
66	PHYSICAL THERAPY	3,708,716			35,655		66
67	OCCUPATIONAL THERAPY	1,590,085			13,720		67
68	SPEECH PATHOLOGY	191,900			7,860		68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	1,563,474			245		69
69.01	CARDIAC REHAB						69.01
70	ELECTROENCEPHALOGRAPHY	633,922					70
71	MEDICAL SUPPLIES CHRGED TO P	5,728,155			24,487		71
72	IMPL. DEV. CHARGED TO PATIEN	2,605,673					72
73	DRUGS CHARGED TO PATIENTS	9,178,373			105,533		73
73.01	ONCOLOGY						73.01
76	OTHER ANCILLARY CHEMICAL DEP						76
76.97	CARDIAC REHABILITATION	673,076					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,813,670					90
90.01	OTTAWA CLINIC	1,669,574					90.01
91	EMERGENCY	8,903,401					91
92	OBSERVATION BEDS	3,166,409					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	124,250,867			246,066		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT	COST SERVICES	COST SVCES NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.261517						50
52 DELIVERY ROOM & LABOR ROOM	1.063350						52
53 ANESTHESIOLOGY	0.064379						53
54 RADIOLOGY-DIAGNOSTIC	0.231734						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076812						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206136						58
60 LABORATORY	0.196897						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.456195						65
66 PHYSICAL THERAPY	0.462159						66
67 OCCUPATIONAL THERAPY	0.328259						67
68 SPEECH PATHOLOGY	0.483726						68
68.01 AUDIOLOGY							68.01
69 ELECTROCARDIOLOGY	0.079935						69
69.01 CARDIAC REHAB							69.01
70 ELECTROENCEPHALOGRAPHY	0.323800						70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.278988						71
72 IMPL. DEV. CHARGED TO PATIENT	0.516768						72
73 DRUGS CHARGED TO PATIENTS	0.271992						73
73.01 ONCOLOGY							73.01
76 OTHER ANCILLARY CHEMICAL DEPEND							76
76.97 CARDIAC REHABILITATION	0.378794						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.167795						90
90.01 OTTAWA CLINIC	1.110962						90.01
91 EMERGENCY	0.292803						91
92 OBSERVATION BEDS	0.363176						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

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
 11/26/2012 10:53

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)			
	1	2	3		5			
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	687,521		687,521	7,844	87.65	755	66,176	30
32 INTENSIVE CARE UNIT	151,295		151,295	984	153.76	42	6,458	31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT								34
40 OTHER SPECIAL CARE (SPECIFY)								35
41 SUBPROVIDER - IPF								40
42 SUBPROVIDER - IRF								41
43 SUBPROVIDER I								42
44 NURSERY	62,294		62,294	408	152.68	257	39,239	43
45 SKILLED NURSING FACILITY	38,058		38,058	255	149.25			44
200 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	939,168		939,168	9,491		1,054	111,873	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL
	COST	CHARGES	COST TO		
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)
	COL. 26)	COL. 8)	COL.2)		5
	1	2	3	4	
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	742,021	16,777,742	0.044227		50
52 DELIVERY ROOM & LABOR ROOM	90,859	439,559	0.206705		52
53 ANESTHESIOLOGY	53,265	3,908,941	0.013626		53
54 RADIOLOGY-DIAGNOSTIC	1,067,883	21,208,034	0.050353		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	378,125	12,389,475	0.030520		57
58 MAGNETIC RESONANCE IMAGING (M	360,849	4,398,570	0.082038		58
60 LABORATORY	277,194	20,886,557	0.013271		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	60,926	1,815,561	0.033558		65
66 PHYSICAL THERAPY	105,904	3,708,716	0.028555		66
67 OCCUPATIONAL THERAPY	52,709	1,590,085	0.033149		67
68 SPEECH PATHOLOGY	8,845	191,900	0.046092		68
68.01 AUDIOLOGY					68.01
69 ELECTROCARDIOLOGY	36,119	1,563,474	0.023102		69
69.01 CARDIAC REHAB					69.01
70 ELECTROENCEPHALOGRAPHY	8,135	633,922	0.012833		70
71 MEDICAL SUPPLIES CHRGD TO PA	76,270	5,728,155	0.013315		71
72 IMPL. DEV. CHARGED TO PATIENT	45,711	2,605,673	0.017543		72
73 DRUGS CHARGED TO PATIENTS	214,899	9,178,373	0.023414		73
73.01 ONCOLOGY					73.01
76 OTHER ANCILLARY CHEMICAL DEPE					76
76.97 CARDIAC REHABILITATION	37,286	673,076	0.055396		76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	32,736	2,813,670	0.011635		90
90.01 OTTAWA CLINIC	153,651	1,669,574	0.092030		90.01
91 EMERGENCY	200,293	8,903,401	0.022496		91
92 OBSERVATION BEDS	111,665	3,166,409	0.035266		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	4,115,345	124,250,867			200

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
 11/26/2012 10:53

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	7,844		755		30
31 INTENSIVE CARE UNIT	984		42		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	408		257		43
44 SKILLED NURSING FACILITY	255				44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	9,491		1,054		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1				SCHOOL 2	HEALTH 3
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
68.01 AUDIOLOGY						68.01
69 ELECTROCARDIOLOGY						69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 OTTAWA CLINIC						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX]	HOSPITAL (14-0026)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS	
APPLICABLE	[] TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA	
BOXES	[XX] TITLE XIX	[]	IRF	[]	NF	[]		[]	OTHER	
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)		RATIO OF COST TO CHARGES (COL. 5 + COL. 7)		O/P RATIO OF COST TO CHARGES (COL. 6 + COL. 7)		INPAT PGM CHARGES (COL. 10)		O/P PGM CHARGES (COL. 12)	
	7		8		9		10		11	
									12	
									13	
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM		16,777,742							50
52	DELIVERY ROOM & LABOR ROOM		439,559							52
53	ANESTHESIOLOGY		3,908,941							53
54	RADIOLOGY-DIAGNOSTIC		21,208,034							54
57	COMPUTED TOMOGRAPHY (CT) SCA		12,389,475							57
58	MAGNETIC RESONANCE IMAGING (4,398,570							58
60	LABORATORY		20,886,557							60
62.30	BLOOD CLOTTING FOR HEMOPHILI									62.30
65	RESPIRATORY THERAPY		1,815,561							65
66	PHYSICAL THERAPY		3,708,716							66
67	OCCUPATIONAL THERAPY		1,590,085							67
68	SPEECH PATHOLOGY		191,900							68
68.01	AUDIOLOGY									68.01
69	ELECTROCARDIOLOGY		1,563,474							69
69.01	CARDIAC REHAB									69.01
70	ELECTROENCEPHALOGRAPHY		633,922							70
71	MEDICAL SUPPLIES CHRGED TO P		5,728,155							71
72	IMPL. DEV. CHARGED TO PATIEN		2,605,673							72
73	DRUGS CHARGED TO PATIENTS		9,178,373							73
73.01	ONCOLOGY									73.01
76	OTHER ANCILLARY CHEMICAL DEP									76
76.97	CARDIAC REHABILITATION		673,076							76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC		2,813,670							90
90.01	OTTAWA CLINIC		1,669,574							90.01
91	EMERGENCY		8,903,401							91
92	OBSERVATION BEDS		3,166,409							92
OTHER REIMBURSABLE COST CENTERS										
200	TOTAL (SUM OF LINES 50-199)		124,250,867							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT	COST SERVICES	COST SVCES NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS				
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.261517						50
52 DELIVERY ROOM & LABOR ROOM	1.063350						52
53 ANESTHESIOLOGY	0.064379						53
54 RADIOLOGY-DIAGNOSTIC	0.231734						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076812						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206136						58
60 LABORATORY	0.196897						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.456195						65
66 PHYSICAL THERAPY	0.462159						66
67 OCCUPATIONAL THERAPY	0.328259						67
68 SPEECH PATHOLOGY	0.483726						68
68.01 AUDIOLOGY							68.01
69 ELECTROCARDIOLOGY	0.079935						69
69.01 CARDIAC REHAB							69.01
70 ELECTROENCEPHALOGRAPHY	0.323800						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.278988						71
72 IMPL. DEV. CHARGED TO PATIENT	0.516768						72
73 DRUGS CHARGED TO PATIENTS	0.271992						73
73.01 ONCOLOGY							73.01
76 OTHER ANCILLARY CHEMICAL DEPEND							76
76.97 CARDIAC REHABILITATION	0.378794						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.167795						90
90.01 OTTAWA CLINIC	1.110962						90.01
91 EMERGENCY	0.292803						91
92 OBSERVATION BEDS	0.363176						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 (14-0026) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	7,844	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,844	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	36	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,534	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,899	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)	7,080,316	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	7,080,316	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,430,140	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	35,640	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,394,500	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.101114	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	990.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	978.65	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	11.35	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	12.50	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	450	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	7,079,866	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 902.64 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 4,422,033 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 4,422,033 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	1,750,981	984	1,779.45	512	911,078	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					6,052,701	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					11,385,812	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 508,122 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 625,033 51
 52 TOTAL PROGRAM EXCLUDABLE COST 1,133,155 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 10,252,657 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 THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,274 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 902.64 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,149,963 89

COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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) 5	
90 CAPITAL-RELATED COST	687,521	7,080,316	0.097103	1,149,963	111,665	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	255	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	255	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	255	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)	255	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)	306,463	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	306,463	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	107,950	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	107,950	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.838935	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)	423.33	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)	306,463	37

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
11/26/2012 10:53

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	306,463	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	1,201.82	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	306,464	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)	306,464	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)	306,464	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	77,985	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	384,449	86

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	7,844	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,844	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	36	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,534	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)	755	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)	408	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	257	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)	7,080,316	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	7,080,316	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	6,430,140	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	35,640	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	6,394,500	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.101114	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	990.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	978.65	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	11.35	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	12.50	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	450	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	7,079,866	37

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 902.64 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 681,493 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) 681,493 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	385,889	408	945.81	257	243,073 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	1,750,981	984	1,779.45	42	74,737 43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					999,303 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 111,873 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 111,873 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 887,430 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 THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63
 PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 1,274 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

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		4,901,156		30
31 INTENSIVE CARE UNIT		967,680		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.261517	2,761,398	722,153	50
52 DELIVERY ROOM & LABOR ROOM	1.063350			52
53 ANESTHESIOLOGY	0.064379	736,219	47,397	53
54 RADIOLOGY-DIAGNOSTIC	0.231734	2,475,129	573,572	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076812	1,598,250	122,765	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206136	72,862	15,019	58
60 LABORATORY	0.196897	3,938,663	775,511	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.456195	1,209,713	551,865	65
66 PHYSICAL THERAPY	0.462159	419,145	193,712	66
67 OCCUPATIONAL THERAPY	0.328259	89,685	29,440	67
68 SPEECH PATHOLOGY	0.483726	22,240	10,758	68
68.01 AUDIOLOGY				68.01
69 ELECTROCARDIOLOGY	0.079935	358,985	28,695	69
69.01 CARDIAC REHAB				69.01
70 ELECTROENCEPHALOGRAPHY	0.323800	754	244	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.278988	1,786,694	498,466	71
72 IMPL. DEV. CHARGED TO PATIENT	0.516768	1,309,988	676,960	72
73 DRUGS CHARGED TO PATIENTS	0.271992	4,536,364	1,233,855	73
73.01 ONCOLOGY				73.01
76 OTHER ANCILLARY CHEMICAL DEPEND				76
76.97 CARDIAC REHABILITATION	0.378794			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.167795	25,832	4,334	90
90.01 OTTAWA CLINIC	1.180325			90.01
91 EMERGENCY	0.311236	1,564,188	486,832	91
92 OBSERVATION BEDS	0.363176	223,370	81,123	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		23,129,479	6,052,701	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		23,129,479		202

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
 11/26/2012 10:53

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.261517			50
52 DELIVERY ROOM & LABOR ROOM	1.063350			52
53 ANESTHESIOLOGY	0.064379			53
54 RADIOLOGY-DIAGNOSTIC	0.231734	2,457	569	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076812			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206136			58
60 LABORATORY	0.196897	32,857	6,469	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.456195	23,252	10,607	65
66 PHYSICAL THERAPY	0.462159	35,655	16,478	66
67 OCCUPATIONAL THERAPY	0.328259	13,720	4,504	67
68 SPEECH PATHOLOGY	0.483726	7,860	3,802	68
68.01 AUDIOLOGY				68.01
69 ELECTROCARDIOLOGY	0.079935	245	20	69
69.01 CARDIAC REHAB				69.01
70 ELECTROENCEPHALOGRAPHY	0.323800			70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.278988	24,487	6,832	71
72 IMPL. DEV. CHARGED TO PATIENT	0.516768			72
73 DRUGS CHARGED TO PATIENTS	0.271992	105,533	28,704	73
73.01 ONCOLOGY				73.01
76 OTHER ANCILLARY CHEMICAL DEPEND				76
76.97 CARDIAC REHABILITATION	0.378794			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.167795			90
90.01 OTTAWA CLINIC	1.110962			90.01
91 EMERGENCY	0.292803			91
92 OBSERVATION BEDS	0.363176			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		246,066	77,985	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		246,066		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.261517			50
52 DELIVERY ROOM & LABOR ROOM	1.063350			52
53 ANESTHESIOLOGY	0.064379			53
54 RADIOLOGY-DIAGNOSTIC	0.231734			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.076812			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.206136			58
60 LABORATORY	0.196897			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.456195			65
66 PHYSICAL THERAPY	0.462159			66
67 OCCUPATIONAL THERAPY	0.328259			67
68 SPEECH PATHOLOGY	0.483726			68
68.01 AUDIOLOGY				68.01
69 ELECTROCARDIOLOGY	0.079935			69
69.01 CARDIAC REHAB				69.01
70 ELECTROENCEPHALOGRAPHY	0.323800			70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.278988			71
72 IMPL. DEV. CHARGED TO PATIENT	0.516768			72
73 DRUGS CHARGED TO PATIENTS	0.271992			73
73.01 ONCOLOGY				73.01
76 OTHER ANCILLARY CHEMICAL DEPEND				76
76.97 CARDIAC REHABILITATION	0.378794			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.167795			90
90.01 OTTAWA CLINIC	1.180325			90.01
91 EMERGENCY	0.311236			91
92 OBSERVATION BEDS	0.363176			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	7,927,740	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	70,214	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	93.52	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0213	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1337	31
32	SUM OF LINES 30 AND 31	0.1550	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0283	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	224,355	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)	8,222,309	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	10,911,420	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	10,239,142	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	646,646	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	10,885,788	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	10,885,788	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1,011,396	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	18,009	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	180,509	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	126,356	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	116,895	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	9,982,739	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)	9,982,739	71
72	INTERIM PAYMENTS	9,867,823	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	114,916	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		9,779,078		4,133,801
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 03/30/2012	88,745	03/30/2012	3,640
	.02			3.01
	.03			3.02
	.04			3.03
	.05			3.04
	.06			3.05
	.07			3.06
	.08			3.07
	.09			3.08
	.50	NONE		3.09
	.51			3.50
	.52			3.51
	.53			3.52
	.54			3.53
	.55			3.54
	.56			3.55
	.57			3.56
	.58			3.57
	.59			3.58
	.99			3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		88,745		3,640
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		9,867,823		4,137,441

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	114,916		56,852	6.01
	TO PROVIDER .02				6.02
	PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		9,982,739		4,194,293	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		73,011		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		3.01
	.02			3.02
	.03			3.03
	.04			3.04
	.05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50	NONE		3.50
	.51		NONE	3.51
	.52			3.52
	.53			3.53
	.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)		73,011		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	1,250			6.01
	TO PROVIDER .02				6.02
	PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		74,261			7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
11/26/2012 10:53

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0026) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	2,120	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	5,411	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	7,554	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	135,316,710	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	7,677,764	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	85,180 1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS	2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS	3
4	SUBTOTAL (SUM OF LINES 1-3)	85,180 4
COMPUTATION OF NET COST OF COVERED SERVICES		
5	MEDICAL AND OTHER SERVICES	5
6	DEDUCTIBLES	6
7	COINSURANCE	12,169 7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	1,786 8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	1,250 10
11	UTILIZATION REVIEW	11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	74,261 12
13	INPATIENT PRIMARY PAYER PAYMENTS	13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	74,261 15
16	INTERIM PAYMENTS	73,011 16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)	1,250 18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

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

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

	INPATIENT	OUTPATIENT	
	TITLE V OR	TITLE V OR	
	TITLE XIX	TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

SECTION 115.2

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	-419,989			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	47,073,196			4
5	OTHER RECEIVABLES	459,157			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-39,057,317			6
7	INVENTORY	931,503			7
8	PREPAID EXPENSES	477,871			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	9,464,421			11
FIXED ASSETS					
12	LAND	1,234,827			12
13	LAND IMPROVEMENTS	979,977			13
14	ACCUMULATED DEPRECIATION	-708,522			14
15	BUILDINGS	42,899,299			15
16	ACCUMULATED DEPRECIATION	-15,161,609			16
17	LEASEHOLD IMPROVEMENTS	245,433			17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	8,728,093			19
20	ACCUMULATED DEPRECIATION	-5,377,946			20
21	AUTOMOBILES AND TRUCKS	216,851			21
22	ACCUMULATED DEPRECIATION	-154,593			22
23	MAJOR MOVABLE EQUIPMENT	25,468,371			23
24	ACCUMULATED DEPRECIATION	-18,830,787			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)	39,539,394			30
OTHER ASSETS					
31	INVESTMENTS	30,418,890			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	2,846,239			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	33,265,129			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	82,268,944			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,968,428			37
38	SALARIES, WAGES & FEES PAYABLE	2,397,381			38
39	PAYROLL TAXES PAYABLE	-1,893			39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME	3,656,255			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	119,061			43
44	OTHER CURRENT LIABILITIES	2,604,123			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	10,743,355			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	10,037,783			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	18,390,783			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	28,428,566			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	39,171,921			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	43,097,023			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)	43,097,023			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	82,268,944			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	3	5	7	
	2	4	6	8	
1 FUND BALANCES AT BEGINNING OF PERIOD	53,945,229				1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	-1,812,178				2
3 TOTAL (SUM OF LINE 1 AND LINE 2)	52,133,051				3
4 ADDITIONS (CREDIT ADJUSTMENTS)	46,252				4
5 NET ASSET RELEASED FROM REST	27,483				5
6 PROCEEDS FROM REST. GRANT FO	195,290				6
7					7
8					8
9					9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)	269,025				10
11 SUBTOTAL (LINE 3 PLUS LINE 10)	52,402,076				11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13 TRANSFER TO AFFILIATE	2,798,000				13
14 MINIMUM PENSION LIABILITY	6,507,053				14
15					15
16					16
17					17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)	9,305,053				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	43,097,023				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	6,988,470		6,988,470	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY	107,950		107,950	8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	7,096,420		7,096,420	
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	2,716,778		2,716,778	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	2,716,778		2,716,778	
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	9,813,198		9,813,198	17
18 ANCILLARY SERVICES	34,331,933	99,135,035	133,466,968	18
19 OUTPATIENT SERVICES		3,216,665	3,216,665	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY		912,470	912,470	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER PATIENT REVENUES		39,080	39,080	27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	44,145,131	103,303,250	147,448,381	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		53,785,501	29
30 ADD (SPECIFY)			30
31 ROUNDING ADJ	17		31
32			32
33			33
34			34
35 LAP SCH DEP ADJUSTMENT			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		17	36
37 DEPR. DIFFERENCE	-2		37
38 LAP SCH DEP ADJUSTMENT	-2,531		38
39 LAP SCH DEP ADJUSTMENT	-9,854		39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-12,387	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		53,773,131	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	147,448,381	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	95,649,857	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	51,798,524	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	53,773,131	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,974,607	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	15,939	6
7	INCOME FROM INVESTMENTS	819,627	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	5,202	10
11	REBATES AND REFUNDS OF EXPENSES	-4,765	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	15	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	23,649	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	1,441	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	21,765	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	50,424	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	238,592	22
23	GOVERNMENTAL APPROPRIATIONS		23
24			24
24.01	OTHER (NON OPERATING UNREALIZED GAIN (LOSS))	-1,224,848	24.01
24.02	OTHER (WK COMP & G/P LIABILITY FUND INCOME)	20,259	24.02
24.03	OTHER (OTHER REVENUE)	195,129	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	162,429	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,812,178	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-1,812,178	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO. : 14-7173

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED-BLDGS & FIXTURES						1
2 CAPITAL RELATED-MOVABLE EQUIPMENT						2
3 PLANT OPERATION & MAINTENANCE						3
4 TRANSPORTATION (SEE INSTRUCTIONS)						4
5 ADMINISTRATIVE AND GENERAL	306,417				47,025	353,442 5
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	275,508					275,508 6
7 PHYSICAL THERAPY	107,547					107,547 7
8 OCCUPATIONAL THERAPY	8,859					8,859 8
9 SPEECH PATHOLOGY	1,139					1,139 9
10 MEDICAL SOCIAL SERVICES	19,327					19,327 10
11 HOME HEALTH AIDE	5,658					5,658 11
12 SUPPLIES (SEE INSTRUCTIONS)					7,019	7,019 12
13 DRUGS						13
14 DME						14
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						15
16 RESPIRATORY THERAPY						16
17 PRIVATE DUTY NURSING						17
18 CLINIC						18
19 HEALTH PROMOTION ACTIVITIES						19
20 DAY CARE PROGRAM						20
21 HOME DELIVERED MEALS PROGRAM						21
22 HOMEMAKER SERVICE						22
23 ALL OTHERS						23
24 TOTAL (SUM OF LINES 1-23)	724,455				54,044	778,499 24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO. : 14-7173

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5	-29,260	324,182		324,182	5
6					6
7	-107,547	275,508		275,508	7
8	-8,859				8
9	-1,139				9
10	-19,327				10
11		5,658		5,658	11
12	-7,019				12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24	-173,151	605,348		605,348	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7173

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATIN & MAINT 3	TRANSPORT- ATION 4	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6
1								1
2								2
3								3
4								4
5								5
	324,182					324,182	324,182	
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
	5,658					5,658	6,524	12,182
							1	1
								13
								14
								15
								16
								17
								18
								19
								20
								21
								22
								23
	605,348					605,348		605,348

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO. : 14-7173

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-324,182	281,167	5
6 SKILLED NURSING CARE						275,508	6
7 PHYSICAL THERAPY							7
8 OCCUPATIONAL THERAPY							8
9 SPEECH PATHOLOGY							9
10 MEDICAL SOCIAL SERVICES							10
11 HOME HEALTH AIDE						5,658	11
12 SUPPLIES (SEE INSTRUCTIONS)					1	1	12
13 DRUGS							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-324,181	281,167	24
25 COST TO BE ALLOC (PER W/S H)						324,182	25
26 UNIT COST MULTIPLIER						1.152987	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7173

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	335,963		335,963			1
2 SKILLED NURSING CARE	893,310		893,310	317,870	1,211,180	2
3 PHYSICAL THERAPY						3
4 OCCUPATIONAL THERAPY						4
5 SPEECH PATHOLOGY						5
6 MEDICAL SOCIAL SERVICES	32,780		32,780	11,664	44,444	6
7 HOME HEALTH AIDE	18,068		18,068	6,429	24,497	7
8 SUPPLIES	1		1		1	8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	1,280,122		1,280,122	335,963	1,280,122	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.355833		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7173

WORKSHEET H-2
 PART II

HHA COST CENTER	NEW CAP- REL COSTS BLDG&FIXT SQUARE FEET	NEW CAP- REL COSTS MOV EQUIP DOLLAR VA OR SQ. FEE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	MAINTEN- ANCE AND REPAIRS MAINTENANC HOURS	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	3,710			259,251		94,976	400	3,710	1
2 SKILLED NURSING CARE				293,770		677,980			2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE				5,302		13,713			7
8 SUPPLIES						1			8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	3,710			558,323		786,670	400	3,710	20
21 TOTAL COST TO BE ALLOCATED	20,127			161,195		249,850	6,487	69,353	21
22 UNIT COST MULTIPLIER	5.425067						16.217500		22
22 UNIT COST MULTIPLIER				0.288713		0.317605		18.693531	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7173

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE-KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA DIRECT HO OF SERVICE 11	MAINT OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINI-STRATION (DIRECT NRSNG HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15
1 ADMINISTRATIVE AND GENERAL				121		121	581,721	1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)				121		121	581,721	20
21 TOTAL COST TO BE ALLOCATED				8,592		124,097	2,293	21
22 UNIT COST MULTIPLIER							0.003942	22
22 UNIT COST MULTIPLIER				71.008264		1,025.595041		22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7173

WORKSHEET H-2
 PART II

HHA COST CENTER	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	PARAMED ED (ASSIGNED TIME)	
	16	17	19	20	21	22	23	
1 ADMINISTRATIVE AND GENERAL								1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES		867						6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)		867						20
21 TOTAL COST TO BE ALLOCATED		32,780						21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER		37.808535						22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7173

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	4	(COL.3 ÷ COL.4)	
1	SKILLED NURSING CARE	2	1,211,180	2	1,211,180	3,296	367.47	1
2	PHYSICAL THERAPY	3		122,472	122,472	1,325	92.43	2
3	OCCUPATIONAL THERAPY	4		10,110	10,110	154	65.65	3
4	SPEECH PATHOLOGY	5		8,514	8,514	88	96.75	4
5	MEDICAL SOCIAL SERVICES	6	44,444		44,444	131	339.27	5
6	HOME HEALTH AIDE	7	24,497		24,497	271	90.39	6
7	TOTAL (SUM OF LINES 1-6)		1,280,121	141,096	1,421,217	5,265		7
PATIENT SERVICES								
8	SKILLED NURSING CARE							8
8.01	SKILLED NURSING CARE							8.01
9	PHYSICAL THERAPY							9
9.01	PHYSICAL THERAPY							9.01
10	OCCUPATIONAL THERAPY							10
10.01	OCCUPATIONAL THERAPY							10.01
11	SPEECH PATHOLOGY							11
11.01	SPEECH PATHOLOGY							11.01
12	MEDICAL SOCIAL SERVICES							12
12.01	MEDICAL SOCIAL SERVICES							12.01
13	HOME HEALTH AIDE							13
13.01	HOME HEALTH AIDE							13.01
14	TOTAL (SUM OF LINES 8-13)							14
SUPPLIES AND DRUGS COST COMPUTATIONS								
OTHER PATIENT SERVICES		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)	
15	COST OF MEDICAL SUPPLIES	8	1	7,411	7,412	26,564	0.279024	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7173

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

PATIENT SERVICES	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS. 9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
1 SKILLED NURSING CARE	6 1,686	7 1,137	8	9 619,554	10 417,813	11	12 1,037,367
2 PHYSICAL THERAPY	691	378		63,869	34,939		98,808
3 OCCUPATIONAL THERAPY	62	79		4,070	5,186		9,256
4 SPEECH PATHOLOGY	34	40		3,290	3,870		7,160
5 MEDICAL SOCIAL SERVICES	58	69		19,678	23,410		43,088
6 HOME HEALTH AIDE	92	160		8,316	14,462		22,778
7 TOTAL (SUM OF LINES 1-6)	2,623	1,863		718,777	499,680		1,218,457

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	1	2 37900	3 127	4 48
8.01 SKILLED NURSING CARE	99914	1,559	1,089	8.01 8
9 PHYSICAL THERAPY	37900	51	36	9 9
9.01 PHYSICAL THERAPY	99914	640	342	9.01 9.01
10 OCCUPATIONAL THERAPY	37900	1	12	10 10
10.01 OCCUPATIONAL THERAPY	99914	61	67	10.01 10.01
11 SPEECH PATHOLOGY	37900	5		11 11
11.01 SPEECH PATHOLOGY	99914	29	40	11.01 11.01
12 MEDICAL SOCIAL SERVICES	37900		3	12 12
12.01 MEDICAL SOCIAL SERVICES	99914	58	66	12.01 12.01
13 HOME HEALTH AIDE	37900		6	13 13
13.01 HOME HEALTH AIDE	99914	92	154	13.01 13.01
14 TOTAL (SUM OF LINES 8-13)		2,623	1,863	14 14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES		
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR
15 COST OF MEDICAL SUPPLIES	6	7	8	9	10	11
16 COST OF DRUGS						

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

FROM WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL. 1 x COL. 2)	TRANSFER TO PART I AS INDICATED	TOTAL
1 PHYSICAL THERAPY	66	0.462159	265,000	122,472	COL 2, LINE 2
2 OCCUPATIONAL THERAPY	67	0.328259	30,800	10,110	COL 2, LINE 3
3 SPEECH PATHOLOGY	68	0.483726	17,600	8,514	COL 2, LINE 4
3.01 AUDIOLOGY	68.01				COL 2, LINE 4
4 MEDICAL SUPPLIES CHRGD TO PAT	71	0.278988	26,564	7,411	COL 2, LINE 15
5 DRUGS CHARGED TO PATIENTS	73	0.271992			COL 2, LINE 16
5.01 ONCOLOGY	73.01				COL 2, LINE 16

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7173

WORKSHEET H-4
 PARTS I & II

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

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

DESCRIPTION	----- PART B -----		
	PART A 1	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3
1 REASONABLE COST OF PART A & PART B SERVICES			1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)			1
2 TOTAL CHARGES			2
CUSTOMARY CHARGES			
3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)			3
4 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			4
5 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)			5
6 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			6
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)			7
8 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)			8
9 PRIMARY PAYER PAYMENTS			9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	444,593	291,169	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	9,794	6,542	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	3,214	1,014	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	457,601	298,725	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	457,601	298,725	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	457,601	298,725	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	457,601	298,725	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	457,601	298,725	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	457,601	298,725	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

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

HHA NO.: 14-7173

WORKSHEET H-5

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		457,601		298,725	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
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99				3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		457,601		298,725	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	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
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01				6.01
	PROVIDER PROVIDER TO .02				6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		457,601		298,725	7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____		NPR DATE: _____	8

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	634,655	1
2	CAPITAL DRG OUTLIER PAYMENTS	11,991	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	20.94	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	646,646	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL	I&R COST &		TOTAL
	NARY CAP- REL COSTS	(COLS.0-4) 2A	SUBTOTAL 24	POST STEP- DOWN ADJS 25	
	0				
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR)					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
68.01 AUDIOLOGY					68.01
69 ELECTROCARDIOLOGY					69
69.01 CARDIAC REHAB					69.01
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
73.01 ONCOLOGY					73.01
76 OTHER ANCILLARY CHEMICAL DEPEN					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 OTTAWA CLINIC					90.01
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 OTHER NONREIMBURSABLE COST					194

PROVIDER CCN: 14-0026 ST. MARY'S HOSPITAL
PERIOD FROM 07/01/2011 TO 06/30/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2011.10
11/26/2012 10:53

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

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	62.46		9.63				72.09 30
31 INTENSIVE CARE UNIT	52.03		4.27				56.30 31
43 NURSERY			62.99				62.99 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	16.46	33.14					49.60 50
52 DELIVERY ROOM & LABOR ROOM		0.23					0.23 52
53 ANESTHESIOLOGY	18.83	24.12					42.95 53
54 RADIOLOGY-DIAGNOSTIC	11.67	29.79					41.46 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	12.90	32.98					45.88 57
58 MAGNETIC RESONANCE IMAGING (MRI)	1.66	30.43					32.09 58
60 LABORATORY	18.86	2.87					21.73 60
65 RESPIRATORY THERAPY	66.63	5.72					72.35 65
66 PHYSICAL THERAPY	11.30	0.01					11.31 66
67 OCCUPATIONAL THERAPY	5.64						5.64 67
68 SPEECH PATHOLOGY	11.59						11.59 68
68.01 AUDIOLOGY		9.96					9.96 68.01
69 ELECTROCARDIOLOGY	22.96	38.34					61.30 69
70 ELECTROENCEPHALOGRAPHY	0.12	30.85					30.97 70
71 MEDICAL SUPPLIES CHRGD TO PATI	31.19	24.72					55.91 71
72 IMPL. DEV. CHARGED TO PATIENT	50.27	15.95					66.22 72
73 DRUGS CHARGED TO PATIENTS	49.42	29.79					79.21 73
76.97 CARDIAC REHABILITATION		59.73					59.73 76.97
90 CLINIC	0.92	27.94					28.86 90
90.01 OTTAWA CLINIC		4.93					4.93 90.01
91 EMERGENCY	17.57	17.58					35.15 91
92 OBSERVATION BEDS	7.05	19.65					26.70 92
200 TOTAL CHARGES	18.61	22.35					40.96 200

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

SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
44 SKILLED NURSING FACILITY	100.00						100.00 44
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.01						0.01 54
60 LABORATORY	0.16						0.16 60
65 RESPIRATORY THERAPY	1.28						1.28 65
66 PHYSICAL THERAPY	0.96						0.96 66
67 OCCUPATIONAL THERAPY	0.86						0.86 67
68 SPEECH PATHOLOGY	4.10						4.10 68
69 ELECTROCARDIOLOGY	0.02						0.02 69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.43						0.43 71
73 DRUGS CHARGED TO PATIENTS	1.15						1.15 73
200 TOTAL CHARGES	0.20						0.20 200

COST CENTER		---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	1,549,916	3.60	-1,549,916	-6.49			1
2	CAP REL COSTS-MVBLE EQUIP	3,005,243	6.98	-3,005,243	-12.59			2
3	OTHER CAPITAL RELATED COSTS							3
4	EMPLOYEE BENEFITS	4,859,016	11.28	-4,859,016	-20.36			4
5	ADMINISTRATIVE & GENERAL	8,666,727	20.12	-8,666,727	-36.31			5
6	MAINTENANCE & REPAIRS	975,703	2.27	-975,703	-4.09			6
7	OPERATION OF PLANT	1,190,222	2.76	-1,190,222	-4.99			7
8	LAUNDRY & LINEN SERVICE	192,660	0.45	-192,660	-0.81			8
9	HOUSEKEEPING	723,274	1.68	-723,274	-3.03			9
10	DIETARY	567,152	1.32	-567,152	-2.38			10
11	CAFETERIA	44,677	0.10	-44,677	-0.19			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	842,271	1.96	-842,271	-3.53			13
14	CENTRAL SERVICES & SUPPLY	120,825	0.28	-120,825	-0.51			14
15	PHARMACY	550,844	1.28	-550,844	-2.31			15
16	MEDICAL RECORDS & LIBRARY	563,172	1.31	-563,172	-2.36			16
17	SOCIAL SERVICE	19,327	0.04	-19,327	-0.08			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SRVCES-SALARY & FRINGES APP							21
22	I&R SRVCES-OTHER PRGM COSTS APP							22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	2,153,783	5.00	4,926,533	20.64	7,080,316	16.44	30
31	INTENSIVE CARE UNIT	662,702	1.54	1,088,279	4.56	1,750,981	4.07	31
43	NURSERY	122,802	0.29	263,087	1.10	385,889	0.90	43
44	SKILLED NURSING FACILITY	84,082	0.20	222,381	0.93	306,463	0.71	44
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,470,518	3.41	2,917,153	12.22	4,387,671	10.19	50
52	DELIVERY ROOM & LABOR ROOM	138,394	0.32	329,011	1.38	467,405	1.09	52
53	ANESTHESIOLOGY	124,537	0.29	127,116	0.53	251,653	0.58	53
54	RADIOLOGY-DIAGNOSTIC	2,147,953	4.99	2,766,671	11.59	4,914,624	11.41	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	312,891	0.73	638,771	2.68	951,662	2.21	57
58	MAGNETIC RESONANCE IMAGING (MRI)	300,463	0.70	606,239	2.54	906,702	2.10	58
60	LABORATORY	2,544,798	5.91	1,567,700	6.57	4,112,498	9.55	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	391,751	0.91	436,498	1.83	828,249	1.92	65
66	PHYSICAL THERAPY	977,597	2.27	736,421	3.08	1,714,018	3.98	66
67	OCCUPATIONAL THERAPY	241,144	0.56	280,815	1.18	521,959	1.21	67
68	SPEECH PATHOLOGY	42,177	0.10	50,650	0.21	92,827	0.22	68
68.01	AUDIOLOGY	-10,546	-0.02	5,743	0.02	-4,803	-0.01	68.01
69	ELECTROCARDIOLOGY	36,934	0.09	88,042	0.37	124,976	0.29	69
69.01	CARDIAC REHAB							69.01
70	ELECTROENCEPHALOGRAPHY	146,907	0.34	58,357	0.24	205,264	0.48	70
71	MEDICAL SUPPLIES CHRGD TO PATI	1,147,465	2.66	450,619	1.89	1,598,084	3.71	71
72	IMPL. DEV. CHARGED TO PATIENT	1,021,953	2.37	324,576	1.36	1,346,529	3.13	72
73	DRUGS CHARGED TO PATIENTS	964,850	2.24	1,531,593	6.42	2,496,443	5.80	73
73.01	ONCOLOGY							73.01
76	OTHER ANCILLARY CHEMICAL DEPEND							76
76.97	CARDIAC REHABILITATION	74,623	0.17	180,334	0.76	254,957	0.59	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
90	CLINIC	205,403	0.48	266,717	1.12	472,120	1.10	90
90.01	OTTAWA CLINIC	1,062,086	2.47	792,747	3.32	1,854,833	4.31	90.01
91	EMERGENCY	980,773	2.28	1,626,169	6.81	2,606,942	6.05	91
92	OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS								
OUTPATIENT SERVICE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	605,348	1.41	674,774	2.83	1,280,122	2.97	101
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CAN	32,310	0.08	22,054	0.09	54,364	0.13	190
192	PHYSICIANS' PRIVATE OFFICES	977,775	2.27	655,512	2.75	1,633,287	3.79	192
194	OTHER NONREIMBURSABLE COST	241,563	0.56	236,467	0.99	478,030	1.11	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	43,074,065	100.00			43,074,065	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	742,021	16,777,742	0.044227	2,761,398	122,128	50
52 DELIVERY ROOM & LABOR ROOM	90,859	439,559	0.206705			52
53 ANESTHESIOLOGY	53,265	3,908,941	0.013626	736,219	10,032	53
54 RADIOLOGY-DIAGNOSTIC	1,067,883	21,208,034	0.050353	2,475,129	124,630	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	378,125	12,389,475	0.030520	1,598,250	48,779	57
58 MAGNETIC RESONANCE IMAGING (MRI)	360,849	4,398,570	0.082038	72,862	5,977	58
60 LABORATORY	277,194	20,886,557	0.013271	3,938,663	52,270	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	60,926	1,815,561	0.033558	1,209,713	40,596	65
66 PHYSICAL THERAPY	105,904	3,708,716	0.028555	419,145	11,969	66
67 OCCUPATIONAL THERAPY	52,709	1,590,085	0.033149	89,685	2,973	67
68 SPEECH PATHOLOGY	8,845	191,900	0.046092	22,240	1,025	68
68.01 AUDIOLOGY						68.01
69 ELECTROCARDIOLOGY	36,119	1,563,474	0.023102	358,985	8,293	69
69.01 CARDIAC REHAB						69.01
70 ELECTROENCEPHALOGRAPHY	8,135	633,922	0.012833	754	10	70
71 MEDICAL SUPPLIES CHRGD TO PATI	76,270	5,728,155	0.013315	1,786,694	23,790	71
72 IMPL. DEV. CHARGED TO PATIENT	45,711	2,605,673	0.017543	1,309,988	22,981	72
73 DRUGS CHARGED TO PATIENTS	214,899	9,178,373	0.023414	4,536,364	106,214	73
73.01 ONCOLOGY						73.01
76 OTHER ANCILLARY CHEMICAL DEPEND						76
76.97 CARDIAC REHABILITATION	37,286	673,076	0.055396			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	32,736	2,813,670	0.011635	25,832	301	90
90.01 OTTAWA CLINIC	153,651	1,669,574	0.092030			90.01
91 EMERGENCY	200,293	8,903,401	0.022496	1,564,188	35,188	91
92 OBSERVATION BEDS	111,665	3,166,409	0.035266	223,370	7,877	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	4,115,345	124,250,867		23,129,479	625,033	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	687,521		687,521	7,844	87.65	4,899	429,397 30
31	INTENSIVE CARE UNIT	151,295		151,295	984	153.76	512	78,725 31
200	TOTAL	838,816		838,816	8,828		5,411	508,122 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								508,122
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								625,033
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								1,133,155
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								1,273
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								5,411
PER DISCHARGE CAPITAL COSTS								890.15
PER DIEM CAPITAL COSTS								209.42

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	10,252,657
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	28,998,315
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.354

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	1,133,155
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.039

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	6,245,491
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	27,716,752
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.225