

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 11-29-2013 TIME: 11:29
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. ANTHONY'S MEMORIAL HOSPITAL (14-0032) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, 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		372,262	58,370	-23,834	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		-591			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		371,671	58,370	-23,834	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: 503 N MAPLE
 2 CITY: EFFINGHAM

STATE: IL

P.O.BOX:
 ZIP CODE: 62401-

COUNTY: EFFINGHAM

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-0032	41180	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	14-5940	41180		06/27/1997	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA	14-7661	41180		02/17/1997	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: 07/01/2012			TO: 06/30/2013				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.							2	N 23

		IN-STATE		OUT-OF-STATE		OUT-OF-STATE		OTHER	
		MEDICAID		MEDICAID		MEDICAID			
		PAID	ELIGIBLE	PAID	ELIGIBLE	HMO	MEDICAID		
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS		
		1	2	3	4	5	6		
24	IF THIS PROVIDER IS AN IPPS 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.	2,675	235					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.							37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							1 N	2 N 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX
		1	2	3
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N
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	N
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	1 N	2	3	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 HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME	61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06

OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND
 THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS)
 ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE,
 ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4
 DIRECT GME FTE UNWEIGHTED COUNT.

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
1	2	3	4	
				61.10

OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY,
 AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS)
 ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE,
 ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4
 DIRECT GME FTE UNWEIGHTED COUNT.

61.20

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
64	ENTER IN COLUMN 1, 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)	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 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.3+COL.4) 5
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SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

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

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.3+COL.4) 5
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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
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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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		V	XIX	
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.	1	2	
		N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97

RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108

109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	PHY- SICAL	OCCUP- ATIONAL	SPEECH RATORY	RESPI- RATORY	109
		N	N	N	N	

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.					115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.					118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: SELF INSURANCE:					118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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	
	Y		140

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

141	NAME: HOSPITAL SISTERS HEALTH SYSTEM CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET: 4936 LAVERNA ROAD P.O. BOX:		142
143	CITY: SPRINGFIELD, IL 62707 STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y	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	XIX
	1	2	3	4
155	HOSPITAL	N	N	N 155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161
161.10	CORF			161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs?
 ENTER 'Y' FOR YES OR 'N' FOR NO.

	N	165
--	---	-----

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
 COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.

	Y	167
--	---	-----

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
 ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.

		168
--	--	-----

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
 (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

	1.00	169
--	------	-----

170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE
 FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)

	06/02/2012	08/30/2012	170
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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)	Y		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.	Y		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	
BED COMPLEMENT					
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			Y 12 N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

	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: RICK	LAST NAME: SCHUMACHER	TITLE: BUSINESS OFFICE MANA	41
42	EMPLOYER: ST ANTHONY'S MEMORIAL HOSPITAL			42
43	PHONE NUMBER: 217-347-1299	E-MAIL ADDRESS: RICK.SCHUMACHER@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	32,491,084	992,008	33,483,092	1,334,694.00	25.09
2	NON-PHYSICIAN ANESTHETIST PART A						1
3	NON-PHYSICIAN ANESTHETIST PART B						2
4	PHYSICIAN-PART A ADMINISTRATIVE						3
4.01	PHYSICIAN-PART A - TEACHING						4
5	PHYSICIAN-PART B						4.01
6	NON-PHYSICIAN-PART B						5
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					6
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7
8	HOME OFFICE PERSONNEL						7.01
9	SNF	44	707,977		707,977	29,284.00	24.18
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		923,111		923,111	34,717.00	26.59
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		422,364		422,364	5,210.00	81.07
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						11
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE						12
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		2,628,351		2,628,351	48,684.00	53.99
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						13
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						14
	WAGE-RELATED COSTS						15
17	WAGE-RELATED COSTS (CORE)		13,643,171		13,643,171		16
18	WAGE-RELATED COSTS (OTHER)						17
19	EXCLUDED AREAS		702,227		702,227		18
20	NON-PHYSICIAN ANESTHETIST PART A						19
21	NON-PHYSICIAN ANESTHETIST PART B						20
22	PHYSICIAN PART A - ADMINISTRATIVE						21
22.01	PHYSICIAN PART A - TEACHING						22
23	PHYSICIAN PART B						22.01
24	WAGE-RELATED COSTS (RHC/FQHC)						23
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						24
	OVERHEAD COSTS - DIRECT SALARIES						25
26	EMPLOYEE BENEFITS DEPARTMENT		66,767	239,163	305,930	9,521.00	32.13
27	ADMINISTRATIVE & GENERAL		4,096,449	752,845	4,849,294	187,542.00	25.86
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		179,414		179,414	1,662.00	107.95
29	MAINTENANCE & REPAIRS		600,038		600,038	27,610.00	21.73
30	OPERATION OF PLANT		155,860		155,860	10,263.00	15.19
31	LAUNDRY & LINEN SERVICE		83,516		83,516	6,751.00	12.37
32	HOUSEKEEPING		640,250		640,250	55,143.00	11.61
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						32
34	DIETARY		683,590	-425,702	257,888	17,952.00	14.37
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						33
36	CAFETERIA		75,357	425,702	501,059	37,662.00	13.30
37	MAINTENANCE OF PERSONNEL						34
38	NURSING ADMINISTRATION		657,675		657,675	15,052.00	43.69
39	CENTRAL SERVICES AND SUPPLY						35
40	PHARMACY		1,235,501		1,235,501	31,845.00	38.80
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		2,257,873		2,257,873	90,477.00	24.96
42	SOCIAL SERVICE						36
43	OTHER GENERAL SERVICE						37

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	32,670,498	992,008	33,662,506	1,336,356.00	25.19	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	1,631,088		1,631,088	64,001.00	25.49	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	31,039,410	992,008	32,031,418	1,272,355.00	25.17	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	3,050,715		3,050,715	53,894.00	56.61	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	13,643,171		13,643,171		42.59	5
6	TOTAL (SUM OF LINES 3 THRU 5)	47,733,296	992,008	48,725,304	1,326,249.00	36.74	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	10,732,290	992,008	11,724,298	491,480.00	23.86	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)	2,924,933 4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	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	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,924,933 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/29/2013 11:29

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7661

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: EFFINGHAM

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		1,023		43	1,066	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		516.00	57.00	129.00	689.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .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)					4
5 OTHER ADMINISTRATIVE PERSONNEL			54,377.00	54,377.00	5
6 DIRECT NURSING SERVICE			603,227.00	603,227.00	6
7 NURSING SUPERVISOR					7
8 PHYSICAL THERAPY SERVICE			101,607.00	101,607.00	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE			12,256.00	12,256.00	10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE			3,139.00	3,139.00	12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE			5,062.00	5,062.00	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE			52,001.00	52,001.00	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.	1	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).	99914	20

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	4,303	685	247	184	5,419	21
22 SKILLED NURSING VISIT CHARGES	569,792	91,182	32,316	24,490	717,780	22
23 PHYSICAL THERAPY VISITS	912	1	24	39	976	23
24 PHYSICAL THERAPY VISIT CHARGES	141,444	156	3,735	6,075	151,410	24
25 OCCUPATIONAL THERAPY VISITS	414	1	5	7	427	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	64,056	156	780	1,092	66,084	26
27 SPEECH PATHOLOGY VISITS	27			1	28	27
28 SPEECH PATHOLOGY VISIT CHARGES	4,212			156	4,368	28
29 MEDICAL SOCIAL SERVICE VISITS	21	1	1	1	24	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	4,095	184	195	184	4,658	30
31 HOME HEALTH AIDE VISITS	509		2	4	515	31
32 HOME HEALTH AIDE VISIT CHARGES	39,476		156	312	39,944	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	6,186	688	279	236	7,389	33
34 OTHER CHARGES	53,342	21,247	1,627	843	77,059	34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	876,417	112,925	38,809	33,152	1,061,303	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	369		43	14	426	36
37 TOTAL NUMBER OF OUTLIER EPISODES						37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES		9			9	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) 4
	GROUP				SNF	SWING BED	
	1				DAYS	SNF DAYS	
					2	3	
3	RUX						3
4	RUL						4
5	RVX						5
6	RVL						6
7	RHX						7
8	RHL				16		16 8
9	RMX				38		38 9
10	RML				41		41 10
11	RLX						11
12	RUC						12
13	RUB						13
14	RUA						14
15	RVC						15
16	RVB						16
17	RVA				36		36 17
18	RHC				120		120 18
19	RHB				75		75 19
20	RHA				450		450 20
21	RMC				143		143 21
22	RMB				77		77 22
23	RMA				1,095		1,095 23
24	RLB						24
25	RLA						25
26	ES3						26
27	ES2				12		12 27
28	ES1				58		58 28
29	HE2						29
30	HE1				8		8 30
31	HD2						31
32	HD1				10		10 32
33	HC2						33
34	HC1				3		3 34
35	HB2						35
36	HB1				199		199 36
37	LE2						37
38	LE1				9		9 38
39	LD2						39
40	LD1						40
41	LC2				12		12 41
42	LC1				11		11 42
43	LB2						43
44	LB1						44
45	CE2						45
46	CE1						46
47	CD2						47
48	CD1				38		38 48
49	CC2						49
50	CC1				12		12 50
51	CB2						51
52	CB1				51		51 52
53	CA2						53
54	CA1				124		124 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				15		15 66
67	BA2						67
68	BA1						68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		SNF	SWING BED	TOTAL
		DAYS	SNF DAYS	(COLS.
GROUP		2	3	2 + 3)
	1			4
69	PE2			69
70	PE1	5		5 70
71	PD2			71
72	PD1	15		15 72
73	PC2			73
74	PC1	14		14 74
75	PB2			75
76	PB1	143		143 76
77	PA2			77
78	PA1	72		72 78
199	AAA			199
200	TOTAL	2,902		2,902 200

CBSA AT
 BEGINNING
 OF COST
 REPORTING
 PERIOD
 1

CBSA ON/AFTER
 OCT 1 OF THE
 COST REPORTING
 PERIOD (IF
 APPLICABLE)
 2

SNF SERVICES

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)

ASSOCIATED
 WITH
 DIRECT
 PATIENT
 CARE AND
 RELATED
 EXPENSES PERCENTAGE EXPENSES?
 1 2 3

202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	905,054		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)				0.329507	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID					2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					Y 3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					N 4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES					6
7	MEDICAID COST (LINE 1 TIMES LINE 6)					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.					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					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)					19
		UNINSURED	INSURED			
		PATIENTS	PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY				0	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)				0	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				0	22
23	COST OF CHARITY CARE				0	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)					26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				749,578	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				-749,578	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				-246,991	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				-246,991	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				-246,991	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		1,906,177	1,906,177	506,255	1
2	00200		5,247,486	5,247,486	84,936	2
3	00300					3
4	00400	66,767	14,049,381	14,116,148	650,986	4
5	00500	4,096,449	15,023,754	19,120,203	-730,695	5
6	00600	600,038	435,593	1,035,631		6
7	00700	155,860	1,293,815	1,449,675		7
8	00800	83,516	491,128	574,644		8
9	00900	640,250	282,029	922,279		9
10	01000	683,590	400,326	1,083,916	-692,355	10
11	01100	75,357	583	75,940	692,355	11
12	01200					12
13	01300	657,675	31,533	689,208		13
14	01400		1,382,420	1,382,420	-1,378,041	14
15	01500	1,235,501	2,914,277	4,149,778	-2,808,883	15
16	01600	2,257,873	930,392	3,188,265		16
17	01700		1,862	1,862		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	6,206,571	288,330	6,494,901		30
31	03100	1,240,584	49,541	1,290,125		31
43	04300		20,011	20,011		43
44	04400	707,977	38,094	746,071		44
ANCILLARY SERVICE COST CENTERS						
50	05000	3,325,101	10,957,701	14,282,802		50
52	05200	141,622	89,277	230,899		52
53	05300	1,313,981	1,841,561	3,155,542		53
54	05400	1,510,776	714,397	2,225,173		54
54.01	03630	167,263	56,379	223,642		54.01
54.02	03450	218,398	381,074	599,472		54.02
54.04	03480		54,123	54,123		54.04
54.06	05401		154,565	154,565		54.06
57	05700	223,036	539,553	762,589		57
58	05800	179,566	295,077	474,643		58
59	05900	182,947	152,425	335,372		59
60	06000	1,199,642	2,399,672	3,599,314		60
62.30	06250					62.30
65	06500	791,521	103,816	895,337		65
66	06600	966,344	34,230	1,000,574		66
67	06700	182,944	30,408	213,352		67
69	06900	460,294	314,650	774,944		69
70	07000	124,853	170,666	295,519		70
71	07100				1,378,041	71
73	07300				2,808,883	73
74	07400		43,886	43,886		74
76	03050					76
76.01	03650	172,035	45,346	217,381		76.01
76.02	03651	70,623	1,882	72,505		76.02
76.03	03950	204,780	911,549	1,116,329		76.03
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	1,424,239	717,828	2,142,067		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	831,669	199,851	1,031,520		101
SPECIAL PURPOSE COST CENTERS						
113	11300		511,482	511,482	-511,482	113
118		32,399,642	65,508,130	97,907,772		118
NONREIMBURSABLE COST CENTERS						
190	19000		21,861	21,861		190
194	07950	91,442	-134,765	-43,323		194
194.01	07951					194.01
194.02	07952					194.02
194.03	07953		3,273,281	3,273,281		194.03
200		32,491,084	68,668,507	101,159,591		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	
1	00100 GENERAL SERVICE COST CENTERS				
2	00200 CAP REL COSTS-BLDG & FIXT	2,412,432	401,126	2,813,558	1
3	00300 CAP REL COSTS-MVBLE EQUIP	5,332,422	-88,939	5,243,483	2
4	00400 OTHER CAP REL COSTS				3
5	00400 EMPLOYEE BENEFITS DEPARTMENT	14,767,134	-258,002	14,509,132	4
6	00500 ADMINISTRATIVE & GENERAL	18,389,508	-3,100,719	15,288,789	5
7	00600 MAINTENANCE & REPAIRS	1,035,631	-16,176	1,019,455	6
8	00700 OPERATION OF PLANT	1,449,675	-5,470	1,444,205	7
9	00800 LAUNDRY & LINEN SERVICE	574,644		574,644	8
10	00900 HOUSEKEEPING	922,279	-50	922,229	9
11	01000 DIETARY	391,561	-39,240	352,321	10
12	01100 CAFETERIA	768,295		768,295	11
13	01200 MAINTENANCE OF PERSONNEL				12
14	01300 NURSING ADMINISTRATION	689,208	-380	688,828	13
15	01400 CENTRAL SERVICES & SUPPLY	4,379		4,379	14
16	01500 PHARMACY	1,340,895	-1,800	1,339,095	15
17	01600 MEDICAL RECORDS & LIBRARY	3,188,265	-69,336	3,118,929	16
18	01700 SOCIAL SERVICE	1,862		1,862	17
19	01900 NONPHYSICIAN ANESTHETISTS				19
20	02000 NURSING SCHOOL				20
21	02100 I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTERS				23
30	03000 ADULTS & PEDIATRICS	6,494,901	-61,652	6,433,249	30
31	03100 INTENSIVE CARE UNIT	1,290,125		1,290,125	31
43	04300 NURSERY	20,011		20,011	43
44	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	746,071		746,071	44
50	05000 OPERATING ROOM	14,282,802	-2,095,731	12,187,071	50
52	05200 DELIVERY ROOM & LABOR ROOM	230,899		230,899	52
53	05300 ANESTHESIOLOGY	3,155,542	-1,441,985	1,713,557	53
54	05400 RADIOLOGY-DIAGNOSTIC	2,225,173	-17,187	2,207,986	54
54.01	03630 ULTRASOUND	223,642		223,642	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	599,472		599,472	54.02
54.04	03480 RADIATION ONC	54,123		54,123	54.04
54.06	05401 PET SCAN	154,565		154,565	54.06
57	05700 CT SCAN	762,589		762,589	57
58	05800 MRI	474,643		474,643	58
59	05900 CARDIAC CATHETERIZATION	335,372		335,372	59
60	06000 LABORATORY	3,599,314	-28,378	3,570,936	60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500 RESPIRATORY THERAPY	895,337	-20,940	874,397	65
66	06600 PHYSICAL THERAPY	1,000,574		1,000,574	66
67	06700 OCCUPATIONAL THERAPY	213,352	-4,192	209,160	67
69	06900 ELECTROCARDIOLOGY	774,944	-197,412	577,532	69
70	07000 ELECTROENCEPHALOGRAPHY	295,519	-136,650	158,869	70
71	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,378,041	-1,049	1,376,992	71
73	07300 DRUGS CHARGED TO PATIENTS	2,808,883	-45,227	2,763,656	73
74	07400 RENAL DIALYSIS	43,886		43,886	74
76	03050 BACTERIOLOGY & MICROBIOLOGY				76
76.01	03650 VASCULAR LAB	217,381	-245	217,136	76.01
76.02	03651 CARDIAC REHAB	72,505		72,505	76.02
76.03	03950 WOUND CARE	1,116,329	-310,988	805,341	76.03
76.97	07697 CARDIAC REHABILITATION				76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699 LITHOTRIPSY				76.99
91	09100 EMERGENCY	2,142,067	-607,735	1,534,332	91
92	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92
94	09400 HOME PROGRAM DIALYSIS				94
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
101	10100 HOME HEALTH AGENCY	1,031,520	-125	1,031,395	101
113	11300 INTEREST EXPENSE				113
118	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	97,907,772	-8,148,482	89,759,290	118
190	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,861		21,861	190
194	07950 PHILANTHROPY DEVELOPMENT	-43,323		-43,323	194
194.01	07951 VENDING				194.01
194.02	07952 MEALS ON WHEELS				194.02
194.03	07953 PRAIRIE CARDIOVASCULAR	3,273,281		3,273,281	194.03
200	TOTAL (SUM OF LINES 118-199)	101,159,591	-8,148,482	93,011,109	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	-----		INCREASE	-----	
		COST CENTER	LINE #		SALARY	OTHER
	1	2	3	4	5	
1 PERSONNELCOSTS	A	EMPLOYEE BENEFITS DEPARTMENT	4	239,163	54,700	1
500 TOTAL RECLASSIFICATIONS				239,163	54,700	500
CODE LETTER - A						
1 CAFETERIA COSTS	B	CAFETERIA	11	425,702	266,653	1
500 TOTAL RECLASSIFICATIONS				425,702	266,653	500
CODE LETTER - B						
1 PHARMACY DRUGS	C	DRUGS CHARGED TO PATIENTS	73		2,808,883	1
500 TOTAL RECLASSIFICATIONS					2,808,883	500
CODE LETTER - C						
1 CENTRAL SUPPLY	D	MEDICAL SUPPLIES CHARGED TO P	71		1,378,041	1
500 TOTAL RECLASSIFICATIONS					1,378,041	500
CODE LETTER - D						
1 BUSINESS PROPERTY INSURANCE	E	CAP REL COSTS-BLDG & FIXT	1		79,709	1
500 TOTAL RECLASSIFICATIONS					79,709	500
CODE LETTER - E						
1 INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		426,546	1
2 INTEREST EXPENSE	F	CAP REL COSTS-MVBLE EQUIP	2		84,936	2
500 TOTAL RECLASSIFICATIONS					511,482	500
CODE LETTER - F						
1 DIVISIONAL EXPENSES SALARIES	G	ADMINISTRATIVE & GENERAL	5	992,008		1
2 DIVISIONAL EXPENSES BENEFITS	G	EMPLOYEE BENEFITS DEPARTMENT	4		357,123	2
500 TOTAL RECLASSIFICATIONS				992,008	357,123	500
CODE LETTER - G						
GRAND TOTAL (INCREASES)				1,656,873	5,456,591	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE		WKST A-7 REF. 10	
			LINE # 7	SALARY 8		
1 PERSONNEL COSTS	A	ADMINISTRATIVE & GENERAL	5	239,163	54,700	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				239,163	54,700	500
1 CAFETERIA COSTS	B	DIETARY	10	425,702	266,653	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B				425,702	266,653	500
1 PHARMACY DRUGS	C	PHARMACY	15		2,808,883	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					2,808,883	500
1 CENTRAL SUPPLY	D	CENTRAL SERVICES & SUPPLY	14		1,378,041	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					1,378,041	500
1 BUSINESS PROPERTY INSURANCE	E	ADMINISTRATIVE & GENERAL	5		79,709	9 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					79,709	500
1 INTEREST EXPENSE	F					9 1
2 INTEREST EXPENSE	F	INTEREST EXPENSE	113		511,482	9 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					511,482	500
1 DIVISIONAL EXPENSES SALARIES	G	ADMINISTRATIVE & GENERAL	5		992,008	1
2 DIVISIONAL EXPENSES BENEFITS	G	ADMINISTRATIVE & GENERAL	5		357,123	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					1,349,131	500
GRAND TOTAL (DECREASES)				664,865	6,448,599	

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	1,246,628	1,780,000		1,780,000		3,026,628		1
2 LAND IMPROVEMENTS	2,074,344					2,074,344	1,640,295	2
3 BUILDINGS AND FIXTURES	61,121,118	2,625,451		2,625,451		63,746,569	23,916,688	3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	14,606,257	464,334		464,334		15,070,591	13,425,632	5
6 MOVABLE EQUIPMENT	63,503,334	4,718,364		4,718,364	17,940	68,203,758	53,099,157	6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	142,551,681	9,588,149		9,588,149	17,940	152,121,890	92,081,772	8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	142,551,681	9,588,149		9,588,149	17,940	152,121,890	92,081,772	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,906,177						1,906,177
2 CAP REL COSTS-MVBLE EQUIP	4,203,508	1,043,978					5,247,486
3 TOTAL (SUM OF LINES 1-2)	6,109,685	1,043,978					7,153,663

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	3,240,104		-426,546				2,813,558
2 CAP REL COSTS-MVBLE EQUIP	4,284,441	1,043,978	-84,936				5,243,483
3 TOTAL	7,524,545	1,043,978	-511,482				8,057,041

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-426,546	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-84,936	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-5,683	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)	A	-4,004	CAP REL COSTS-MVBLE EQUIP	2	9 7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,955,178			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-1,813	RADIOLOGY-DIAGNOSTIC	54	11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-122,204			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					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	-69,336	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	A	827,672	CAP REL COSTS-BLDG & FIXT	1	9 26
27 DEPRECIATION--MOVABLE EQUIPMENT	A	1	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 TELEPHONE EMPLOYEE BENEFITS	A	-7,264	EMPLOYEE BENEFITS DEPARTMENT	4	33
34 TELEPHONE A&G SALARIES	A	-16,822	ADMINISTRATIVE & GENERAL	5	34
35 TELEPHONE A&G EXPENSES	A	-3	ADMINISTRATIVE & GENERAL	5	35
36 TELEVISION EMPLOYEE BENEFITS	A	-916	EMPLOYEE BENEFITS DEPARTMENT	4	36
37 TELEVISION MAINTENANCE SALARIES	A	-2,123	MAINTENANCE & REPAIRS	6	37
38 TELEVISION MAINTENANCE CABLE	A	-14,053	MAINTENANCE & REPAIRS	6	38
39 TELEVISION PLANT ELECTRIC	A	-635	OPERATION OF PLANT	7	39
40 RECYCLING	B	-3,049	OPERATION OF PLANT	7	40
41 BOND INDENTURE FEES	A	-408	ADMINISTRATIVE & GENERAL	5	41
42 NON-OPERATING BUILDINGS	A	-35,531	ADMINISTRATIVE & GENERAL	5	42
43 PHYSICIAN EXPENSE	A	-19,993	ADMINISTRATIVE & GENERAL	5	43
44 COMMUNITY RELATION ADVERTISING	A	-280,956	ADMINISTRATIVE & GENERAL	5	44
45 HOUSEKEEPING	B	-50	HOUSEKEEPING	9	45
45.04 LOBBYING EXPENSE	A	-27,924	ADMINISTRATIVE & GENERAL	5	45.04
45.06 NAME BADGES	B	-180	EMPLOYEE BENEFITS DEPARTMENT	4	45.06
45.07 PHYSICIAN APPLICATIONS	B	-3,100	ADMINISTRATIVE & GENERAL	5	45.07
45.08 GUEST MEALS	B	-34	DIETARY	10	45.08
45.10 PHYSICIAN RECRUITMENT	A	-141,067	ADMINISTRATIVE & GENERAL	5	45.10
45.11 REBATES	B	-378	ADMINISTRATIVE & GENERAL	5	45.11
45.12 REBATES	B	-17,232	DIETARY	10	45.12
45.13 REBATES	B	-45,227	DRUGS CHARGED TO PATIENTS	73	45.13
45.14 REBATES	B	-61,652	ADULTS & PEDIATRICS	30	45.14
45.15 REBATES	B	-2,828	LABORATORY	60	45.15
45.16 REBATES	B	-16	ELECTROCARDIOLOGY	69	45.16
45.17 REBATES	B	-1,049	MEDICAL SUPPLIES CHARGED TO PAT	71	45.17
45.18 REBATES	B	-45,654	OPERATING ROOM	50	45.18
45.19 REBATES	B	-1,786	OPERATION OF PLANT	7	45.19
45.20 REBATES	B	-2,658	RADIOLOGY-DIAGNOSTIC	54	45.20
45.22 ALCOHOLIC BEVERAGES	A	-3,819	ADMINISTRATIVE & GENERAL	5	45.22

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7
			COST CENTER	LINE NO.	
	1	2	3	4	5
45.26 IN-SERVICE	B	-302	ADMINISTRATIVE & GENERAL	5	45.26
45.28 MISC INCOME - SPIRIT COMMITTEE	B	-23,975	EMPLOYEE BENEFITS DEPARTMENT	4	45.28
45.30 IN-SERVICE	B	-380	NURSING ADMINISTRATION	13	45.30
45.40 MISC INC	B	-550	LABORATORY	60	45.40
45.43 DRUGS NON PATIENT	B	-1,800	PHARMACY	15	45.43
45.47 PHYSICIAN DUES	B	-16,000	ADMINISTRATIVE & GENERAL	5	45.47
45.48 DIABETES INSTRUCTION	B	-21,974	DIETARY	10	45.48
45.50 HOUSEKEEPING 900 W TEMPLE	B	-6,185	ADMINISTRATIVE & GENERAL	5	45.50
45.52 ASPR GRANT	B	-30,822	EMERGENCY	91	45.52
45.53 CRNA SALARIES	B	-1,805,016	OPERATING ROOM	50	45.53
45.54 MISC INCOME	B	-46	ADMINISTRATIVE & GENERAL	5	45.54
45.57 BOUTIQUE SALES	B	-11,848	RADIOLOGY-DIAGNOSTIC	54	45.57
46 OCCUPATIONAL THERAPY-IN SERVICE	B	-4,192	OCCUPATIONAL THERAPY	67	46
47 HOME HEALTH MISC	B	-125	HOME HEALTH AGENCY	101	47
48 ALTAMONT DIAG CTR	B	-868	RADIOLOGY-DIAGNOSTIC	54	48
49 MEANINGFUL USE FUNDS	B	-2,645,965	ADMINISTRATIVE & GENERAL	5	49
50 TOTAL (SUM OF LINES 1 THRU 49)		-8,148,482			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,922,600	5,627,707	-3,705,107	1
2	5	ADMINISTRATIVE & GENERAL	CCC (FAMIS) FEE	5,056,154	1,247,584	3,808,570	2
3	4	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	10,560,740	10,786,407	-225,667	3
4							4
5		TOTALS (SUM OF LINES 1-4)		17,539,494	17,661,698	-122,204	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	91 EMERGENCY	EMERGENCY	576,913	576,913				1
2	53 ANESTHESIOLOGY	ANESTHESIA	1,441,985	1,441,985				2
3	69 ELECTROCARDIOLOGY	CARDIOLOGY	197,396	197,396				3
4	65 RESPIRATORY THERAPY	RESPIRATORY CAR	20,940	20,940				4
5	76.01 VASCULAR LAB	VASCULAR LAB	245	245				5
6	60 LABORATORY	LABORATORY	25,000	25,000				6
7	76.03 WOUND CARE	WOUND CARE	310,988	310,988				7
8	54 RADIOLOGY-DIAGNOSTIC	WOMENS WELLNESS						8
9	70 ELECTROENCEPHALOGRAPHY	NEUROLOGY	136,650	136,650				9
10	69 ELECTROCARDIOLOGY	PRAIRIE CARDIOV						10
11	50 OPERATING ROOM	HSHS MEDICAL GR	245,061	245,061				11
12	66 PHYSICAL THERAPY	SPEECH THERAPIS						12
13	54.04 RADIATION ONC	RADIATION ONCOL						13
200	TOTAL		2,955,178	2,955,178				200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	91 EMERGENCY	EMERGENCY						576,913	1
2	53 ANESTHESIOLOGY	ANESTHESIA						1,441,985	2
3	69 ELECTROCARDIOLOGY	CARDIOLOGY						197,396	3
4	65 RESPIRATORY THERAPY	RESPIRATORY CAR						20,940	4
5	76.01 VASCULAR LAB	VASCULAR LAB						245	5
6	60 LABORATORY	LABORATORY						25,000	6
7	76.03 WOUND CARE	WOUND CARE						310,988	7
8	54 RADIOLOGY-DIAGNOSTIC	WOMENS WELLNESS							8
9	70 ELECTROENCEPHALOGRAPHY	NEUROLOGY						136,650	9
10	69 ELECTROCARDIOLOGY	PRAIRIE CARDIOV							10
11	50 OPERATING ROOM	HSHS MEDICAL GR						245,061	11
12	66 PHYSICAL THERAPY	SPEECH THERAPIS							12
13	54.04 RADIATION ONC	RADIATION ONCOL							13
200	TOTAL							2,955,178	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,813,558	2,813,558				1
2 CAP REL COSTS-MVBLE EQUIP	5,243,483		5,243,483			2
4 EMPLOYEE BENEFITS DEPARTMENT	14,509,132	7,032		14,516,164		4
5 ADMINISTRATIVE & GENERAL	15,288,789	748,845	830,942	1,733,148	18,601,724	5
6 MAINTENANCE & REPAIRS	1,019,455	39,661	11,662	269,831	1,340,609	6
7 OPERATION OF PLANT	1,444,205	450,233	1,728,424	70,337	3,693,199	7
8 LAUNDRY & LINEN SERVICE	574,644	28,390	2,129	37,690	642,853	8
9 HOUSEKEEPING	922,229	30,617	2,077	288,936	1,243,859	9
10 DIETARY	352,321	41,386	11,791	116,381	521,879	10
11 CAFETERIA	768,295	14,478	3,687	226,121	1,012,581	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	688,828	15,142	3,791	296,800	1,004,561	13
14 CENTRAL SERVICES & SUPPLY	4,379	54,391			58,770	14
15 PHARMACY	1,339,095	33,410	168,622	557,564	2,098,691	15
16 MEDICAL RECORDS & LIBRARY	3,118,929	24,429	13,094	1,018,946	4,175,398	16
17 SOCIAL SERVICE	1,862				1,862	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,433,249	363,905	135,559	2,800,944	9,733,657	30
31 INTENSIVE CARE UNIT	1,290,125	38,449	99,669	559,858	1,988,101	31
43 NURSERY	20,011	7,158	3,259		30,428	43
44 SKILLED NURSING FACILITY	746,071	53,654	1,283	319,500	1,120,508	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,187,071	264,895	630,334	1,500,572	14,582,872	50
52 DELIVERY ROOM & LABOR ROOM	230,899	42,015	3,249	63,912	340,075	52
53 ANESTHESIOLOGY	1,713,557	1,760	86,881	592,981	2,395,179	53
54 RADIOLOGY-DIAGNOSTIC	2,207,986	111,503	593,792	681,792	3,595,073	54
54.01 ULTRASOUND	223,642	3,862		75,483	302,987	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	599,472	21,834	37,757	98,560	757,623	54.02
54.04 RADIATION ONC	54,123		720		54,843	54.04
54.06 PET SCAN	154,565	1,796			156,361	54.06
57 CT SCAN	762,589	12,583	126,758	100,653	1,002,583	57
58 MRI	474,643	44,727	186,337	81,036	786,743	58
59 CARDIAC CATHETERIZATION	335,372	16,633	253,108	82,561	687,674	59
60 LABORATORY	3,570,936	65,932	124,598	541,382	4,302,848	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	874,397	6,062	43,820	357,202	1,281,481	65
66 PHYSICAL THERAPY	1,000,574	41,557	19,803	436,098	1,498,032	66
67 OCCUPATIONAL THERAPY	209,160	6,350		82,560	298,070	67
69 ELECTROCARDIOLOGY	577,532	27,016		207,724	812,272	69
70 ELECTROENCEPHALOGRAPHY	158,869	6,134	5,087	56,344	226,434	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,376,992				1,376,992	71
73 DRUGS CHARGED TO PATIENTS	2,763,656				2,763,656	73
74 RENAL DIALYSIS	43,886	1,338			45,224	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	217,136	3,422	56,097	77,637	354,292	76.01
76.02 CARDIAC REHAB	72,505	7,257	1,127	31,871	112,760	76.02
76.03 WOUND CARE	805,341	40,030	15,273	92,414	953,058	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,534,332	83,248	26,063	642,739	2,286,382	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	1,031,395	12,017	16,503	375,321	1,435,236	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	89,759,290	2,773,151	5,243,296	14,474,898	89,677,430	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,861	4,967	187		27,015	190
194 PHILANTHROPY DEVELOPMENT	-43,323	1,904		41,266	-153	194
194.01 VENDING		1,437			1,437	194.01

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	3,273,281	32,099			3,305,380	194.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	93,011,109	2,813,558	5,243,483	14,516,164	93,011,109	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & 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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	18,601,724					5
6 MAINTENANCE & REPAIRS	335,140	1,675,749				6
7 OPERATION OF PLANT	923,267	590,289	5,206,755			7
8 LAUNDRY & LINEN SERVICE	160,707	13,564	94,285	911,409		8
9 HOUSEKEEPING	310,954	25,500	101,683		1,681,996	9
10 DIETARY	130,465	44,851	137,446	5,974	47,145	10
11 CAFETERIA	253,136	362	48,082		16,491	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	251,131	17,181	50,290		17,243	13
14 CENTRAL SERVICES & SUPPLY	14,692		180,637		61,954	14
15 PHARMACY	524,654	22,606	110,959		38,051	15
16 MEDICAL RECORDS & LIBRARY	1,043,812	13,745	81,131		27,825	16
17 SOCIAL SERVICE	465					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,433,327	158,424	1,208,560	382,674	414,507	30
31 INTENSIVE CARE UNIT	497,007	83,191	127,692	36,870	43,795	31
43 NURSERY	7,607	21,883	23,773		8,154	43
44 SKILLED NURSING FACILITY	280,117	24,053	178,191	42,183	61,115	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,645,594	246,859	879,739	221,515	301,732	50
52 DELIVERY ROOM & LABOR ROOM	85,016	65,829	139,534		47,857	52
53 ANESTHESIOLOGY	598,773	15,372	5,846		2,006	53
54 RADIOLOGY-DIAGNOSTIC	898,736	69,084	370,311	33,289	127,005	54
54.01 ULTRASOUND	75,744		12,826	3,777	4,399	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	189,399	7,234	72,511	3,345	24,869	54.02
54.04 RADIATION ONC	13,710	1,085				54.04
54.06 PET SCAN	39,089		5,966		2,046	54.06
57 CT SCAN	250,637		41,789	9,599	14,333	57
58 MRI	196,679	181	148,542	19,714	50,947	58
59 CARDIAC CATHETERIZATION	171,912	10,128	55,241		18,946	59
60 LABORATORY	1,075,673	36,532	218,965	613	75,097	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	320,359	56,425	20,134	13,537	6,903	65
66 PHYSICAL THERAPY	374,495	32,915	138,013	4,942	47,337	66
67 OCCUPATIONAL THERAPY	74,515	2,170	21,088	1,065	7,233	67
69 ELECTROCARDIOLOGY	203,061	21,702	89,722	4,087	30,767	69
70 ELECTROENCEPHALOGRAPHY	56,606		20,372	106	6,987	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	344,236					71
73 DRUGS CHARGED TO PATIENTS	690,889					73
74 RENAL DIALYSIS	11,306		4,444		1,524	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	88,570	723	11,364	622	3,898	76.01
76.02 CARDIAC REHAB	28,189	5,425	24,101	739	8,264	76.02
76.03 WOUND CARE	238,256	13,021	132,942	7,381	45,596	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	571,575	57,691	276,473		94,819	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	358,796		39,909	118,263	13,688	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	17,768,296	1,658,025	5,072,561	910,295	1,672,533	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,754	362	16,495		5,658	190
194 PHILANTHROPY DEVELOPMENT			6,323		2,169	194
194.01 VENDING	359	17,362	4,772	1,114	1,636	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	826,315		106,604			194.03

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION		ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	18,601,724	1,675,749	5,206,755	911,409	1,681,996	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	887,760					10
11 CAFETERIA		1,330,652				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		20,499	1,360,905			13
14 CENTRAL SERVICES & SUPPLY				316,053		14
15 PHARMACY		43,354		197	2,838,512	15
16 MEDICAL RECORDS & LIBRARY		123,198				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	748,700	342,006	621,780	4,549	12,559	30
31 INTENSIVE CARE UNIT		57,719	104,922	806	1,805	31
43 NURSERY				341		43
44 SKILLED NURSING FACILITY	114,807	39,877	72,495	431	958	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		185,750	337,750	238,062	2,490	50
52 DELIVERY ROOM & LABOR ROOM				1,880		52
53 ANESTHESIOLOGY		21,441		1,081	58,086	53
54 RADIOLOGY-DIAGNOSTIC		86,091		2,701	4,366	54
54.01 ULTRASOUND		7,054		547		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC		9,319		56	253,226	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 CT SCAN		11,438		775		57
58 MRI		10,138		1,377		58
59 CARDIAC CATHETERIZATION				1,710	57	59
60 LABORATORY		76,603		18,578	57	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		49,981		1,769	10	65
66 PHYSICAL THERAPY		41,829				66
67 OCCUPATIONAL THERAPY		7,424		580		67
69 ELECTROCARDIOLOGY		41,548		494	500	69
70 ELECTROENCEPHALOGRAPHY		7,076		431	370	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				32,452	81	71
73 DRUGS CHARGED TO PATIENTS					2,487,996	73
74 RENAL DIALYSIS				5		74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB		8,265				76.01
76.02 CARDIAC REHAB		3,118		40		76.02
76.03 WOUND CARE		13,681		3,819	12,277	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		81,358	147,792	1,818	3,664	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		41,885	76,166	1,554	10	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	863,507	1,330,652	1,360,905	316,053	2,838,512	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
194 PHILANTHROPY DEVELOPMENT						194
194.01 VENDING	24,253					194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR						194.03

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PART I

COST CENTER DESCRIPTION		DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	887,760	1,330,652	1,360,905	316,053	2,838,512	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 DEPARTMENT						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	5,465,109					16
17 SOCIAL SERVICE		2,327				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,299,402	1,830	20,361,975		20,361,975	30
31 INTENSIVE CARE UNIT	443,220	189	3,385,317		3,385,317	31
43 NURSERY			92,186		92,186	43
44 SKILLED NURSING FACILITY	722,487	308	2,657,530		2,657,530	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			20,642,363		20,642,363	50
52 DELIVERY ROOM & LABOR ROOM			680,191		680,191	52
53 ANESTHESIOLOGY			3,097,784		3,097,784	53
54 RADIOLOGY-DIAGNOSTIC			5,186,656		5,186,656	54
54.01 ULTRASOUND			407,334		407,334	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC			1,317,582		1,317,582	54.02
54.04 RADIATION ONC			69,638		69,638	54.04
54.06 PET SCAN			203,462		203,462	54.06
57 CT SCAN			1,331,154		1,331,154	57
58 MRI			1,214,321		1,214,321	58
59 CARDIAC CATHETERIZATION			945,668		945,668	59
60 LABORATORY			5,804,966		5,804,966	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			1,750,599		1,750,599	65
66 PHYSICAL THERAPY			2,137,563		2,137,563	66
67 OCCUPATIONAL THERAPY			412,145		412,145	67
69 ELECTROCARDIOLOGY			1,204,153		1,204,153	69
70 ELECTROENCEPHALOGRAPHY			318,382		318,382	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			1,753,761		1,753,761	71
73 DRUGS CHARGED TO PATIENTS			5,942,541		5,942,541	73
74 RENAL DIALYSIS			62,503		62,503	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB			467,734		467,734	76.01
76.02 CARDIAC REHAB			182,636		182,636	76.02
76.03 WOUND CARE			1,420,031		1,420,031	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY			3,521,572		3,521,572	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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			2,085,507		2,085,507	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	5,465,109	2,327	88,657,254		88,657,254	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			56,284		56,284	190
194 PHILANTHROPY DEVELOPMENT			8,339		8,339	194
194.01 VENDING			50,933		50,933	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR			4,238,299		4,238,299	194.03

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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
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	5,465,109	2,327	93,011,109		93,011,109 202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT		7,032		7,032	7,032	4
5 ADMINISTRATIVE & GENERAL		748,845	830,942	1,579,787	841	5
6 MAINTENANCE & REPAIRS		39,661	11,662	51,323	131	6
7 OPERATION OF PLANT		450,233	1,728,424	2,178,657	34	7
8 LAUNDRY & LINEN SERVICE		28,390	2,129	30,519	18	8
9 HOUSEKEEPING		30,617	2,077	32,694	140	9
10 DIETARY		41,386	11,791	53,177	56	10
11 CAFETERIA		14,478	3,687	18,165	110	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		15,142	3,791	18,933	144	13
14 CENTRAL SERVICES & SUPPLY		54,391		54,391		14
15 PHARMACY		33,410	168,622	202,032	271	15
16 MEDICAL RECORDS & LIBRARY		24,429	13,094	37,523	494	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		363,905	135,559	499,464	1,347	30
31 INTENSIVE CARE UNIT		38,449	99,669	138,118	272	31
43 NURSERY		7,158	3,259	10,417		43
44 SKILLED NURSING FACILITY		53,654	1,283	54,937	155	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		264,895	630,334	895,229	728	50
52 DELIVERY ROOM & LABOR ROOM		42,015	3,249	45,264	31	52
53 ANESTHESIOLOGY		1,760	86,881	88,641	288	53
54 RADIOLOGY-DIAGNOSTIC		111,503	593,792	705,295	331	54
54.01 ULTRASOUND		3,862		3,862	37	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC		21,834	37,757	59,591	48	54.02
54.04 RADIATION ONC			720	720		54.04
54.06 PET SCAN		1,796		1,796		54.06
57 CT SCAN		12,583	126,758	139,341	49	57
58 MRI		44,727	186,337	231,064	39	58
59 CARDIAC CATHETERIZATION		16,633	253,108	269,741	40	59
60 LABORATORY		65,932	124,598	190,530	263	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		6,062	43,820	49,882	173	65
66 PHYSICAL THERAPY		41,557	19,803	61,360	212	66
67 OCCUPATIONAL THERAPY		6,350		6,350	40	67
69 ELECTROCARDIOLOGY		27,016		27,016	101	69
70 ELECTROENCEPHALOGRAPHY		6,134	5,087	11,221	27	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS		1,338		1,338		74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB		3,422	56,097	59,519	38	76.01
76.02 CARDIAC REHAB		7,257	1,127	8,384	15	76.02
76.03 WOUND CARE		40,030	15,273	55,303	45	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		83,248	26,063	109,311	312	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		12,017	16,503	28,520	182	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		2,773,151	5,243,296	8,016,447	7,012	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		4,967	187	5,154		190
194 PHILANTHROPY DEVELOPMENT		1,904		1,904	20	194
194.01 VENDING		1,437		1,437		194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR		32,099		32,099		194.03

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION		DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)		2,813,558	5,243,483	8,057,041	7,032 202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & 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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	1,580,628					5
6 MAINTENANCE & REPAIRS	28,477	79,931				6
7 OPERATION OF PLANT	78,451	28,156	2,285,298			7
8 LAUNDRY & LINEN SERVICE	13,655	647	41,383	86,222		8
9 HOUSEKEEPING	26,422	1,216	44,630		105,102	9
10 DIETARY	11,086	2,139	60,326	565	2,946	10
11 CAFETERIA	21,509	17	21,104		1,030	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	21,339	819	22,073		1,077	13
14 CENTRAL SERVICES & SUPPLY	1,248		79,283		3,871	14
15 PHARMACY	44,580	1,078	48,701		2,378	15
16 MEDICAL RECORDS & LIBRARY	88,694	656	35,609		1,739	16
17 SOCIAL SERVICE	40					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	206,762	7,557	530,447	36,202	25,899	30
31 INTENSIVE CARE UNIT	42,231	3,968	56,046	3,488	2,737	31
43 NURSERY	646	1,044	10,434		510	43
44 SKILLED NURSING FACILITY	23,802	1,147	78,210	3,991	3,819	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	309,791	11,775	386,126	20,956	18,854	50
52 DELIVERY ROOM & LABOR ROOM	7,224	3,140	61,243		2,990	52
53 ANESTHESIOLOGY	50,878	733	2,566		125	53
54 RADIOLOGY-DIAGNOSTIC	76,367	3,295	162,533	3,149	7,936	54
54.01 ULTRASOUND	6,436		5,629	357	275	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	16,093	345	31,826	316	1,554	54.02
54.04 RADIATION ONC	1,165	52				54.04
54.06 PET SCAN	3,321		2,618		128	54.06
57 CT SCAN	21,297		18,341	908	896	57
58 MRI	16,712	9	65,197	1,865	3,184	58
59 CARDIAC CATHETERIZATION	14,608	483	24,246		1,184	59
60 LABORATORY	91,401	1,743	96,106	58	4,693	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	27,221	2,691	8,837	1,281	431	65
66 PHYSICAL THERAPY	31,821	1,570	60,575	468	2,958	66
67 OCCUPATIONAL THERAPY	6,332	104	9,256	101	452	67
69 ELECTROCARDIOLOGY	17,254	1,035	39,380	387	1,923	69
70 ELECTROENCEPHALOGRAPHY	4,810		8,942	10	437	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	29,250					71
73 DRUGS CHARGED TO PATIENTS	58,706					73
74 RENAL DIALYSIS	961		1,951		95	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	7,526	35	4,988	59	244	76.01
76.02 CARDIAC REHAB	2,395	259	10,578	70	516	76.02
76.03 WOUND CARE	20,245	621	58,350	698	2,849	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	48,567	2,752	121,347		5,925	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	30,487		17,517	11,188	855	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,509,810	79,086	2,226,398	86,117	104,510	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	574	17	7,240		354	190
194 PHILANTHROPY DEVELOPMENT			2,775		136	194
194.01 VENDING	31	828	2,095	105	102	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	70,213		46,790			194.03

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION		ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,580,628	79,931	2,285,298	86,222	105,102	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	130,295					10
11 CAFETERIA		61,935				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		954	65,339			13
14 CENTRAL SERVICES & SUPPLY				138,793		14
15 PHARMACY		2,018		86	301,144	15
16 MEDICAL RECORDS & LIBRARY		5,734				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	109,885	15,918	29,852	1,998	1,332	30
31 INTENSIVE CARE UNIT		2,687	5,037	354	192	31
43 NURSERY				150		43
44 SKILLED NURSING FACILITY	16,850	1,856	3,481	189	102	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		8,646	16,216	104,544	264	50
52 DELIVERY ROOM & LABOR ROOM				826		52
53 ANESTHESIOLOGY		998		475	6,162	53
54 RADIOLOGY-DIAGNOSTIC		4,007		1,186	463	54
54.01 ULTRASOUND		328		240		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC		434		25	26,865	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 CT SCAN		532		340		57
58 MRI		472		605		58
59 CARDIAC CATHETERIZATION				751	6	59
60 LABORATORY		3,565		8,158	6	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		2,326		777	1	65
66 PHYSICAL THERAPY		1,947				66
67 OCCUPATIONAL THERAPY		346		255		67
69 ELECTROCARDIOLOGY		1,934		217	53	69
70 ELECTROENCEPHALOGRAPHY		329		189	39	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				14,251	9	71
73 DRUGS CHARGED TO PATIENTS					263,958	73
74 RENAL DIALYSIS				2		74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB		385				76.01
76.02 CARDIAC REHAB		145		18		76.02
76.03 WOUND CARE		637		1,677	1,302	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		3,787	7,096	798	389	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		1,950	3,657	682	1	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	126,735	61,935	65,339	138,793	301,144	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
194 PHILANTHROPY DEVELOPMENT						194
194.01 VENDING	3,560					194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR						194.03

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION		DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	130,295	61,935	65,339	138,793	301,144	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 DEPARTMENT						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	170,449					16
17 SOCIAL SERVICE		40				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	134,093	32	1,600,788		1,600,788	30
31 INTENSIVE CARE UNIT	13,823	3	268,956		268,956	31
43 NURSERY			23,201		23,201	43
44 SKILLED NURSING FACILITY	22,533	5	211,077		211,077	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			1,773,129		1,773,129	50
52 DELIVERY ROOM & LABOR ROOM			120,718		120,718	52
53 ANESTHESIOLOGY			150,866		150,866	53
54 RADIOLOGY-DIAGNOSTIC			964,562		964,562	54
54.01 ULTRASOUND			17,164		17,164	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC			137,097		137,097	54.02
54.04 RADIATION ONC			1,937		1,937	54.04
54.06 PET SCAN			7,863		7,863	54.06
57 CT SCAN			181,704		181,704	57
58 MRI			319,147		319,147	58
59 CARDIAC CATHETERIZATION			311,059		311,059	59
60 LABORATORY			396,523		396,523	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			93,620		93,620	65
66 PHYSICAL THERAPY			160,911		160,911	66
67 OCCUPATIONAL THERAPY			23,236		23,236	67
69 ELECTROCARDIOLOGY			89,300		89,300	69
70 ELECTROENCEPHALOGRAPHY			26,004		26,004	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			43,510		43,510	71
73 DRUGS CHARGED TO PATIENTS			322,664		322,664	73
74 RENAL DIALYSIS			4,347		4,347	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB			72,794		72,794	76.01
76.02 CARDIAC REHAB			22,380		22,380	76.02
76.03 WOUND CARE			141,727		141,727	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY			300,284		300,284	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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			95,039		95,039	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	170,449	40	7,881,607		7,881,607	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			13,339		13,339	190
194 PHILANTHROPY DEVELOPMENT			4,835		4,835	194
194.01 VENDING			8,158		8,158	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR			149,102		149,102	194.03

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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
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	170,449	40	8,057,041		8,057,041 202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	313,268					1
2 CAP REL COSTS-MVBLE EQUIP		7,949,084				2
4 EMPLOYEE BENEFITS DEPARTMENT	783		32,166,209			4
5 ADMINISTRATIVE & GENERAL	83,378	1,259,701	3,840,464	-18,601,724	74,409,538	5
6 MAINTENANCE & REPAIRS	4,416	17,680	597,915		1,340,609	6
7 OPERATION OF PLANT	50,130	2,620,283	155,860		3,693,199	7
8 LAUNDRY & LINEN SERVICE	3,161	3,227	83,516		642,853	8
9 HOUSEKEEPING	3,409	3,149	640,250		1,243,859	9
10 DIETARY	4,608	17,875	257,888		521,879	10
11 CAFETERIA	1,612	5,590	501,059		1,012,581	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,686	5,747	657,675		1,004,561	13
14 CENTRAL SERVICES & SUPPLY	6,056				58,770	14
15 PHARMACY	3,720	255,629	1,235,501		2,098,691	15
16 MEDICAL RECORDS & LIBRARY	2,720	19,850	2,257,873		4,175,398	16
17 SOCIAL SERVICE					1,862	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	40,518	205,507	6,206,571		9,733,657	30
31 INTENSIVE CARE UNIT	4,281	151,097	1,240,584		1,988,101	31
43 NURSERY	797	4,941			30,428	43
44 SKILLED NURSING FACILITY	5,974	1,945	707,977		1,120,508	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	29,494	955,581	3,325,101		14,582,872	50
52 DELIVERY ROOM & LABOR ROOM	4,678	4,925	141,622		340,075	52
53 ANESTHESIOLOGY	196	131,711	1,313,981		2,395,179	53
54 RADIOLOGY-DIAGNOSTIC	12,415	900,184	1,510,776		3,595,073	54
54.01 ULTRASOUND	430		167,263		302,987	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	2,431	57,239	218,398		757,623	54.02
54.04 RADIATION ONC		1,091			54,843	54.04
54.06 PET SCAN	200				156,361	54.06
57 CT SCAN	1,401	192,164	223,036		1,002,583	57
58 MRI	4,980	282,485	179,566		786,743	58
59 CARDIAC CATHETERIZATION	1,852	383,710	182,947		687,674	59
60 LABORATORY	7,341	188,890	1,199,642		4,302,848	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	675	66,431	791,521		1,281,481	65
66 PHYSICAL THERAPY	4,627	30,021	966,344		1,498,032	66
67 OCCUPATIONAL THERAPY	707		182,944		298,070	67
69 ELECTROCARDIOLOGY	3,008		460,294		812,272	69
70 ELECTROENCEPHALOGRAPHY	683	7,712	124,853		226,434	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					1,376,992	71
73 DRUGS CHARGED TO PATIENTS					2,763,656	73
74 RENAL DIALYSIS	149				45,224	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	381	85,043	172,035		354,292	76.01
76.02 CARDIAC REHAB	808	1,709	70,623		112,760	76.02
76.03 WOUND CARE	4,457	23,154	204,780		953,058	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	9,269	39,511	1,424,239		2,286,382	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	1,338	25,018	831,669		1,435,236	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	308,769	7,948,800	32,074,767	-18,601,724	71,075,706	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	553	284			27,015	190
194 PHILANTHROPY DEVELOPMENT	212		91,442	153		194
194.01 VENDING	160				1,437	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	3,574				3,305,380	194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,813,558	5,243,483	14,516,164		18,601,724	202
203	UNIT COST MULT-WS B PT I	8.981313	0.659634	0.451286		0.249991	203
204	COST TO BE ALLOC PER B PT II			7,032		1,580,628	204
205	UNIT COST MULT-WS B PT II			0.000219		0.021242	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS MAINT. HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & 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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	9,266					6
7 OPERATION OF PLANT	3,264	174,561				7
8 LAUNDRY & LINEN SERVICE	75	3,161	844,880			8
9 HOUSEKEEPING	141	3,409		1,512,074		9
10 DIETARY	248	4,608	5,538	42,382	76,978	10
11 CAFETERIA	2	1,612		14,825		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	95	1,686		15,501		13
14 CENTRAL SERVICES & SUPPLY		6,056		55,695		14
15 PHARMACY	125	3,720		34,207		15
16 MEDICAL RECORDS & LIBRARY	76	2,720		25,014		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	876	40,518	354,741	372,633	64,920	30
31 INTENSIVE CARE UNIT	460	4,281	34,179	39,371		31
43 NURSERY	121	797		7,330		43
44 SKILLED NURSING FACILITY	133	5,974	39,104	54,941	9,955	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,365	29,494	205,345	271,250		50
52 DELIVERY ROOM & LABOR ROOM	364	4,678		43,022		52
53 ANESTHESIOLOGY	85	196		1,803		53
54 RADIOLOGY-DIAGNOSTIC	382	12,415	30,859	114,174		54
54.01 ULTRASOUND		430	3,501	3,955		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	40	2,431	3,101	22,357		54.02
54.04 RADIATION ONC	6					54.04
54.06 PET SCAN		200		1,839		54.06
57 CT SCAN		1,401	8,898	12,885		57
58 MRI	1	4,980	18,275	45,800		58
59 CARDIAC CATHETERIZATION	56	1,852		17,032		59
60 LABORATORY	202	7,341	568	67,510		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	312	675	12,549	6,206		65
66 PHYSICAL THERAPY	182	4,627	4,581	42,555		66
67 OCCUPATIONAL THERAPY	12	707	987	6,502		67
69 ELECTROCARDIOLOGY	120	3,008	3,789	27,659		69
70 ELECTROENCEPHALOGRAPHY		683	98	6,281		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS		149		1,370		74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	4	381	577	3,504		76.01
76.02 CARDIAC REHAB	30	808	685	7,429		76.02
76.03 WOUND CARE	72	4,457	6,842	40,990		76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	319	9,269		85,240		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		1,338	109,630	12,305		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	9,168	170,062	843,847	1,503,567	74,875	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	553		5,086		190
194 PHILANTHROPY DEVELOPMENT		212		1,950		194
194.01 VENDING	96	160	1,033	1,471	2,103	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR		3,574				194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAIN- TENANCE & REPAIRS MAINT. HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & 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	1,675,749	5,206,755	911,409	1,681,996	887,760	202
203	UNIT COST MULT-WS B PT I	180.849234	29.827711	1.078744	1.112377	11.532646	203
204	COST TO BE ALLOC PER B PT II	79,931	2,285,298	86,222	105,102	130,295	204
205	UNIT COST MULT-WS B PT II	8.626268	13.091687	0.102052	0.069509	1.692626	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
	MEALS SERVED	ADMINIS- TRATION DIRECT NRSING HRS	SERVICES & SUPPLY COSTED REQUIS.	COSTED REQUIS.	RECORDS & LIBRARY TIME SPENT	
	11	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						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	118,659					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,828	549,733				13
14 CENTRAL SERVICES & SUPPLY			13,419,931			14
15 PHARMACY	3,866		8,346	3,204,604		15
16 MEDICAL RECORDS & LIBRARY	10,986				10,000	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	30,498	251,166	193,158	14,179	7,867	30
31 INTENSIVE CARE UNIT	5,147	42,383	34,219	2,038	811	31
43 NURSERY			14,465			43
44 SKILLED NURSING FACILITY	3,556	29,284	18,317	1,082	1,322	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,564	136,433	10,108,338	2,811		50
52 DELIVERY ROOM & LABOR ROOM			79,836			52
53 ANESTHESIOLOGY	1,912		45,904	65,578		53
54 RADIOLOGY-DIAGNOSTIC	7,677		114,700	4,929		54
54.01 ULTRASOUND	629		23,246			54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	831		2,376	285,885		54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 CT SCAN	1,020		32,901			57
58 MRI	904		58,465			58
59 CARDIAC CATHETERIZATION			72,594	64		59
60 LABORATORY	6,831		788,846	64		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	4,457		75,115	11		65
66 PHYSICAL THERAPY	3,730					66
67 OCCUPATIONAL THERAPY	662		24,617			67
69 ELECTROCARDIOLOGY	3,705		20,994	564		69
70 ELECTROENCEPHALOGRAPHY	631		18,301	418		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			1,377,950	91		71
73 DRUGS CHARGED TO PATIENTS				2,808,883		73
74 RENAL DIALYSIS			225			74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	737					76.01
76.02 CARDIAC REHAB	278		1,711			76.02
76.03 WOUND CARE	1,220		162,158	13,860		76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	7,255	59,700	77,180	4,136		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	3,735	30,767	65,969	11		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	118,659	549,733	13,419,931	3,204,604	10,000	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
194 PHILANTHROPY DEVELOPMENT						194
194.01 VENDING						194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR						194.03

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COST ALLOCATION - STATISTICAL BASIS

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COST CENTER DESCRIPTION		CAFETERIA	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	
		MEALS SERVED					
		11	13	14	15	16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,330,652	1,360,905	316,053	2,838,512	5,465,109	202
203	UNIT COST MULT-WS B PT I	11.214084	2.475575	0.023551	0.885761	546.510900	203
204	COST TO BE ALLOC PER B PT II	61,935	65,339	138,793	301,144	170,449	204
205	UNIT COST MULT-WS B PT II	0.521958	0.118856	0.010342	0.093972	17.044900	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 DEPARTMENT			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	10,000		17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SERVICES-SALARY & FRINGES APPRVD			21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	7,867		30
31 INTENSIVE CARE UNIT	811		31
43 NURSERY			43
44 SKILLED NURSING FACILITY	1,322		44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
52 DELIVERY ROOM & LABOR ROOM			52
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC			54
54.01 ULTRASOUND			54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC			54.02
54.04 RADIATION ONC			54.04
54.06 PET SCAN			54.06
57 CT SCAN			57
58 MRI			58
59 CARDIAC CATHETERIZATION			59
60 LABORATORY			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
67 OCCUPATIONAL THERAPY			67
69 ELECTROCARDIOLOGY			69
70 ELECTROENCEPHALOGRAPHY			70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			71
73 DRUGS CHARGED TO PATIENTS			73
74 RENAL DIALYSIS			74
76 BACTERIOLOGY & MICROBIOLOGY			76
76.01 VASCULAR LAB			76.01
76.02 CARDIAC REHAB			76.02
76.03 WOUND CARE			76.03
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
91 EMERGENCY			91
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
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			101
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	10,000		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
194 PHILANTHROPY DEVELOPMENT			194
194.01 VENDING			194.01
194.02 MEALS ON WHEELS			194.02
194.03 PRAIRIE CARDIOVASCULAR			194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	TIME SPENT	
200 CROSS FOOT ADJUSTMENTS		17	200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I		2,327	202
203 UNIT COST MULT-WS B PT I		0.232700	203
204 COST TO BE ALLOC PER B PT II		40	204
205 UNIT COST MULT-WS B PT II		0.004000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	20,361,975		20,361,975		20,361,975	30
31 INTENSIVE CARE UNIT	3,385,317		3,385,317		3,385,317	31
43 NURSERY	92,186		92,186		92,186	43
44 SKILLED NURSING FACILITY	2,657,530		2,657,530		2,657,530	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	20,642,363		20,642,363		20,642,363	50
52 DELIVERY ROOM & LABOR ROOM	680,191		680,191		680,191	52
53 ANESTHESIOLOGY	3,097,784		3,097,784		3,097,784	53
54 RADIOLOGY-DIAGNOSTIC	5,186,656		5,186,656		5,186,656	54
54.01 ULTRASOUND	407,334		407,334		407,334	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	1,317,582		1,317,582		1,317,582	54.02
54.04 RADIATION ONC	69,638		69,638		69,638	54.04
54.06 PET SCAN	203,462		203,462		203,462	54.06
57 CT SCAN	1,331,154		1,331,154		1,331,154	57
58 MRI	1,214,321		1,214,321		1,214,321	58
59 CARDIAC CATHETERIZATION	945,668		945,668		945,668	59
60 LABORATORY	5,804,966		5,804,966		5,804,966	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,750,599		1,750,599		1,750,599	65
66 PHYSICAL THERAPY	2,137,563		2,137,563		2,137,563	66
67 OCCUPATIONAL THERAPY	412,145		412,145		412,145	67
69 ELECTROCARDIOLOGY	1,204,153		1,204,153		1,204,153	69
70 ELECTROENCEPHALOGRAPHY	318,382		318,382		318,382	70
71 MEDICAL SUPPLIES CHARGED TO	1,753,761		1,753,761		1,753,761	71
73 DRUGS CHARGED TO PATIENTS	5,942,541		5,942,541		5,942,541	73
74 RENAL DIALYSIS	62,503		62,503		62,503	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	467,734		467,734		467,734	76.01
76.02 CARDIAC REHAB	182,636		182,636		182,636	76.02
76.03 WOUND CARE	1,420,031		1,420,031		1,420,031	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	3,521,572		3,521,572		3,521,572	91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	2,002,144		2,002,144		2,002,144	92
94 HOME PROGRAM DIALYSIS						94
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	2,085,507		2,085,507		2,085,507	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	90,659,398		90,659,398		90,659,398	200
201 LESS OBSERVATION BEDS	2,002,144		2,002,144		2,002,144	201
202 TOTAL (SEE INSTRUCTIONS)	88,657,254		88,657,254		88,657,254	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	13,258,858		13,258,858			30
31 INTENSIVE CARE UNIT	3,206,812		3,206,812			31
43 NURSERY	1,023,543		1,023,543			43
44 SKILLED NURSING FACILITY	905,054		905,054			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	29,061,054	27,839,328	56,900,382	0.362781	0.362781	0.362781 50
52 DELIVERY ROOM & LABOR ROOM	1,881,370	290,213	2,171,583	0.313224	0.313224	0.313224 52
53 ANESTHESIOLOGY	1,963,794	3,638,872	5,602,666	0.552912	0.552912	0.552912 53
54 RADIOLOGY-DIAGNOSTIC	2,470,004	15,012,845	17,482,849	0.296671	0.296671	0.296671 54
54.01 ULTRASOUND	368,636	2,427,388	2,796,024	0.145683	0.145683	0.145683 54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	1,084,136	10,689,016	11,773,152	0.111914	0.111914	0.111914 54.02
54.04 RADIATION ONC	25,222	2,130	27,352	2.545993	2.545993	2.545993 54.04
54.06 PET SCAN	66,712	729,659	796,371	0.255486	0.255486	0.255486 54.06
57 CT SCAN	5,114,556	21,394,890	26,509,446	0.050214	0.050214	0.050214 57
58 MRI	1,152,695	15,651,613	16,804,308	0.072262	0.072262	0.072262 58
59 CARDIAC CATHETERIZATION	265,521	1,811,254	2,076,775	0.455354	0.455354	0.455354 59
60 LABORATORY	8,377,111	12,065,025	20,442,136	0.283971	0.283971	0.283971 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	4,323,974	906,452	5,230,426	0.334695	0.334695	0.334695 65
66 PHYSICAL THERAPY	1,367,586	1,349,709	2,717,295	0.786651	0.786651	0.786651 66
67 OCCUPATIONAL THERAPY	352,211	199,744	551,955	0.746700	0.746700	0.746700 67
69 ELECTROCARDIOLOGY	1,929,798	9,545,651	11,475,449	0.104933	0.104933	0.104933 69
70 ELECTROENCEPHALOGRAPHY	229,786	1,459,035	1,688,821	0.188523	0.188523	0.188523 70
71 MEDICAL SUPPLIES CHARGED TO	7,622,964	7,351,932	14,974,896	0.117113	0.117113	0.117113 71
73 DRUGS CHARGED TO PATIENTS	16,760,642	7,941,752	24,702,394	0.240565	0.240565	0.240565 73
74 RENAL DIALYSIS	98,668	3,600	102,268	0.611169	0.611169	0.611169 74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	315,686	1,476,070	1,791,756	0.261048	0.261048	0.261048 76.01
76.02 CARDIAC REHAB	874	305,333	306,207	0.596446	0.596446	0.596446 76.02
76.03 WOUND CARE	18,292	4,474,724	4,493,016	0.316053	0.316053	0.316053 76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,658,869	12,296,196	14,955,065	0.235477	0.235477	0.235477 91
92 OBSERVATION BEDS (NON-DISTI	61,872	2,642,444	2,704,316	0.740351	0.740351	0.740351 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		1,589,285	1,589,285			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	105,966,300	163,094,160	269,060,460			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	105,966,300	163,094,160	269,060,460			202

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
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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.1 MINUS COL.2)	(COL.3 + COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,600,788		1,600,788	77.84	11,987	933,068	30
31 INTENSIVE CARE UNIT	268,956		268,956	140.67	1,431	201,299	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	23,201		23,201	14.85			43
44 SKILLED NURSING FACILITY	211,077		211,077	67.72	2,902	196,523	44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	2,104,022		2,104,022		16,320	1,330,890	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] [] []	HOSPITAL (14-0032) IPF IRF	[] [] []	SUB (OTHER)	[XX] []	PPS TEFRA
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,773,129	56,900,382	0.031162	16,609,684	517,591	50
52	DELIVERY ROOM & LABOR ROOM	120,718	2,171,583	0.055590	46,338	2,576	52
53	ANESTHESIOLOGY	150,866	5,602,666	0.026928	986,043	26,552	53
54	RADIOLOGY-DIAGNOSTIC	964,562	17,482,849	0.055172	1,767,543	97,519	54
54.01	ULTRASOUND	17,164	2,796,024	0.006139	195,857	1,202	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	137,097	11,773,152	0.011645	705,382	8,214	54.02
54.04	RADIATION ONC	1,937	27,352	0.070817	25,222	1,786	54.04
54.06	PET SCAN	7,863	796,371	0.009874	38,828	383	54.06
57	CT SCAN	181,704	26,509,446	0.006854	3,385,597	23,205	57
58	MRI	319,147	16,804,308	0.018992	807,758	15,341	58
59	CARDIAC CATHETERIZATION	311,059	2,076,775	0.149780	143,265	21,458	59
60	LABORATORY	396,523	20,442,136	0.019397	6,240,066	121,039	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	93,620	5,230,426	0.017899	2,817,216	50,425	65
66	PHYSICAL THERAPY	160,911	2,717,295	0.059217	787,451	46,630	66
67	OCCUPATIONAL THERAPY	23,236	551,955	0.042098	189,856	7,993	67
69	ELECTROCARDIOLOGY	89,300	11,475,449	0.007782	1,168,007	9,089	69
70	ELECTROENCEPHALOGRAPHY	26,004	1,688,821	0.015398	119,776	1,844	70
71	MEDICAL SUPPLIES CHARGED TO P	43,510	14,974,896	0.002906	4,089,674	11,885	71
73	DRUGS CHARGED TO PATIENTS	322,664	24,702,394	0.013062	10,775,232	140,746	73
74	RENAL DIALYSIS	4,347	102,268	0.042506	95,909	4,077	74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	72,794	1,791,756	0.040627	203,707	8,276	76.01
76.02	CARDIAC REHAB	22,380	306,207	0.073088	395	29	76.02
76.03	WOUND CARE	141,727	4,493,016	0.031544	4,529	143	76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	300,284	14,955,065	0.020079	1,830,950	36,764	91
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	157,403	2,704,316	0.058204	34,493	2,008	92
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	5,839,949	249,076,908		53,068,778	1,156,775	200

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
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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	20,564		11,987		30
31 INTENSIVE CARE UNIT	1,912		1,431		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	1,562				43
44 SKILLED NURSING FACILITY	3,117		2,902		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	27,155		16,320		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0032) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 ULTRASOUND						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC						54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 CT SCAN						57
58 MRI						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB						76.01
76.02 CARDIAC REHAB						76.02
76.03 WOUND CARE						76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
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 (14-0032)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	56,900,382		16,609,684		12,680,517	50
52	DELIVERY ROOM & LABOR ROOM	2,171,583		46,338			52
53	ANESTHESIOLOGY	5,602,666		986,043		1,311,099	53
54	RADIOLOGY-DIAGNOSTIC	17,482,849		1,767,543		2,894,794	54
54.01	ULTRASOUND	2,796,024		195,857		804,083	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	11,773,152		705,382		5,464,573	54.02
54.04	RADIATION ONC	27,352		25,222		2,130	54.04
54.06	PET SCAN	796,371		38,828		281,504	54.06
57	CT SCAN	26,509,446		3,385,597		7,778,518	57
58	MRI	16,804,308		807,758		5,510,670	58
59	CARDIAC CATHETERIZATION	2,076,775		143,265		986,729	59
60	LABORATORY	20,442,136		6,240,066		869,654	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	5,230,426		2,817,216		290,303	65
66	PHYSICAL THERAPY	2,717,295		787,451		4,838	66
67	OCCUPATIONAL THERAPY	551,955		189,856		7,507	67
69	ELECTROCARDIOLOGY	11,475,449		1,168,007		2,844,966	69
70	ELECTROENCEPHALOGRAPHY	1,688,821		119,776		476,238	70
71	MEDICAL SUPPLIES CHARGED TO	14,974,896		4,089,674		2,829,594	71
73	DRUGS CHARGED TO PATIENTS	24,702,394		10,775,232		5,131,002	73
74	RENAL DIALYSIS	102,268		95,909		1,800	74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	1,791,756		203,707		844,031	76.01
76.02	CARDIAC REHAB	306,207		395		187,317	76.02
76.03	WOUND CARE	4,493,016		4,529		842,471	76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	14,955,065		1,830,950		3,194,566	91
92	OBSERVATION BEDS (NON-DISTIN	2,704,316		34,493		1,344,451	92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	249,076,908		53,068,778		56,583,355	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0032) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.362781	12,680,517			4,600,251		50
52 DELIVERY ROOM & LABOR ROOM	0.313224						52
53 ANESTHESIOLOGY	0.552912	1,311,099			724,922		53
54 RADIOLOGY-DIAGNOSTIC	0.296671	2,894,794			858,801		54
54.01 ULTRASOUND	0.145683	804,083			117,141		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.111914	5,464,573			611,562		54.02
54.04 RADIATION ONC	2.545993	2,130			5,423		54.04
54.06 PET SCAN	0.255486	281,504			71,920		54.06
57 CT SCAN	0.050214	7,778,518			390,591		57
58 MRI	0.072262	5,510,670			398,212		58
59 CARDIAC CATHETERIZATION	0.455354	986,729			449,311		59
60 LABORATORY	0.283971	869,654			246,957		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.334695	290,303			97,163		65
66 PHYSICAL THERAPY	0.786651	4,838			3,806		66
67 OCCUPATIONAL THERAPY	0.746700	7,507			5,605		67
69 ELECTROCARDIOLOGY	0.104933	2,844,966			298,531		69
70 ELECTROENCEPHALOGRAPHY	0.188523	476,238			89,782		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.117113	2,829,594			331,382		71
73 DRUGS CHARGED TO PATIENTS	0.240565	5,131,002			1,234,339		73
74 RENAL DIALYSIS	0.611169	1,800			1,100		74
76 BACTERIOLOGY & MICROBIOLOGY							76
76.01 VASCULAR LAB	0.261048	844,031			220,333		76.01
76.02 CARDIAC REHAB	0.596446	187,317			111,724		76.02
76.03 WOUND CARE	0.316053	842,471			266,265		76.03
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.235477	3,194,566			752,247		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.740351	1,344,451			995,366		92
HOME PROGRAM DIALYSIS							
200 SUBTOTAL (SEE INSTRUCTIONS)		56,583,355			12,882,734		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		56,583,355			12,882,734		202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5940) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 ULTRASOUND						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC						54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 CT SCAN						57
58 MRI						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB						76.01
76.02 CARDIAC REHAB						76.02
76.03 WOUND CARE						76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
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 (14-5940)		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	56,900,382		17,248			50
52	DELIVERY ROOM & LABOR ROOM	2,171,583					52
53	ANESTHESIOLOGY	5,602,666		1,553			53
54	RADIOLOGY-DIAGNOSTIC	17,482,849		37,973			54
54.01	ULTRASOUND	2,796,024		7,343			54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	11,773,152		1,121			54.02
54.04	RADIATION ONC	27,352					54.04
54.06	PET SCAN	796,371					54.06
57	CT SCAN	26,509,446		4,400			57
58	MRI	16,804,308					58
59	CARDIAC CATHETERIZATION	2,076,775					59
60	LABORATORY	20,442,136		271,903			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	5,230,426		278,915			65
66	PHYSICAL THERAPY	2,717,295		271,600			66
67	OCCUPATIONAL THERAPY	551,955		80,626			67
69	ELECTROCARDIOLOGY	11,475,449		8,979			69
70	ELECTROENCEPHALOGRAPHY	1,688,821		2,250			70
71	MEDICAL SUPPLIES CHARGED TO	14,974,896		69,920			71
73	DRUGS CHARGED TO PATIENTS	24,702,394		1,139,867			73
74	RENAL DIALYSIS	102,268					74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	1,791,756		14,167			76.01
76.02	CARDIAC REHAB	306,207					76.02
76.03	WOUND CARE	4,493,016		87			76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	14,955,065					91
92	OBSERVATION BEDS (NON-DISTIN OTHER REIMBURSABLE COST CENTERS	2,704,316					92
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	249,076,908		2,207,952			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 (14-5940) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.362781						50
52 DELIVERY ROOM & LABOR ROOM	0.313224						52
53 ANESTHESIOLOGY	0.552912						53
54 RADIOLOGY-DIAGNOSTIC	0.296671						54
54.01 ULTRASOUND	0.145683						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.111914						54.02
54.04 RADIATION ONC	2.545993						54.04
54.06 PET SCAN	0.255486						54.06
57 CT SCAN	0.050214						57
58 MRI	0.072262						58
59 CARDIAC CATHETERIZATION	0.455354						59
60 LABORATORY	0.283971						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.334695						65
66 PHYSICAL THERAPY	0.786651						66
67 OCCUPATIONAL THERAPY	0.746700						67
69 ELECTROCARDIOLOGY	0.104933						69
70 ELECTROENCEPHALOGRAPHY	0.188523						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.117113						71
73 DRUGS CHARGED TO PATIENTS	0.240565						73
74 RENAL DIALYSIS	0.611169						74
76 BACTERIOLOGY & MICROBIOLOGY							76
76.01 VASCULAR LAB	0.261048						76.01
76.02 CARDIAC REHAB	0.596446						76.02
76.03 WOUND CARE	0.316053						76.03
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.235477						91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.740351						92
HOME PROGRAM DIALYSIS							
94							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
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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 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	1,600,788		1,600,788	20,564	77.84	2,729	212,425	30
31 INTENSIVE CARE UNIT	268,956		268,956	1,912	140.67	221	31,088	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	23,201		23,201	1,562	14.85	1,169	17,360	43
44 SKILLED NURSING FACILITY	211,077		211,077	3,117	67.72			44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	2,104,022		2,104,022	27,155		4,119	260,873	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0032) [] IPF [] IRF	[] SUB (OTHER)	[] PPS [] TEFRA [XX] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,773,129	56,900,382	0.031162	1,478,259	46,066	50
52	DELIVERY ROOM & LABOR ROOM	120,718	2,171,583	0.055590	1,232,914	68,538	52
53	ANESTHESIOLOGY	150,866	5,602,666	0.026928	250,619	6,749	53
54	RADIOLOGY-DIAGNOSTIC	964,562	17,482,849	0.055172	249,395	13,760	54
54.01	ULTRASOUND	17,164	2,796,024	0.006139	70,710	434	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	137,097	11,773,152	0.011645	113,739	1,324	54.02
54.04	RADIATION ONC	1,937	27,352	0.070817			54.04
54.06	PET SCAN	7,863	796,371	0.009874	14,089	139	54.06
57	CT SCAN	181,704	26,509,446	0.006854	600,515	4,116	57
58	MRI	319,147	16,804,308	0.018992	142,084	2,698	58
59	CARDIAC CATHETERIZATION	311,059	2,076,775	0.149780	31,025	4,647	59
60	LABORATORY	396,523	20,442,136	0.019397	1,225,370	23,769	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	93,620	5,230,426	0.017899	408,693	7,315	65
66	PHYSICAL THERAPY	160,911	2,717,295	0.059217	52,104	3,085	66
67	OCCUPATIONAL THERAPY	23,236	551,955	0.042098	12,002	505	67
69	ELECTROCARDIOLOGY	89,300	11,475,449	0.007782	182,402	1,419	69
70	ELECTROENCEPHALOGRAPHY	26,004	1,688,821	0.015398	900	14	70
71	MEDICAL SUPPLIES CHARGED TO P	43,510	14,974,896	0.002906	1,126,243	3,273	71
73	DRUGS CHARGED TO PATIENTS	322,664	24,702,394	0.013062	2,247,360	29,355	73
74	RENAL DIALYSIS	4,347	102,268	0.042506			74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	72,794	1,791,756	0.040627	21,883	889	76.01
76.02	CARDIAC REHAB	22,380	306,207	0.073088			76.02
76.03	WOUND CARE	141,727	4,493,016	0.031544			76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	300,284	14,955,065	0.020079	311,231	6,249	91
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	157,403	2,704,316	0.058204	15,392	896	92
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	5,839,949	249,076,908		9,786,929	225,240	200

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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	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	20,564		2,729		30
31 INTENSIVE CARE UNIT	1,912		221		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	1,562		1,169		43
44 SKILLED NURSING FACILITY	3,117				44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	27,155		4,119		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK TITLE V HOSPITAL (14-0032) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX IRF NF OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 ULTRASOUND						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC						54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 CT SCAN						57
58 MRI						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB						76.01
76.02 CARDIAC REHAB						76.02
76.03 WOUND CARE						76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
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 (14-0032)	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[XX] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES (COL. 9 x COL. 12)	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 13)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	56,900,382		1,478,259			50
52	DELIVERY ROOM & LABOR ROOM	2,171,583		1,232,914			52
53	ANESTHESIOLOGY	5,602,666		250,619			53
54	RADIOLOGY-DIAGNOSTIC	17,482,849		249,395			54
54.01	ULTRASOUND	2,796,024		70,710			54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	11,773,152		113,739			54.02
54.04	RADIATION ONC	27,352					54.04
54.06	PET SCAN	796,371		14,089			54.06
57	CT SCAN	26,509,446		600,515			57
58	MRI	16,804,308		142,084			58
59	CARDIAC CATHETERIZATION	2,076,775		31,025			59
60	LABORATORY	20,442,136		1,225,370			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	5,230,426		408,693			65
66	PHYSICAL THERAPY	2,717,295		52,104			66
67	OCCUPATIONAL THERAPY	551,955		12,002			67
69	ELECTROCARDIOLOGY	11,475,449		182,402			69
70	ELECTROENCEPHALOGRAPHY	1,688,821		900			70
71	MEDICAL SUPPLIES CHARGED TO	14,974,896		1,126,243			71
73	DRUGS CHARGED TO PATIENTS	24,702,394		2,247,360			73
74	RENAL DIALYSIS	102,268					74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	1,791,756		21,883			76.01
76.02	CARDIAC REHAB	306,207					76.02
76.03	WOUND CARE	4,493,016					76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	14,955,065		311,231			91
92	OBSERVATION BEDS (NON-DISTIN	2,704,316		15,392			92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	249,076,908		9,786,929			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0032) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.362781		5,486,584			1,990,428		50
52 DELIVERY ROOM & LABOR ROOM	0.313224		266,787			83,564		52
53 ANESTHESIOLOGY	0.552912		744,454			411,618		53
54 RADIOLOGY-DIAGNOSTIC	0.296671		3,480,597			1,032,592		54
54.01 ULTRASOUND	0.145683		819,426			119,376		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.111914		892,482			99,881		54.02
54.04 RADIATION ONC	2.545993							54.04
54.06 PET SCAN	0.255486		288,831			73,792		54.06
57 CT SCAN	0.050214		5,052,170			253,690		57
58 MRI	0.072262		3,915,028			282,908		58
59 CARDIAC CATHETERIZATION	0.455354		174,600			79,505		59
60 LABORATORY	0.283971		3,534,299			1,003,638		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.334695		193,747			64,846		65
66 PHYSICAL THERAPY	0.786651		330,376			259,891		66
67 OCCUPATIONAL THERAPY	0.746700		50,220			37,499		67
69 ELECTROCARDIOLOGY	0.104933		930,563			97,647		69
70 ELECTROENCEPHALOGRAPHY	0.188523		570,121			107,481		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.117113		1,712,454			200,551		71
73 DRUGS CHARGED TO PATIENTS	0.240565		1,591,569			382,876		73
74 RENAL DIALYSIS	0.611169							74
76 BACTERIOLOGY & MICROBIOLOGY								76
76.01 VASCULAR LAB	0.261048		127,652			33,323		76.01
76.02 CARDIAC REHAB	0.596446		6,539			3,900		76.02
76.03 WOUND CARE	0.316053		574,687			181,632		76.03
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.235477		6,286,400			1,480,303		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.740351		475,318			351,902		92
94 HOME PROGRAM DIALYSIS								94
200 SUBTOTAL (SEE INSTRUCTIONS)			37,504,904			8,632,843		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			37,504,904			8,632,843		202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0032) [] 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)	20,564	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	20,564	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	18,542	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)	11,987	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)	20,361,975	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	20,361,975	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	20,361,975	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0032) [] 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) 990.18 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 11,869,288 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) 11,869,288 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	3,385,317	1,912	1,770.56	1,431	2,533,671	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)					14,847,492	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					29,250,451	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 1,134,367 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 1,156,775 51
 52 TOTAL PROGRAM EXCLUDABLE COST 2,291,142 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 26,959,309 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) 2,022 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 990.18 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 2,002,144 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	1,600,788	20,361,975	0.078617	2,002,144	157,403	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5940) [] 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)	3,117	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,117	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	743	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,374	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,902	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)	743	14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,657,530	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,657,530	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	593,608	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	241,175	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	352,433	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	4.476911	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	324.60	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	148.46	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	176.14	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	788.56	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	585,900	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,071,630	37

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/29/2013 11:29

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 (14-5940) [] TEFRA
BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,071,630	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	664.62	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	1,928,727	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)	585,900	73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	2,514,627	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	2,514,627	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	751,710	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	3,266,337	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0032) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	20,564	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	20,564	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	18,542	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,729	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)	1,562	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	1,169	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)	20,361,975	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	20,361,975	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	20,361,975	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0032) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 990.18 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,702,201 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 2,702,201 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)	92,186	1,562	59.02	1,169	68,994 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	3,385,317	1,912	1,770.56	221	391,294 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)					2,533,146 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					5,695,635 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 260,873 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 225,240 51
 52 TOTAL PROGRAM EXCLUDABLE COST 486,113 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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) 2,022 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	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 (14-0032) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		8,351,663			30
31 INTENSIVE CARE UNIT		2,389,525			31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.362781	16,609,684	6,025,678		50
52 DELIVERY ROOM & LABOR ROOM	0.313224	46,338	14,514		52
53 ANESTHESIOLOGY	0.552912	986,043	545,195		53
54 RADIOLOGY-DIAGNOSTIC	0.296671	1,767,543	524,379		54
54.01 ULTRASOUND	0.145683	195,857	28,533		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.111914	705,382	78,942		54.02
54.04 RADIATION ONC	2.545993	25,222	64,215		54.04
54.06 PET SCAN	0.255486	38,828	9,920		54.06
57 CT SCAN	0.050214	3,385,597	170,004		57
58 MRI	0.072262	807,758	58,370		58
59 CARDIAC CATHETERIZATION	0.455354	143,265	65,236		59
60 LABORATORY	0.283971	6,240,066	1,771,998		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.334695	2,817,216	942,908		65
66 PHYSICAL THERAPY	0.786651	787,451	619,449		66
67 OCCUPATIONAL THERAPY	0.746700	189,856	141,765		67
69 ELECTROCARDIOLOGY	0.104933	1,168,007	122,562		69
70 ELECTROENCEPHALOGRAPHY	0.188523	119,776	22,581		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.117113	4,089,674	478,954		71
73 DRUGS CHARGED TO PATIENTS	0.240565	10,775,232	2,592,144		73
74 RENAL DIALYSIS	0.611169	95,909	58,617		74
76 BACTERIOLOGY & MICROBIOLOGY					76
76.01 VASCULAR LAB	0.261048	203,707	53,177		76.01
76.02 CARDIAC REHAB	0.596446	395	236		76.02
76.03 WOUND CARE	0.316053	4,529	1,431		76.03
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.235477	1,830,950	431,147		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.740351	34,493	25,537		92
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		53,068,778	14,847,492		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		53,068,778			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5940) [] 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	0.362781	17,248	6,257	50
52 DELIVERY ROOM & LABOR ROOM	0.313224			52
53 ANESTHESIOLOGY	0.552912	1,553	859	53
54 RADIOLOGY-DIAGNOSTIC	0.296671	37,973	11,265	54
54.01 ULTRASOUND	0.145683	7,343	1,070	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.111914	1,121	125	54.02
54.04 RADIATION ONC	2.545993			54.04
54.06 PET SCAN	0.255486			54.06
57 CT SCAN	0.050214	4,400	221	57
58 MRI	0.072262			58
59 CARDIAC CATHETERIZATION	0.455354			59
60 LABORATORY	0.283971	271,903	77,213	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.334695	278,915	93,351	65
66 PHYSICAL THERAPY	0.786651	271,600	213,654	66
67 OCCUPATIONAL THERAPY	0.746700	80,626	60,203	67
69 ELECTROCARDIOLOGY	0.104933	8,979	942	69
70 ELECTROENCEPHALOGRAPHY	0.188523	2,250	424	70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.117113	69,920	8,189	71
73 DRUGS CHARGED TO PATIENTS	0.240565	1,139,867	274,212	73
74 RENAL DIALYSIS	0.611169			74
76 BACTERIOLOGY & MICROBIOLOGY				76
76.01 VASCULAR LAB	0.261048	14,167	3,698	76.01
76.02 CARDIAC REHAB	0.596446			76.02
76.03 WOUND CARE	0.316053	87	27	76.03
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.235477			91
92 OBSERVATION BEDS (NON-DISTINCT)	0.740351			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,207,952	751,710	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,207,952		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0032) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		2,019,446		30
31 INTENSIVE CARE UNIT		322,051		31
43 NURSERY		763,831		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.362781	1,478,259	536,284	50
52 DELIVERY ROOM & LABOR ROOM	0.313224	1,232,914	386,178	52
53 ANESTHESIOLOGY	0.552912	250,619	138,570	53
54 RADIOLOGY-DIAGNOSTIC	0.296671	249,395	73,988	54
54.01 ULTRASOUND	0.145683	70,710	10,301	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.111914	113,739	12,729	54.02
54.04 RADIATION ONC	2.545993			54.04
54.06 PET SCAN	0.255486	14,089	3,600	54.06
57 CT SCAN	0.050214	600,515	30,154	57
58 MRI	0.072262	142,084	10,267	58
59 CARDIAC CATHETERIZATION	0.455354	31,025	14,127	59
60 LABORATORY	0.283971	1,225,370	347,970	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.334695	408,693	136,788	65
66 PHYSICAL THERAPY	0.786651	52,104	40,988	66
67 OCCUPATIONAL THERAPY	0.746700	12,002	8,962	67
69 ELECTROCARDIOLOGY	0.104933	182,402	19,140	69
70 ELECTROENCEPHALOGRAPHY	0.188523	900	170	70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.117113	1,126,243	131,898	71
73 DRUGS CHARGED TO PATIENTS	0.240565	2,247,360	540,636	73
74 RENAL DIALYSIS	0.611169			74
76 BACTERIOLOGY & MICROBIOLOGY				76
76.01 VASCULAR LAB	0.261048	21,883	5,713	76.01
76.02 CARDIAC REHAB	0.596446			76.02
76.03 WOUND CARE	0.316053			76.03
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.235477	311,231	73,288	91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0.740351	15,392	11,395	92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		9,786,929	2,533,146	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		9,786,929		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0032)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	22,116,189	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	247,221	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)	127.46	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)	0.0338	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.1322	31
32	SUM OF LINES 30 AND 31	0.1660	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0366	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	809,453	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)	23,172,863	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	23,172,863	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	1,773,866	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0032)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	24,946,729	59
60	PRIMARY PAYER PAYMENTS	21,735	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	24,924,994	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,623,037	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	31,984	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	493,519	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	345,463	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	449,794	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	22,615,436	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 (SEE INSTRUCTIONS)	22,615,436	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	113,077	71.01
72	INTERIM PAYMENTS	22,130,097	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	372,262	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	212,315	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0032) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER					1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .11 .15 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99				3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.11 3.15 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		21,793,209 336,888		9,878,089 349,179	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		22,130,097		10,227,268	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	485,339		110,057	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		22,615,436		10,337,325	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 (14-5940)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1
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 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .13 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99			NONE 3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.13 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		797,015		
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		797,015		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99			NONE 5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM		3,411	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			800,426	7

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

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/29/2013 11:29

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0032) [] 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	6,139	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	13,418	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	278	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	20,454	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	269,060,460	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20		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)	2,007,461	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	2,031,295	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	-23,834	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	835,110 1
2 ROUTINE SERVICE OTHER PASS THROUGH COSTS	2
3 ANCILLARY SERVICE OTHER PASS THROUGH COSTS	3
4 SUBTOTAL (SUM OF LINES 1-3)	835,110 4
COMPUTATION OF NET COST OF COVERED SERVICES	
5 MEDICAL AND OTHER SERVICES	5
6 DEDUCTIBLES	6
7 COINSURANCE	34,684 7
8 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	8
9 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9
10 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	10
11 UTILIZATION REVIEW	11
12 SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	800,426 12
13 INPATIENT PRIMARY PAYER PAYMENTS	13
14 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	14
15 SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	800,426 15
15.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	4,002 15.01
16 INTERIM PAYMENTS	797,015 16
17 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	17
18 BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS 15.01, 16 AND 17)	-591 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 (14-0032) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1 INPATIENT HOSPITAL SNF/NF SERVICES	5,695,635		1
2 MEDICAL AND OTHER SERVICES		8,632,843	2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	5,695,635	8,632,843	4
5 INPATIENT PRIMARY PAYER PAYMENTS			5
6 OUTPATIENT PRIMARY PAYER PAYMENTS			6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	5,695,635	8,632,843	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8 ROUTINE SERVICE CHARGES			8
9 ANCILLARY SERVICE CHARGES	9,786,929	37,504,904	9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	9,786,929	37,504,904	12
CUSTOMARY CHARGES			
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000	15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	9,786,929	37,504,904	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	4,091,294	28,872,061	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))			18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	5,695,635	8,632,843	21
PROSPECTIVE PAYMENT AMOUNT			
22 OTHER THAN OUTLIER PAYMENTS			22
23 OUTLIER PAYMENTS			23
24 PROGRAM CAPITAL PAYMENTS			24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)			27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)			28
29 SUM OF LINES 27 AND 21	5,695,635	8,632,843	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30 EXCESS OF REASONABLE COST (FROM LINE 18)			30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	5,695,635	8,632,843	31
32 DEDUCTIBLES			32
33 COINSURANCE			33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			34
35 UTILIZATION REVIEW			35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	5,695,635	8,632,843	36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38 SUBTOTAL (LINE 36 ± LINE 37)	5,695,635	8,632,843	38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)			39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	5,695,635	8,632,843	40
41 INTERIM PAYMENTS	5,695,635	8,632,843	41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)			42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	5,921,801			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	46,993,638			4
5	OTHER RECEIVABLES	-49,206			5
6	ALLOWANCE FOR UNCOLLECTIBLE				
	NOTES & ACCOUNTS RECEIVABLE	-28,653,380			6
7	INVENTORY	4,788,025			7
8	PREPAID EXPENSES	239,131			8
9	OTHER CURRENT ASSETS	8,532,984			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	37,772,993			11
FIXED ASSETS					
12	LAND	3,026,627			12
13	LAND IMPROVEMENTS	2,074,344			13
14	ACCUMULATED DEPRECIATION	-1,640,295			14
15	BUILDINGS	78,817,160			15
16	ACCUMULATED DEPRECIATION	-37,342,320			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	68,203,758			19
20	ACCUMULATED DEPRECIATION	-53,099,156			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	60,040,118			30
OTHER ASSETS					
31	INVESTMENTS	249,249,811			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	153,087			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	249,402,898			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	347,216,009			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	5,547,950			37
38	SALARIES, WAGES & FEES PAYABLE				38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	8,054,075			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	13,012,466			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	26,614,491			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	21,337,704			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	10,455,563			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	31,793,267			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	58,407,758			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	288,808,251			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)	288,808,251			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	347,216,009			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		252,143,202							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		32,124,283							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		284,267,485							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 REV. RECOGN. OF MIN. PENSION LIAB		7,386,524							5
6 NET ASSETS RELEASED FROM RESTRICT		275,001							6
7 CHG IN TEMP. RESTRICTED NET ASSET									7
8 PROCEEDS FROM GRANT FOR EQUIP									8
9 PRAIRIE REVENUE									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		7,661,525							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		291,929,010							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 TRANSFER (TO)/FROM AFFILIATES		2,990,150							13
14 REV. RECOGN. OF MIN. PENSION LIAB									14
15 CHG IN TEMP. RESTRICTED NET ASSET		130,609							15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		3,120,759							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		288,808,251							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	16,527,542		16,527,542	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	905,054		905,054	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	17,432,596		17,432,596	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	17,432,596		17,432,596	18
19 ANCILLARY SERVICES	87,510,161		87,510,161	19
20 OUTPATIENT SERVICES		161,504,875	161,504,875	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY		1,589,285	1,589,285	23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER PATIENT REVENUES	1,023,543		1,023,543	28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	105,966,300	163,094,160	269,060,460	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		101,159,591	29
30 PROVISION FOR BAD DEBT	5,238,655		30
31 PRAIRIE			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		5,238,655	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		106,398,246	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	269,060,460	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	150,355,309	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	118,705,151	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	106,398,246	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	12,306,905	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	14,620,520	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	5,683	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	42,899	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	1,800	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	69,336	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (AUXILIARY)	43,533	24
24.01	OTHER (DIABETES INSTRUCTION)	21,974	24.01
24.02	OTHER (HOUSEKEEPING)	50	24.02
24.03	OTHER (PHYSICIAN APPLICATION)	3,100	24.03
24.04	OTHER (RENTAL INCOME-900 W TEMPLE (EMC))	590,442	24.04
24.05	OTHER (RECYCLING)	3,049	24.05
24.06	OTHER (UNCLAIMED PROPERTY)		24.06
24.07	OTHER (PHYSICIAN DUES)	16,000	24.07
24.08	OTHER (PERSONNEL - NAME TAGS)	180	24.08
24.09	OTHER (LIFELINE - HOME CARE)	125	24.09
24.10	OTHER (MEDICAL OFFICE - INHOUSE)		24.10
24.11	OTHER (RENTAL INCOME)	106,514	24.11
24.12	OTHER (HOUSEKEEPING-900 W TEMPLE (EMC))	6,185	24.12
24.13	OTHER (NEUROLOGY - EEG)		24.13
24.14	OTHER (SPIRIT COMMITTEE ACTIVITIES)	23,975	24.14
24.15	OTHER (ASSETS RELEASED FOR OPERATIONS)		24.15
24.16	OTHER (COMMUNITY SERVICES - IN SERVICE)	302	24.16
24.17	OTHER (PATIENT SERVICES)	45	24.17
24.18	OTHER (QUALITY OKLAHOMA STUDY)		24.18
24.19	OTHER (PET SCAN ALLIANCE IMAGING SALARIES)		24.19
24.20	OTHER (RADIATION ONCOLOGY CARLE RN SALARIE)		24.20
24.21	OTHER (RADIATION ONCOLOGY - RN BENEFITS)		24.21
24.22	OTHER (RADIATION ONCOLOGY - RENT)		24.22
24.23	OTHER (ASPR)	30,822	24.23
24.24	OTHER (NUC MED REIMBURSEMENT STUDENT FEES)		24.24
24.25	OTHER (IHA GRANT T1)		24.25
24.26	OTHER (PHYSICAL THERAPY)		24.26
24.27	OTHER (LAB-SURVEILLANCE PROGRAM)	550	24.27
24.28	OTHER (RADIOLOGY FILM/SCRAP)	1,813	24.28
24.29	OTHER (ANESTHESIA LEASE INCOME)	1,805,016	24.29
24.30	OTHER (WOMENS WELLNESS RETAIL)	11,848	24.30
24.31	OTHER (NURSING SERVICE ADMIN)	380	24.31
24.32	OTHER (OCCUPATIONAL THERAPY-IN SERVICE)	4,192	24.32
24.33	OTHER (ADMINISTRATION-MEANINGFUL USE FUNDS)	2,645,965	24.33
24.34	OTHER (ALTAMONT DIAG CTR-MISC)	868	24.34
24.99	OTHER (GAIN/LOSS ON SALE OF FIXED ASSETS)	9,644	24.99
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	20,066,810	25
26	TOTAL (LINE 5 PLUS LINE 25)	32,373,715	26
27	OTHER EXPENSES (GAIN/LOSS ON SALE OF FIXED ASSETS)		27
27.01	OTHER EXPENSES (RENTAL PROPERTIES DEPRECIATION)	137,564	27.01
27.02	OTHER EXPENSES (RENTAL PROPERTIES EXPENSE)	111,868	27.02
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	249,432	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	32,124,283	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7661

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					31,104	31,104 3
4 TRANSPORTATION (SEE INSTRUCTIONS)						4
5 ADMINISTRATIVE AND GENERAL	54,377		203	615	34,163	89,358 5
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	603,227		42,175			645,402 6
7 PHYSICAL THERAPY			7,189			7,189 7
8 OCCUPATIONAL THERAPY	101,607		4,944			106,551 8
9 SPEECH PATHOLOGY			643			643 9
10 MEDICAL SOCIAL SERVICES	12,256		208			12,464 10
11 HOME HEALTH AIDE			12,502			12,502 11
12 SUPPLIES (SEE INSTRUCTIONS)	3,139				65,980	69,119 12
13 DRUGS						13
14 DME	5,062					5,062 14
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						15
16 RESPIRATORY THERAPY	52,001					52,001 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)	831,669		67,864	615	131,247	1,031,395 24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7661

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		31,104		31,104	3
4					4
5		89,358		89,358	5
6					6
7		645,402		645,402	7
8		7,189		7,189	8
9		106,551		106,551	9
10		643		643	10
11		12,464		12,464	11
12		12,502		12,502	12
13		69,119		69,119	13
14					14
15		5,062		5,062	15
16					16
17		52,001		52,001	17
18					18
19					19
20					20
21					21
22					22
23					23
24		1,031,395		1,031,395	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7661

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTER									
1 CAPITAL RELATED-BLDGS & FIXT									1
2 CAPITAL RELATED-MOVABLE EQUIP									2
3 PLANT OPERATION & MAINTENANCE	31,104			31,104					3
4 TRANSPORTATION (SEE INSTR.)									4
5 ADMINISTRATIVE AND GENERAL	89,358			31,104		120,462	120,462		5
HHA REIMBURSABLE SERVICES									
6 SKILLED NURSING CARE	645,402					645,402	85,349	730,751	6
7 PHYSICAL THERAPY	7,189					7,189	951	8,140	7
8 OCCUPATIONAL THERAPY	106,551					106,551	14,090	120,641	8
9 SPEECH PATHOLOGY	643					643	85	728	9
10 MEDICAL SOCIAL SERVICES	12,464					12,464	1,648	14,112	10
11 HOME HEALTH AIDE	12,502					12,502	1,653	14,155	11
12 SUPPLIES (SEE INSTRUCTIONS)	69,119					69,119	9,140	78,259	12
13 DRUGS									13
14 DME	5,062					5,062	669	5,731	14
HHA NONREIMBURSABLE SERVICES									
15 HOME DIALYSIS AIDE SERVICES									15
16 RESPIRATORY THERAPY	52,001					52,001	6,877	58,878	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)	1,031,395			31,104		1,031,395		1,031,395	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7661

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			31,104				3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES			31,104		-120,462	910,933	5
6 SKILLED NURSING CARE						645,402	6
7 PHYSICAL THERAPY						7,189	7
8 OCCUPATIONAL THERAPY						106,551	8
9 SPEECH PATHOLOGY						643	9
10 MEDICAL SOCIAL SERVICES						12,464	10
11 HOME HEALTH AIDE						12,502	11
12 SUPPLIES (SEE INSTRUCTIONS)						69,119	12
13 DRUGS							13
14 DME						5,062	14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY						52,001	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)			31,104		-120,462	910,933	24
25 COST TO BE ALLOC (PER W/S H)			31,104			120,462	25
26 UNIT COST MULTIPLIER			1.000000			0.132240	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7661

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	357,800		357,800			1
2 SKILLED NURSING CARE	1,253,714		1,253,714	259,638	1,513,352	2
3 PHYSICAL THERAPY	67,492		67,492	13,977	81,469	3
4 OCCUPATIONAL THERAPY	157,714		157,714	32,662	190,376	4
5 SPEECH PATHOLOGY	2,681		2,681	555	3,236	5
6 MEDICAL SOCIAL SERVICES	20,495		20,495	4,244	24,739	6
7 HOME HEALTH AIDE	47,027		47,027	9,739	56,766	7
8 SUPPLIES	97,823		97,823	20,259	118,082	8
9 DRUGS						9
10 DME	7,164		7,164	1,484	8,648	10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY	73,597		73,597	15,242	88,839	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)	2,085,507		2,085,507	357,800	2,085,507	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.				0.207095		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7661

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS MAINT. HOURS	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	1,338	25,018		54,377		53,060		1,338	1
2 SKILLED NURSING CARE				603,227		1,002,979			2
3 PHYSICAL THERAPY				101,607		53,994			3
4 OCCUPATIONAL THERAPY				12,256		126,172			4
5 SPEECH PATHOLOGY				3,139		2,145			5
6 MEDICAL SOCIAL SERVICES				5,062		16,396			6
7 HOME HEALTH AIDE				52,001		37,622			7
8 SUPPLIES						78,259			8
9 DRUGS									9
10 DME						5,731			10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY						58,878			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)	1,338	25,018		831,669		1,435,236		1,338	20
21 TOTAL COST TO BE ALLOCATED	12,017	16,503		375,321		358,796		39,909	21
22 UNIT COST MULTIPLIER	8.981315								22
22 UNIT COST MULTIPLIER		0.659645		0.451287		0.249991		29.827354	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7661

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15		
1 ADMINISTRATIVE AND GENERAL	109,630	12,305		3,735		30,767	65,969	11	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)	109,630	12,305		3,735		30,767	65,969	11	20	
21 TOTAL COST TO BE ALLOCATED	118,263	13,688		41,885		76,166	1,554	10	21	
22 UNIT COST MULTIPLIER	1.078747						0.023557		22	
22 UNIT COST MULTIPLIER		1.112393		11.214190		2.475574		0.909091	22	

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7661

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)		(COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,513,352		1,513,352	7,543	200.63	1
2	PHYSICAL THERAPY	3	81,469		81,469	1,394	58.44	2
3	OCCUPATIONAL THERAPY	4	190,376		190,376	537	354.52	3
4	SPEECH PATHOLOGY	5	3,236		3,236	35	92.46	4
5	MEDICAL SOCIAL SERVICES	6	24,739		24,739	39	634.33	5
6	HOME HEALTH AIDE	7	56,766		56,766	553	102.65	6
7	TOTAL (SUM OF LINES 1-6)		1,869,938		1,869,938	10,101		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERVICES							12
13	HOME HEALTH AIDE							13
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 (FROM HHA RECORD)	RATIO (COL.3 ÷ COL.4)	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)			
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	118,082		118,082			15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7661

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS				COST OF SERVICES				TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART B		PART B		PART B		PART B		
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	
1 SKILLED NURSING CARE	6	7	8	9	10	11			12
2 PHYSICAL THERAPY	2,868	2,551		575,407	511,807				1,087,214
3 OCCUPATIONAL THERAPY	695	281		40,616	16,422				57,038
4 SPEECH PATHOLOGY	252	175		89,339	62,041				151,380
5 MEDICAL SOCIAL SERVICES	26	2		2,404	185				2,589
6 HOME HEALTH AIDE	18	6		11,418	3,806				15,224
7 TOTAL (SUM OF LINES 1-6)	228	287		23,404	29,461				52,865
	4,087	3,302		742,588	623,722				1,366,310

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A
8 SKILLED NURSING CARE	1	2	3	4	8
9 PHYSICAL THERAPY	99914	2,868	2,551		9
10 OCCUPATIONAL THERAPY	99914	695	281		10
11 SPEECH PATHOLOGY	99914	252	175		11
12 MEDICAL SOCIAL SERVICES	99914	26	2		12
13 HOME HEALTH AIDE	99914	18	6		13
14 TOTAL (SUM OF LINES 8-13)	99914	228	287		14
		4,087	3,302		

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

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

FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED
1 PHYSICAL THERAPY	66	0.786651		COL 2, LINE 2
2 OCCUPATIONAL THERAPY	67	0.746700		COL 2, LINE 3
3 SPEECH PATHOLOGY	68			COL 2, LINE 4
4 MEDICAL SUPPLIES CHARGED TO PA	71	0.117113		COL 2, LINE 15
5 DRUGS CHARGED TO PATIENTS	73	0.240565		COL 2, LINE 16

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7661

WORKSHEET H-4
 PARTS I & II

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	659,627	412,165	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	15,107	18,973	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	16,027	18,300	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	8,486	10,739	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	6,213	8,280	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)	705,460	468,457	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	705,460	468,457	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	705,460	468,457	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)	705,460	468,457	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	705,460	468,457	31
31.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			31.01
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	705,460	468,457	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2			35

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

HHA NO.: 14-7661

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		705,460		468,457	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		705,460		468,457	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 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM				6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		705,460		468,457	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

COMPONENT NO: -

WORKSHEET I-1

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	TOTAL COSTS	BASIS	STATISTICS	FTEs PER 2080 HOURS
	1	2	3	4
1 REGISTERED NURSES		HOURS OF SERVICE		1
2 LICENSED PRACTICAL NURSES		HOURS OF SERVICE		2
3 NURSES AIDES		HOURS OF SERVICE		3
4 TECHNICIANS		HOURS OF SERVICE		4
5 SOCIAL WORKERS		HOURS OF SERVICE		5
6 DIETICIANS		HOURS OF SERVICE		6
7 PHYSICIANS		ACCUMULATED COST		7
8 NON-PATIENT CARE SALARY		ACCUMULATED COST		8
9 SUBTOTAL (SUM OF LINES 1-8)				9
10 EMPLOYEE BENEFITS		SALARY		10
11 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET		11
12 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME		12
13 MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME		13
14 SUPPLIES		REQUISITIONS		14
15 DRUGS		REQUISITIONS		15
16 OTHER		ACCUMULATED COST		16
17 SUBTOTAL (SUM OF LINES 9-16)				17
18 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET		18
19 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME		19
20 EMPLOYEE BENEFITS DEPARTMENT		SALARY		20
21 ADMINISTRATIVE AND GENERAL		ACCUMULATED COST		21
22 MAINT./REPAIRS-OPERATION-HOUSEKEEPING		SQUARE FEET		22
23 MEDICAL EDUCATION PROGRAM COSTS				23
24 CENTRAL SERVICES & SUPPLIES		REQUISITIONS		24
25 PHARMACY		REQUISITIONS		25
26 OTHER ALLOCATED COSTS		ACCUMULATED COST		26
27 SUBTOTAL (SUM OF LINES 17-26)				27
28 LABORATORY		CHARGES		28
29 RESPIRATORY THERAPY		CHARGES		29
30 BACTERIOLOGY & MICROBIOLOGY		CHARGES		30
30.01 VASCULAR LAB		CHARGES		30.01
30.02 CARDIAC REHAB		CHARGES		30.02
30.03 WOUND CARE		CHARGES		30.03
30.97 CARDIAC REHABILITATION		CHARGES		30.97
30.98 HYPERBARIC OXYGEN THERAPY		CHARGES		30.98
30.99 LITHOTRIPSY		CHARGES		30.99
31 TOTAL COSTS (SUM OF LINES 27-30)				31

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/29/2013 11:29

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE	SALARY	EMPLOYEE	
	BUILDING	EQUIPMENT	RNs	OTHER	BENEFITS	DRUGS
	1	2	3	4	5	6
1	TOTAL RENAL DEPT COSTS					1
	MAINTENANCE					
2	HEMODIALYSIS					2
3	INTERMITTENT PERITONEAL					3
	TRAINING					
4	HEMODIALYSIS					4
5	INTERMITTENT PERITONEAL					5
6	CAPD					6
7	CCPD					7
	HOME					
8	HEMODIALYSIS					8
9	INTERMITTENT PERITONEAL					9
10	CAPD					10
11	CCPD					11
	OTHER BILLABLE SERVICES					
12	INPATIENT DIALYSIS					12
13	METHOD II HOME PATIENT					13
14	EPO (INCL IN RENAL DEPT)					14
15	ARANESP (INCL IN RENAL DEPT)					15
16	OTHER					16
17	TOTAL (SUM OF LINES 2-16)					17
18	MEDICAL EDUC PGM COSTS					18
19	TOTAL RENAL COSTS (LINES 17+18)					19

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2
 (CONTINUED)

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL.9 + COL.10) 11	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/29/2013 11:29

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3

CHECK APPLICABLE BOX:

[XX] RENAL DIALYSIS DEPARTMENT

[] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE
	BUILDING	EQUIPMENT	RNs	OTHER	BENEFITS
	(SQUARE	(% OF	(HOURS)	(HOURS)	DEPARTMENT
	FEET)	TIME)			(SALARY)
	1	2	3	4	5
1	TOTAL RENAL DEPT COSTS				1
	MAINTENANCE				
2	HEMODIALYSIS				2
3	INTERMITTENT PERITONEAL				3
	TRAINING				
4	HEMODIALYSIS				4
5	INTERMITTENT PERITONEAL				5
6	CAPD				6
7	CCPD				7
	HOME				
8	HEMODIALYSIS				8
9	INTERMITTENT PERITONEAL				9
10	CAPD				10
11	CCPD				11
	OTHER BILLABLE SERVICES				
12	INPT DIAL TRTMNTS				
13	METHOD II HOME PATIENT				13
14	EPO				14
15	ARANESP				15
16	OTHER				16
17	TOTAL STATISTICAL BASIS				17
18	UNIT COST MULTIPLIER				18
	(LINE 1 ÷ LINE 17)				

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DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3
(CONTINUED)

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	DRUGS (REQUIST.)	MEDICAL SUPPLIES (REQUIST.)	ROUTINE ANCILLARY SERVICES (CHARGES)	SUBTOTAL	OVERHEAD (ACCUM. COST)	
	6	7	8	9	10	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18

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COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

COMPONENT NO: -

WORKSHEET I-4
(CONTINUED)

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (COL. 6 ÷ COL. 4)	AVERAGE PAYMENT RATE (COL. 6.01 ÷ COL. 4.01)	AVERAGE PAYMENT RATE (COL. 6.02 ÷ COL. 4.02)	
1 MAINTENANCE - HEMODIALYSIS							1
2 MAINTENANCE - PERITONEAL DIALYSIS							2
3 TRAINING - HEMODIALYSIS							3
4 TRAINING - PERITONEAL DIALYSIS							4
5 TRAINING - CAPD							5
6 TRAINING - CCPD							6
7 HOME PROGRAM - HEMODIALYSIS							7
8 HOME PROGRAM - PERITONEAL DIALYSIS							8
9 HOME PROGRAM - CAPD							9
10 HOME PROGRAM - CCPD							10
11 TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)	6	6.01	6.02	7	7.01	7.02	11
12 TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))							12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

COMPONENT NO: -

WORKSHEET I-5

DESCRIPTION

1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11)(SEE INSTRUCTIONS)	1	2	2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11)(SEE INSTRUCTIONS)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11)(SEE INSTRUCTIONS)			2.02
2.03	TOTAL PAYMENT DUE (SEE INSTRUCTIONS)			2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.03
4	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4
4.01	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (SUM OF LINE 5 THROUGH LINE 5.04)			5.05
6	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			8
9	PROGRAM PAYMENT (SEE INSTRUCTIONS)			9
10	UNRECOVERED FROM MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (TRANSFER TO WKST E, PART B, LINE 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

12	TOTAL ALLOWABLE EXPENSES (SEE INSTRUCTIONS)			12
13	TOTAL COMPOSITE COSTS (FROM WKST I-4, COL. 2, LINE 11)			13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (LINE 13 DIVIDED BY LINE 12)			14

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-003) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER		1,753,612		1
3	CAPITAL DRG OUTLIER PAYMENTS		20,254		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		56.04		3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)				4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)				5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)				6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)				7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)				8
10	SUM OF LINES 7 AND 8				9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)				10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)				11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)		1,773,866		12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL (COLS.0-4)	SUBTOTAL 24	I&R COST &	TOTAL 26
	NARY CAP- REL COSTS 0			POST STEP- DOWN ADJS 25	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					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 SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					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
54.01 ULTRASOUND					54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC					54.02
54.04 RADIATION ONC					54.04
54.06 PET SCAN					54.06
57 CT SCAN					57
58 MRI					58
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHARGED TO PA					71
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76 BACTERIOLOGY & MICROBIOLOGY					76
76.01 VASCULAR LAB					76.01
76.02 CARDIAC REHAB					76.02
76.03 WOUND CARE					76.03
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					92
94 HOME PROGRAM DIALYSIS					94
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
194 PHILANTHROPY DEVELOPMENT					194
194.01 VENDING					194.01
194.02 MEALS ON WHEELS					194.02
194.03 PRAIRIE CARDIOVASCULAR					194.03

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ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

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

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4)

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period		
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)		
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
If this date occurs after the period shown on line 2, stop here and see instructions.		
STEP 3: Average Pension Contributions During the Averaging Period		
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
STEP 4: Total Pension Cost for Wage Index		
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19