

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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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. <input checked="" type="checkbox"/> Electronically filed cost report Date: _____ Time: _____	
	2. <input type="checkbox"/> Manually submitted cost report	
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report	
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 WERE 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 certification 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

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX	
		PART A	PART B			
	1	2	3	4	5	
1 HOSPITAL		686,981	-174,618	-172,639	-6,434,328	1
2 SUBPROVIDER - IPF		2			-67,863	2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		686,983	-174,618	-172,639	-6,502,191	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 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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence

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PARTS I, II & III**

not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 2875 W. 19TH STREET	P.O. Box:								1
2	City: CHICAGO	State: IL	ZIP Code: 60623	County: COOK						2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST ANTHONY HOSPITAL	14-0095	16974	1	07 / 01 / 1967	N	P	O	3
4	Subprovider - IPF	PSYCHIATRIC UNIT	14-S095	16974	4	11 / 01 / 1988	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015							20
21	Type of control (see instructions)	1								21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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.	1	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	6,509	739			5,134		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		V	XVIII	XIX	
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)	N	N		39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	Y		40
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline 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 osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs 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	

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.

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 Nonprovider Settings

63	Has your facility trained residents in nonprovider 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 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider 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 nonprovider 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)		2.46		64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
65		1350		1.38	65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider 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 nonprovider 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)		2.46		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	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67		1350		1.38	67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N		71

Inpatient Rehabilitation Facility PPS

		1	2	3	
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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.		N		81

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.				86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.		N		87

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**WORKSHEET S-2
PART I**

Title V and XIX Services		V	XIX	
		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID 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

		1	2		
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? (see instructions)			106	
107	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. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			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	
		Physical	Occupational	Speech	Respiratory
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.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	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.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:				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 high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		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:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §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 V	Title XIX	
		Part A	Part B			
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					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. (see instructions)						166
	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 is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
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. (see instructions)	0.75				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2014	09 / 30 / 2014		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N		171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	Y			5

		Y/N	Y/N	
Approved Educational Activities				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

		Y/N	
Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/13/2014	Y	11/13/2014
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL 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 relifed 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 capitalization 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	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: RAJ	Last name: SHAH	Title: SR REIMBURSEMENT CONSULTAN	41
42	Employer: STRATEGIC REIMBURSEMENT, INC.			42
43	Phone number: 630-530-7100 EXT 107	E-mail Address: RAJ.SHAH@SRGROUP.LLC		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	94	34,310			3,724	4,527	15,316	1
2	HMO and other (see instructions)						181	5,134		2
3	HMO IPF Subprovider							5,147		3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		94	34,310			3,724	4,527	15,316	7
8	Intensive Care Unit	31	15	5,475			806	312	2,010	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						2,097	3,194	13
14	Total (see instructions)		109	39,785			4,530	6,936	20,520	14
15	CAH Visits									15
16	Subprovider - IPF	40	42	15,330			2,573	2,798	8,709	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		151							27
28	Observation Bed Days								1,701	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							312	475	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					795	1,605	4,869	1
2	HMO and other (see instructions)					14	1,048		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	3.11	709.97			795	1,605	4,869	14
15	CAH Visits								15
16	Subprovider - IPF		37.17			244	343	1,063	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	3.11	747.14						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
SALARIES								
1	Total salaries (see instructions)	200	54,990,726		54,990,726	1,563,237.00	35.18	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		2,726,266		2,726,266	20,604.00	132.32	4
4.01	Physician-Part A - Teaching		1,645,611		1,645,611	17,430.00	94.41	4.01
5	Physician-Part B		6,110,244		6,110,244	61,027.00	100.12	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		3,765,500		3,765,500	128,278.00	29.35	10
OTHER WAGES & RELATED COSTS								
11	Contract labor (see instructions)		52,847		52,847	739.00	71.51	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS								
17	Wage-related costs (core)(see instructions)		9,147,303		9,147,303			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		777,757		777,757			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		161,578		161,578			22
22.01	Physician Part A - Teaching		113,563		113,563			22.01
23	Physician Part B		409,813		409,813			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits Department		967,346		967,346	22,226.00	43.52	26
27	Administrative & General		9,111,027		9,111,027	233,796.00	38.97	27
28	Administrative & General under contract (see instructions)		869,377		869,377	5,280.00	164.65	28
29	Maintenance & Repairs		401,718		401,718	12,937.00	31.05	29
30	Operation of Plant		1,277,244		1,277,244	57,801.00	22.10	30
31	Laundry & Linen Service							31
32	Housekeeping		842,406		842,406	61,806.00	13.63	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		799,910	-466,247	333,663	24,533.00	13.60	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			466,247	466,247	33,878.00	13.76	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,180,917		1,180,917	33,374.00	35.38	38
39	Central Services and Supply		310,753		310,753	20,488.00	15.17	39
40	Pharmacy		1,328,212		1,328,212	34,436.00	38.57	40
41	Medical Records & Medical Records Library		593,243		593,243	23,416.00	25.33	41
42	Social Service		656,728		656,728	17,480.00	37.57	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		48,104,248		48,104,248	1,490,060.00	32.28	1
2	Excluded area salaries (see instructions)		3,765,500		3,765,500	128,278.00	29.35	2
3	Subtotal salaries (line 1 minus line 2)		44,338,748		44,338,748	1,361,782.00	32.56	3
4	Subtotal other wages & related costs (see instructions)		52,847		52,847	739.00	71.51	4
5	Subtotal wage-related costs (see instructions)		9,308,881		9,308,881		20.99%	5
6	Total (sum of lines 3 through 5)		53,700,476		53,700,476	1,362,521.00	39.41	6
7	Total overhead cost (see instructions)		18,338,881		18,338,881	581,451.00	31.54	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	1,550,669	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)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	4,607,886	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	182,129	10
11	Life Insurance (If employee is owner or beneficiary)	67,001	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	121,563	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	484,904	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	3,536,149	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	114,000	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	233,447	23
24	Total Wage Related cost (Sum of lines 1-23)	10,897,748	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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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	DEPOSIT DATE(S)	CONTRIBUTION(S) 11
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

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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 Labor	Benefit Cost	
	0	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

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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Erythropoiesis-Stimulating Agents (ESA) Statistics:		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.272676	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	54,255,391	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	165,373,682	6
7	Medicaid cost (line 1 times line 6)	45,093,434	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 fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		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	19,293,246	3,291,656	22,584,902	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,260,805	897,556	6,158,361	21
22	Partial payment by patients approved for charity care	6,980,188	901,328	7,881,516	22
23	Cost of charity care (line 21 minus line 22)	-1,719,383	-3,772	-1,723,155	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)	12,100,738	26
27	Medicare bad debts for the entire hospital complex (see instructions)	796,551	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	11,304,187	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,082,380	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,359,225	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,359,225	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		3,336,657	3,336,657		3,336,657	404,392	3,741,049	1
2	00200	Cap Rel Costs-Mvble Equip								2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	967,346	7,139,756	8,107,102		8,107,102	-14	8,107,088	4
5.01	00580	CASHIERING								5.01
5.06	00590	ADMINISTRATIVE & GENERAL	9,111,027	16,985,494	26,096,521		26,096,521	-8,941,591	17,154,930	5.06
6	00600	Maintenance & Repairs	401,718	1,379,127	1,780,845		1,780,845		1,780,845	6
7	00700	Operation of Plant	1,277,244	1,517,755	2,794,999		2,794,999	-39,560	2,755,439	7
8	00800	Laundry & Linen Service				480,850	480,850		480,850	8
9	00900	Housekeeping	842,406	1,008,299	1,850,705		1,850,705		1,850,705	9
10	01000	Dietary	799,910	1,347,592	2,147,502	-1,251,723	895,779	-71,152	824,627	10
11	01100	Cafeteria				1,251,723	1,251,723	-628,769	622,954	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,180,917	242,630	1,423,547		1,423,547	-7,995	1,415,552	13
14	01400	Central Services & Supply	310,753	356,023	666,776	-480,850	185,926		185,926	14
15	01500	Pharmacy	1,328,212	4,300,900	5,629,112	-4,239,771	1,389,341	-106,648	1,282,693	15
16	01600	Medical Records & Library	593,243	268,186	861,429		861,429	-259	861,170	16
17	01700	Social Service	656,728	82,937	739,665		739,665	-51,000	688,665	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	1,906,930	1,004,501	2,911,431		2,911,431	-2,045,027	866,404	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	5,939,259	877,402	6,816,661		6,816,661	-536,336	6,280,325	30
31	03100	Intensive Care Unit	1,492,424	309,296	1,801,720		1,801,720	-2,918	1,798,802	31
40	04000	Subprovider - IPF	2,154,562	266,225	2,420,787		2,420,787	-3,418	2,417,369	40
43	04300	Nursery	1,391,409	135,747	1,527,156		1,527,156	-514,860	1,012,296	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,282,009	3,921,252	5,203,261	-3,288,256	1,915,005	-18,702	1,896,303	50
51	05100	Recovery Room	332,103	34,465	366,568		366,568		366,568	51
52	05200	Delivery Room & Labor Room	4,187,701	653,656	4,841,357		4,841,357	-2,242,502	2,598,855	52
53	05300	Anesthesiology	1,862,025	594,252	2,456,277		2,456,277	-1,603,093	853,184	53
54	05400	Radiology-Diagnostic	2,030,001	774,792	2,804,793		2,804,793	-3,080	2,801,713	54
57	05700	CT Scan	383,759	96,289	480,048		480,048		480,048	57
58	05800	MRI	148,664	29,218	177,882		177,882		177,882	58
60	06000	Laboratory	1,550,018	1,679,655	3,229,673		3,229,673	-19,858	3,209,815	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.	57,134	448,912	506,046		506,046		506,046	63
65	06500	Respiratory Therapy	662,369	196,917	859,286	-139,058	720,228	-3,570	716,658	65
66	06600	Physical Therapy	909,537	195,135	1,104,672		1,104,672		1,104,672	66
69	06900	Electrocardiology	463,008	161,128	624,136		624,136		624,136	69
70	07000	Electroencephalography	47,350	6,912	54,262		54,262		54,262	70
71	07100	Medical Supplies Charged to Patients				2,602,532	2,602,532		2,602,532	71
72	07200	Impl. Dev. Charged to Patients				1,277,288	1,277,288		1,277,288	72
73	07300	Drugs Charged to Patients				4,239,771	4,239,771		4,239,771	73
75	07500	ASC (Non-Distinct Part)	407,234	43,771	451,005		451,005		451,005	75
76	03950	HEMODIALYSIS		278,474	278,474		278,474		278,474	76
76.01	03951	DIABETES CENTER								76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	1,395,828	539,243	1,935,071		1,935,071	-40,516	1,894,555	90
90.01	09001	CHEMOTHERAPY	621,893	70,083	691,976		691,976	-7,825	684,151	90.01
90.02	09002	KEDZIE CLINIC	1,006,936	489,489	1,496,425		1,496,425	-212,447	1,283,978	90.02
90.03	09003	LITTLE VILLAGE CLINIC	673,295	1,087,778	1,761,073		1,761,073	-193,020	1,568,053	90.03
91	09100	Emergency	5,004,836	1,284,889	6,289,725	-452,506	5,837,219	-1,941,207	3,896,012	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLO- CATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	53,379,788	53,144,837	106,524,625		106,524,625	-18,830,975	87,693,650	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	39,227	48,235	87,462		87,462		87,462	190
192	19200	Physicians' Private Offices	1,052,243	490,558	1,542,801		1,542,801		1,542,801	192
192.0 1	19210	OTHER NON-REIMBURSABLE	234,101	42,348	276,449		276,449		276,449	192.0 1
192.0 2	19202	NEPHROLOGY	285,367	443,951	729,318		729,318		729,318	192.0 2
200		TOTAL (sum of lines 118-199)	54,990,726	54,169,929	109,160,655		109,160,655	-18,830,975	90,329,680	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA RECLASS	B	Cafeteria	11	466,247	785,476	1
500	Total reclassifications				466,247	785,476	500
	Code Letter - B						
1	COST OF MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		2,602,532	1
2			Impl. Dev. Charged to Patient	72		1,277,288	2
3							3
500	Total reclassifications					3,879,820	500
	Code Letter - C						
1	COST OF DRUGS SOLD	D	Drugs Charged to Patients	73		4,239,771	1
500	Total reclassifications					4,239,771	500
	Code Letter - D						
1	RECLASS LAUNDRY COSTS	E	Laundry & Linen Service	8		480,850	1
500	Total reclassifications					480,850	500
	Code Letter - E						
	GRAND TOTAL (Increases)				466,247	9,385,917	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	CAFETERIA RECLASS	B	Dietary	10	466,247	785,476	1	
500	Total reclassifications				466,247	785,476	500	
	Code letter - B							
1	COST OF MEDICAL SUPPLIES	C	Operating Room	50		3,288,256	1	
2			Respiratory Therapy	65		139,058	2	
3			Emergency	91		452,506	3	
500	Total reclassifications					3,879,820	500	
	Code letter - C							
1	COST OF DRUGS SOLD	D	Pharmacy	15		4,239,771	1	
500	Total reclassifications					4,239,771	500	
	Code letter - D							
1	RECLASS LAUNDRY COSTS	E	Central Services & Supply	14		480,850	1	
500	Total reclassifications					480,850	500	
	Code letter - E							
	GRAND TOTAL (Decreases)				466,247	9,385,917		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	472,850					472,850		1
2	Land Improvements	500,937					500,937		2
3	Buildings and Fixtures	31,490,603	403,741		403,741	1,036,340	30,858,004		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	35,809,731	2,431,552		2,431,552		38,241,283		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	68,274,121	2,835,293		2,835,293	1,036,340	70,073,074		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	68,274,121	2,835,293		2,835,293	1,036,340	70,073,074		10

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

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	3,336,657							3,336,657	1
2	Cap Rel Costs-Mvble Equip									2
3	Total (sum of lines 1-2)	3,336,657							3,336,657	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may

have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	31,991,540		31,991,540	0.471843					1
2	Cap Rel Costs-Mvble Equ	35,809,731		35,809,731	0.528157					2
3	Total (sum of lines 1-2)	67,801,271		67,801,271	1.000000					3

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	3,741,049							3,741,049	1
2	Cap Rel Costs-Mvble Equip									2
3	Total (sum of lines 1-2)	3,741,049							3,741,049	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,

Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)	B	-92,688	ADMINISTRATIVE & GENERAL	5.06	5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-7,452,352			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1				12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-628,769	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					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 overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		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					32
33						33
34						34
35	CAPITAL IMPAIRMENT AMORTIZATION	A	569,823	Cap Rel Costs-Bldg & Fixt	1	9 35
36	OTHER REVENUE	B	-14	Employee Benefits Department	4	36
36.01	OTHER REVENUE	B	-32,578	ADMINISTRATIVE & GENERAL	5.06	36.01
36.02	OTHER REVENUE	B	-39,560	Operation of Plant	7	36.02
36.03	OTHER REVENUE	B	-7,995	Nursing Administration	13	36.03
36.04	OTHER REVENUE	B	-106,648	Pharmacy	15	36.04
36.05	OTHER REVENUE	B	-51,000	Social Service	17	36.05
36.08	OTHER REVENUE	B	-259	Medical Records & Library	16	36.08
36.09	OTHER REVENUE	B	-1,716,830	I&R Services-Other Prgm Costs Apprvd	22	36.09
36.10	OTHER REVENUE	B	-24,166	Adults & Pediatrics	30	36.10
36.11	OTHER REVENUE	B	-2,918	Intensive Care Unit	31	36.11
36.12	OTHER REVENUE	B	-3,418	Subprovider - IPF	40	36.12
36.13	OTHER REVENUE	B	-6,287	Nursery	43	36.13
36.14	OTHER REVENUE	B	-3,080	Radiology-Diagnostic	54	36.14
36.15	OTHER REVENUE	B	-19,858	Laboratory	60	36.15
36.16	OTHER REVENUE- NEGATIVE REV	B	-3,570	Respiratory Therapy	65	36.16
36.17	OTHER REVENUE	B	-8,266	Clinic	90	36.17
36.18	SPONSORSHIP	A	-140,330	ADMINISTRATIVE & GENERAL	5.06	36.18
36.19	MARKETING	A	-395,925	ADMINISTRATIVE & GENERAL	5.06	36.19
36.20	MEDICAID TAX	A	-7,184,856	ADMINISTRATIVE & GENERAL	5.06	36.20
36.21	TELECOMMUNICATIONS REVENUE	B	-36,779	ADMINISTRATIVE & GENERAL	5.06	36.21
36.22	DIETARY OTHER REVENUE	B	-71,152	Dietary	10	36.22
36.23	RENTAL REVENUE	B	-165,431	Cap Rel Costs-Bldg & Fixt	1	9 36.23

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ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
36.24	OTHER REVENUE	B	-7,825	CHEMOTHERAPY	90.01	36.24
36.25	OTHER REVENUE	B	-670	KEDZIE CLINIC	90.02	36.25
36.26	OTHER REVENUE	B	-10,080	Emergency	91	36.26
36.27	LOBBYING	A	-14,935	ADMINISTRATIVE & GENERAL	5.06	36.27
36.28	OTHER REVENUE ADMIN	B	-46,307	ADMINISTRATIVE & GENERAL	5.06	36.28
36.29	MIDWIFERY PROGRAM	A	-897,201	Delivery Room & Labor Room	52	36.29
37						37
38						38
39						39
40						40
41						41
42						42
43						43
44	MILLENIUUM BLDG-1ST FLOOR	A	-229,051	ADMINISTRATIVE & GENERAL	5.06	44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-18,830,975			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripsts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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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 CLAIMED HOME OFFICE COSTS:

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1						1	
2						2	
3						3	
4						4	
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12						5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	Type of Business
	1	2	3	4	5	6
6						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:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit		
	1	2	3	4	5	6	7	8	9		
	1	5.06	ADMINISTRATIVE & GEN AGGREGATE	1,798,628	55,671	1,742,957	177,200	12,096	1,030,486	51,524	1
	2										2
	3										3
	4										4
	5										5
	6										6
	7	22	I&R Services-Other P AGGREGATE	1,645,611	192,703	1,452,908	177,200	15,464	1,317,414	65,871	7
	8										8
	9	30	Adults & Pediatrics AGGREGATE	512,170	512,170						9
	10										10
	11										11
	12										12
	13	43	Nursery AGGREGATE	695,996	460,679	235,317	177,200	2,200	187,423	9,371	13
	14										14
	15	50	Operating Room AGGREGATE	18,702	18,702						15
	16										16
	17	52	Delivery Room & Labo AGGREGATE	1,345,301	1,345,301						17
	18										18
	19	53	Anesthesiology AGGREGATE	1,780,804	1,447,946	332,858	177,200	2,086	177,711	8,886	19
	20										20
	27	90	Clinic AGGREGATE	101,220	32,250	68,970	177,200	1,160	98,823	4,941	27
	28	90.01	CHEMOTHERAPY	62,813		62,813	177,200	891	75,906	3,795	28
	29	90.02	KEDZIE CLINIC AGGREGATE	396,730	113,878	282,852	177,200	2,171	184,953	9,248	29
	30	90.03	LITTLE VILLAGE CLINI AGGREGATE	193,020	193,020						30
	32	91	Emergency AGGREGATE	1,931,127	1,931,127						32
	200		TOTAL	10,482,122	6,303,447	4,178,675		36,068	3,072,716	153,636	200

KPMG LLP Compu-Max 2552-10

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowanc e	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.06	ADMINISTRATIVE & GEN AGGREGATE					1,030,486	712,471	768,142	1
2										2
3										3
4										4
5										5
6										6
7	22	I&R Services-Other P AGGREGATE					1,317,414	135,494	328,197	7
8										8
9	30	Adults & Pediatrics AGGREGATE							512,170	9
10										10
11										11
12										12
13	43	Nursery AGGREGATE					187,423	47,894	508,573	13
14										14
15	50	Operating Room AGGREGATE							18,702	15
16										16
17	52	Delivery Room & Labo AGGREGATE							1,345,301	17
18										18
19	53	Anesthesiology AGGREGATE					177,711	155,147	1,603,093	19
20										20
27	90	Clinic AGGREGATE					98,823		32,250	27
28	90.01	CHEMOTHERAPY					75,906			28
29	90.02	KEDZIE CLINIC AGGREGATE					184,953	97,899	211,777	29
30	90.03	LITTLE VILLAGE CLINI AGGREGATE							193,020	30
32	91	Emergency AGGREGATE							1,931,127	32
200		TOTAL					3,072,716	1,148,905	7,452,352	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	EMPLOYEE BENEFITS DEPARTMENT T	SUBTOTAL (cols.0-4)	A+G	MAINTENANCE AND REPAIRS	
		0	1	4	4A	5.06	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,741,049	3,741,049					1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	8,107,088	14,713	8,121,801				4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL	17,154,930	461,502	1,623,178	19,239,610	19,239,610		5.06
6	Maintenance & Repairs	1,780,845	139,798	70,475	1,991,118	538,870	2,529,988	6
7	Operation of Plant	2,755,439	461,281	224,071	3,440,791	931,205	373,447	7
8	Laundry & Linen Service	480,850	65,220		546,070	147,787	52,801	8
9	Housekeeping	1,850,705	33,579	147,786	2,032,070	549,953	27,185	9
10	Dietary	824,627	67,693	58,536	950,856	257,337	54,804	10
11	Cafeteria	622,954	93,740	81,795	798,489	216,101	75,891	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,415,552	65,478	207,172	1,688,202	456,890	53,010	13
14	Central Services & Supply	185,926	96,546	54,516	336,988	91,201	78,163	14
15	Pharmacy	1,282,693	53,387	233,012	1,569,092	424,654	43,221	15
16	Medical Records & Library	861,170	68,210	104,074	1,033,454	279,691	55,222	16
17	Social Service	688,665	18,423	115,212	822,300	222,545	14,915	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	866,404		333,443	1,199,847	324,723		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,280,325	778,001	952,091	8,010,417	2,167,926	629,859	30
31	Intensive Care Unit	1,798,802	105,850	261,820	2,166,472	586,327	85,695	31
40	Subprovider - IPF	2,417,369	232,726	377,981	3,028,076	819,509	188,412	40
43	Nursery	1,012,296	23,407	122,272	1,157,975	313,391	18,950	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,896,303	107,032	221,626	2,224,961	602,157	86,651	50
51	Recovery Room	366,568		58,262	424,830	114,975		51
52	Delivery Room & Labor Room	2,598,855	71,681	498,651	3,169,187	857,699	58,032	52
53	Anesthesiology	853,184	13,808	14,249	881,241	238,496	11,179	53
54	Radiology-Diagnostic	2,801,713	198,428	356,129	3,356,270	908,331	160,644	54
57	CT Scan	480,048		67,324	547,372	148,139		57
58	MRI	177,882		26,081	203,963	55,200		58
60	Laboratory	3,209,815	131,602	271,924	3,613,341	977,904	106,543	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	506,046		10,023	516,069	139,667		63
65	Respiratory Therapy	716,658	24,238	116,201	857,097	231,962	19,623	65
66	Physical Therapy	1,104,672	31,899	159,563	1,296,134	350,782	25,825	66
69	Electrocardiology	624,136	18,497	81,227	723,860	195,903	14,975	69
70	Electroencephalography	54,262	11,685	8,307	74,254	20,096	9,460	70
71	Medical Supplies Charged to Patients	2,602,532			2,602,532	704,341		71
72	Impl. Dev. Charged to Patients	1,277,288			1,277,288	345,681		72
73	Drugs Charged to Patients	4,239,771			4,239,771	1,147,439		73
75	ASC (Non-Distinct Part)	451,005		71,442	522,447	141,393		75
76	HEMODIALYSIS	278,474			278,474	75,365		76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,894,555	111,536	205,329	2,211,420	598,492	90,298	90
90.01	CHEMOTHERAPY	684,151		109,101	793,252	214,683		90.01
90.02	KEDZIE CLINIC	1,283,978		84,256	1,368,234	370,295		90.02
90.03	LITTLE VILLAGE CLINIC	1,568,053		84,256	1,652,309	447,176		90.03
91	Emergency	3,896,012	68,579	539,172	4,503,763	1,218,885	55,521	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	87,693,650	3,568,539	7,950,557	87,349,896	18,433,171	2,390,326	118
	NONREIMBURSABLE COST CENTERS							

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	EMPLOYEE BENEFITS DEPARTMEN T	SUBTOTAL (cols.0-4)	A+G	MAINTEN-ANCE AND REPAIRS	
		0	1	4	4A	5.06	6	
190	Gift, Flower, Coffee Shop & Canteen	87,462	2,769	6,882	97,113	26,282	2,242	190
192	Physicians' Private Offices	1,542,801	169,741	73,230	1,785,772	483,296	137,420	192
192.0	OTHER NON-REIMBURSABLE	276,449		41,069	317,518	85,932		192.0
1								1
192.0	NEPHROLOGY	729,318		50,063	779,381	210,929		192.0
2								2
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	90,329,680	3,741,049	8,121,801	90,329,680	19,239,610	2,529,988	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant	4,745,443						7
8	Laundry & Linen Service	116,188	862,846					8
9	Housekeeping	59,820		2,669,028				9
10	Dietary	120,594		70,440	1,454,031			10
11	Cafeteria	166,997		97,544		1,355,022		11
12	Maintenance of Personnel							12
13	Nursing Administration	116,648		68,135		51,169	2,434,054	13
14	Central Services & Supply	171,996		100,464		24,884		14
15	Pharmacy	95,107		55,553		41,646		15
16	Medical Records & Library	121,515		70,978		24,394		16
17	Social Service	32,821		19,171		25,159		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					28,971		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,385,998	434,615	809,566	897,717	210,569	641,457	30
31	Intensive Care Unit	188,571	57,037	110,145	61,215	47,585	144,958	31
40	Subprovider - IPF	414,599	247,131	242,169	495,099	95,093	289,681	40
43	Nursery	41,700	90,635	24,357		32,104	97,797	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	190,675		111,374		52,948	161,295	50
51	Recovery Room					7,198	21,927	51
52	Delivery Room & Labor Room	127,698	33,428	74,589		109,062	332,233	52
53	Anesthesiology	24,599		14,368		19,737	60,124	53
54	Radiology-Diagnostic	353,496		206,479		82,711		54
57	CT Scan					8,128		57
58	MRI					3,770		58
60	Laboratory	234,447		136,942		69,850		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					2,346		63
65	Respiratory Therapy	43,180		25,222		32,611		65
66	Physical Therapy	56,828		33,193		37,716		66
69	Electrocardiology	32,952		19,248		18,598		69
70	Electroencephalography	20,817		12,159		2,209		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)					16,466	50,161	75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	198,700		116,061		67,699	193,335	90
90.01	CHEMOTHERAPY					24,440	74,450	90.01
90.02	KEDZIE CLINIC					28,865		90.02
90.03	LITTLE VILLAGE CLINIC					19,506		90.03
91	Emergency	122,173		71,362		120,355	366,636	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,438,119	862,846	2,489,519	1,454,031	1,305,789	2,434,054	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,933		2,881		2,635		190
192	Physicians' Private Offices	302,391		176,628		25,705		192

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	
		7	8	9	10	11	13	
192.0 1	OTHER NON-REIMBURSABLE					10,637		192.0 1
192.0 2	NEPHROLOGY					10,256		192.0 2
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,745,443	862,846	2,669,028	1,454,031	1,355,022	2,434,054	202

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	803,696						14
15	Pharmacy	30,675	2,259,948					15
16	Medical Records & Library	3		1,585,257				16
17	Social Service				1,136,911			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					1,553,541		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	41,841		162,400	572,662	621,417	16,586,444	30
31	Intensive Care Unit	14,081		35,312	75,153		3,572,551	31
40	Subprovider - IPF	2,750		71,875	325,628		6,220,022	40
43	Nursery	4,519		24,690	119,423		1,925,541	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	21,143		90,569			3,541,773	50
51	Recovery Room	1,449		6,997			577,376	51
52	Delivery Room & Labor Room	33,539		54,661	44,045		4,894,173	52
53	Anesthesiology	23,252		47,722			1,320,718	53
54	Radiology-Diagnostic	10,432	41,517	111,398			5,231,278	54
57	CT Scan	8,810		84,377			796,826	57
58	MRI	367		18,181			281,481	58
60	Laboratory	19,621		143,844			5,302,492	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			12,550			670,632	63
65	Respiratory Therapy			38,214			1,247,909	65
66	Physical Therapy	9,334		35,119			1,844,931	66
69	Electrocardiology	2,050		29,192			1,036,778	69
70	Electroencephalography	371		4,614			143,980	70
71	Medical Supplies Charged to Patients	372,608		37,585			3,717,066	71
72	Impl. Dev. Charged to Patients	175,450		20,746			1,819,165	72
73	Drugs Charged to Patients		2,218,431	240,762			7,846,403	73
75	ASC (Non-Distinct Part)	902		11,094			742,463	75
76	HEMODIALYSIS			3,560			357,399	76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	11,522		16,823		310,708	3,815,058	90
90.01	CHEMOTHERAPY			27,338			1,134,163	90.01
90.02	KEDZIE CLINIC	3,658		19,240			1,790,292	90.02
90.03	LITTLE VILLAGE CLINIC	1,456		20,045			2,140,492	90.03
91	Emergency	1,420		216,349		621,416	7,297,880	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	791,253	2,259,948	1,585,257	1,136,911	1,553,541	85,855,286	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						136,086	190
192	Physicians' Private Offices	4,090					2,915,302	192

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
192.0 1	OTHER NON-REIMBURSABLE	14					414,101	192.0 1
192.0 2	NEPHROLOGY	8,339					1,008,905	192.0 2
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	803,696	2,259,948	1,585,257	1,136,911	1,553,541	90,329,680	202

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	CASHIERING						5.01
5.06	ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R 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	-621,417	15,965,027				30
31	Intensive Care Unit		3,572,551				31
40	Subprovider - IPF		6,220,022				40
43	Nursery		1,925,541				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		3,541,773				50
51	Recovery Room		577,376				51
52	Delivery Room & Labor Room		4,894,173				52
53	Anesthesiology		1,320,718				53
54	Radiology-Diagnostic		5,231,278				54
57	CT Scan		796,826				57
58	MRI		281,481				58
60	Laboratory		5,302,492				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		670,632				63
65	Respiratory Therapy		1,247,909				65
66	Physical Therapy		1,844,931				66
69	Electrocardiology		1,036,778				69
70	Electroencephalography		143,980				70
71	Medical Supplies Charged to Patients		3,717,066				71
72	Impl. Dev. Charged to Patients		1,819,165				72
73	Drugs Charged to Patients		7,846,403				73
75	ASC (Non-Distinct Part)		742,463				75
76	HEMODIALYSIS		357,399				76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	-310,708	3,504,350				90
90.01	CHEMOTHERAPY		1,134,163				90.01
90.02	KEDZIE CLINIC		1,790,292				90.02
90.03	LITTLE VILLAGE CLINIC		2,140,492				90.03
91	Emergency	-621,416	6,676,464				91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	-1,553,541	84,301,745				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		136,086				190
192	Physicians' Private Offices		2,915,302				192

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
192.0 1	OTHER NON-REIMBURSABLE		414,101				192.0 1
192.0 2	NEPHROLOGY		1,008,905				192.0 2
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	-1,553,541	88,776,139				202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMEN T	A+G	MAINTEN- ANCE AND REPAIRS	
		0	1	2A	4	5.06	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		14,713	14,713	14,713			4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL		461,502	461,502	2,931	464,433		5.06
6	Maintenance & Repairs		139,798	139,798	128	13,008	152,934	6
7	Operation of Plant		461,281	461,281	406	22,479	22,574	7
8	Laundry & Linen Service		65,220	65,220		3,567	3,192	8
9	Housekeeping		33,579	33,579	268	13,276	1,643	9
10	Dietary		67,693	67,693	106	6,212	3,313	10
11	Cafeteria		93,740	93,740	148	5,217	4,587	11
12	Maintenance of Personnel							12
13	Nursing Administration		65,478	65,478	376	11,029	3,204	13
14	Central Services & Supply		96,546	96,546	99	2,202	4,725	14
15	Pharmacy		53,387	53,387	422	10,251	2,613	15
16	Medical Records & Library		68,210	68,210	189	6,752	3,338	16
17	Social Service		18,423	18,423	209	5,372	902	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				604	7,839		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		778,001	778,001	1,726	52,334	38,074	30
31	Intensive Care Unit		105,850	105,850	475	14,154	5,180	31
40	Subprovider - IPF		232,726	232,726	685	19,782	11,389	40
43	Nursery		23,407	23,407	222	7,565	1,146	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		107,032	107,032	402	14,536	5,238	50
51	Recovery Room				106	2,775		51
52	Delivery Room & Labor Room		71,681	71,681	904	20,704	3,508	52
53	Anesthesiology		13,808	13,808	26	5,757	676	53
54	Radiology-Diagnostic		198,428	198,428	646	21,927	9,711	54
57	CT Scan				122	3,576		57
58	MRI				47	1,332		58
60	Laboratory		131,602	131,602	493	23,606	6,440	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.				18	3,371		63
65	Respiratory Therapy		24,238	24,238	211	5,599	1,186	65
66	Physical Therapy		31,899	31,899	289	8,468	1,561	66
69	Electrocardiology		18,497	18,497	147	4,729	905	69
70	Electroencephalography		11,685	11,685	15	485	572	70
71	Medical Supplies Charged to Patients					17,002		71
72	Impl. Dev. Charged to Patients					8,345		72
73	Drugs Charged to Patients					27,698		73
75	ASC (Non-Distinct Part)				130	3,413		75
76	HEMODIALYSIS					1,819		76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		111,536	111,536	372	14,447	5,458	90
90.01	CHEMOTHERAPY				198	5,182		90.01
90.02	KEDZIE CLINIC				153	8,939		90.02
90.03	LITTLE VILLAGE CLINIC				153	10,795		90.03
91	Emergency		68,579	68,579	977	29,423	3,356	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,568,539	3,568,539	14,403	444,967	144,491	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,769	2,769	12	634	136	190

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMEN T	A+G	MAINTEN- ANCE AND REPAIRS	
		0	1	2A	4	5.06	6	
192	Physicians' Private Offices		169,741	169,741	133	11,666	8,307	192
192.0 1	OTHER NON-REIMBURSABLE				74	2,074		192.0 1
192.0 2	NEPHROLOGY				91	5,092		192.0 2
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,741,049	3,741,049	14,713	464,433	152,934	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant	506,740						7
8	Laundry & Linen Service	12,407	84,386					8
9	Housekeeping	6,388		55,154				9
10	Dietary	12,878		1,456	91,658			10
11	Cafeteria	17,833		2,016		123,541		11
12	Maintenance of Personnel							12
13	Nursing Administration	12,456		1,408		4,665	98,616	13
14	Central Services & Supply	18,367		2,076		2,269		14
15	Pharmacy	10,156		1,148		3,797		15
16	Medical Records & Library	12,976		1,467		2,224		16
17	Social Service	3,505		396		2,294		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					2,641		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	148,002	42,506	16,729	56,589	19,201	25,991	30
31	Intensive Care Unit	20,136	5,578	2,276	3,859	4,338	5,873	31
40	Subprovider - IPF	44,273	24,169	5,004	31,210	8,670	11,736	40
43	Nursery	4,453	8,864	503		2,927	3,962	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,361		2,301		4,827	6,535	50
51	Recovery Room					656	888	51
52	Delivery Room & Labor Room	13,636	3,269	1,541		9,943	13,460	52
53	Anesthesiology	2,627		297		1,799	2,436	53
54	Radiology-Diagnostic	37,748		4,267		7,541		54
57	CT Scan					741		57
58	MRI					344		58
60	Laboratory	25,035		2,830		6,368		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					214		63
65	Respiratory Therapy	4,611		521		2,973		65
66	Physical Therapy	6,068		686		3,439		66
69	Electrocardiology	3,519		398		1,696		69
70	Electroencephalography	2,223		251		201		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)					1,501	2,032	75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	21,218		2,398		6,172	7,833	90
90.01	CHEMOTHERAPY					2,228	3,016	90.01
90.02	KEDZIE CLINIC					2,632		90.02
90.03	LITTLE VILLAGE CLINIC					1,778		90.03
91	Emergency	13,046		1,475		10,973	14,854	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	473,922	84,386	51,444	91,658	119,052	98,616	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	527		60		240		190
192	Physicians' Private Offices	32,291		3,650		2,344		192

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINI- STRATION	
		7	8	9	10	11	13	
192.0 1	OTHER NON-REIMBURSABLE					970		192.0 1
192.0 2	NEPHROLOGY					935		192.0 2
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	506,740	84,386	55,154	91,658	123,541	98,616	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	126,284						14
15	Pharmacy	4,820	86,594					15
16	Medical Records & Library	1		95,157				16
17	Social Service				31,101			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					11,084		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,574		9,754	15,665		1,211,146	30
31	Intensive Care Unit	2,213		2,121	2,056		174,109	31
40	Subprovider - IPF	432		4,317	8,908		403,301	40
43	Nursery	710		1,483	3,267		58,509	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,322		5,440			169,994	50
51	Recovery Room	228		420			5,073	51
52	Delivery Room & Labor Room	5,270		3,283	1,205		148,404	52
53	Anesthesiology	3,654		2,866			33,946	53
54	Radiology-Diagnostic	1,639	1,591	6,691			290,189	54
57	CT Scan	1,384		5,068			10,891	57
58	MRI	58		1,092			2,873	58
60	Laboratory	3,083		8,640			208,097	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			754			4,357	63
65	Respiratory Therapy			2,295			41,634	65
66	Physical Therapy	1,467		2,109			55,986	66
69	Electrocardiology	322		1,753			31,966	69
70	Electroencephalography	58		277			15,767	70
71	Medical Supplies Charged to Patients	58,547		2,257			77,806	71
72	Impl. Dev. Charged to Patients	27,568		1,246			37,159	72
73	Drugs Charged to Patients		85,003	14,405			127,106	73
75	ASC (Non-Distinct Part)	142		666			7,884	75
76	HEMODIALYSIS			214			2,033	76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,810		1,010			172,254	90
90.01	CHEMOTHERAPY			1,642			12,266	90.01
90.02	KEDZIE CLINIC	575		1,156			13,455	90.02
90.03	LITTLE VILLAGE CLINIC	229		1,204			14,159	90.03
91	Emergency	223		12,994			155,900	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	124,329	86,594	95,157	31,101		3,486,264	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						4,378	190
192	Physicians' Private Offices	643					228,775	192

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-OTHER PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
192.0 1	OTHER NON-REIMBURSABLE	2					3,120	192.0 1
192.0 2	NEPHROLOGY	1,310					7,428	192.0 2
200	Cross Foot Adjustments					11,084	11,084	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	126,284	86,594	95,157	31,101	11,084	3,741,049	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	CASHIERING						5.01
5.06	ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R 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		1,211,146				30
31	Intensive Care Unit		174,109				31
40	Subprovider - IPF		403,301				40
43	Nursery		58,509				43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		169,994				50
51	Recovery Room		5,073				51
52	Delivery Room & Labor Room		148,404				52
53	Anesthesiology		33,946				53
54	Radiology-Diagnostic		290,189				54
57	CT Scan		10,891				57
58	MRI		2,873				58
60	Laboratory		208,097				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		4,357				63
65	Respiratory Therapy		41,634				65
66	Physical Therapy		55,986				66
69	Electrocardiology		31,966				69
70	Electroencephalography		15,767				70
71	Medical Supplies Charged to Patients		77,806				71
72	Impl. Dev. Charged to Patients		37,159				72
73	Drugs Charged to Patients		127,106				73
75	ASC (Non-Distinct Part)		7,884				75
76	HEMODIALYSIS		2,033				76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		172,254				90
90.01	CHEMOTHERAPY		12,266				90.01
90.02	KEDZIE CLINIC		13,455				90.02
90.03	LITTLE VILLAGE CLINIC		14,159				90.03
91	Emergency		155,900				91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		3,486,264				118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		4,378				190
192	Physicians' Private Offices		228,775				192

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
192.0 1	OTHER NON-REIMBURSABLE		3,120				192.0 1
192.0 2	NEPHROLOGY		7,428				192.0 2
200	Cross Foot Adjustments		11,084				200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)		3,741,049				202

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT T GROSS SALARIES	RECON-CILIATION	A+G ACCUM COST	MAINTEN-ANCE AND REPAIRS SQUARE FEET	
		1	2	4	5A.06	5.06	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	202,656						1
2	Cap Rel Costs-Mvble Equip		202,656					2
4	Employee Benefits Department	797	797	46,295,675				4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL	25,000	25,000	9,252,356	-19,239,610	71,090,070		5.06
6	Maintenance & Repairs	7,573	7,573	401,718		1,991,118	169,286	6
7	Operation of Plant	24,988	24,988	1,277,244		3,440,791	24,988	7
8	Laundry & Linen Service	3,533	3,533			546,070	3,533	8
9	Housekeeping	1,819	1,819	842,406		2,032,070	1,819	9
10	Dietary	3,667	3,667	333,663		950,856	3,667	10
11	Cafeteria	5,078	5,078	466,247		798,489	5,078	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,547	3,547	1,180,917		1,688,202	3,547	13
14	Central Services & Supply	5,230	5,230	310,753		336,988	5,230	14
15	Pharmacy	2,892	2,892	1,328,212		1,569,092	2,892	15
16	Medical Records & Library	3,695	3,695	593,243		1,033,454	3,695	16
17	Social Service	998	998	656,728		822,300	998	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			1,900,685		1,199,847		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,145	42,145	5,427,089		8,010,417	42,145	30
31	Intensive Care Unit	5,734	5,734	1,492,424		2,166,472	5,734	31
40	Subprovider - IPF	12,607	12,607	2,154,562		3,028,076	12,607	40
43	Nursery	1,268	1,268	696,972		1,157,975	1,268	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,798	5,798	1,263,307		2,224,961	5,798	50
51	Recovery Room			332,103		424,830		51
52	Delivery Room & Labor Room	3,883	3,883	2,842,400		3,169,187	3,883	52
53	Anesthesiology	748	748	81,221		881,241	748	53
54	Radiology-Diagnostic	10,749	10,749	2,030,001		3,356,270	10,749	54
57	CT Scan			383,759		547,372		57
58	MRI			148,664		203,963		58
60	Laboratory	7,129	7,129	1,550,018		3,613,341	7,129	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			57,134		516,069		63
65	Respiratory Therapy	1,313	1,313	662,369		857,097	1,313	65
66	Physical Therapy	1,728	1,728	909,537		1,296,134	1,728	66
69	Electrocardiology	1,002	1,002	463,008		723,860	1,002	69
70	Electroencephalography	633	633	47,350		74,254	633	70
71	Medical Supplies Charged to Patients					2,602,532		71
72	Impl. Dev. Charged to Patients					1,277,288		72
73	Drugs Charged to Patients					4,239,771		73
75	ASC (Non-Distinct Part)			407,234		522,447		75
76	HEMODIALYSIS					278,474		76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,042	6,042	1,170,413		2,211,420	6,042	90
90.01	CHEMOTHERAPY			621,893		793,252		90.01
90.02	KEDZIE CLINIC			480,275		1,368,234		90.02
90.03	LITTLE VILLAGE CLINIC			480,275		1,652,309		90.03
91	Emergency	3,715	3,715	3,073,378		4,503,763	3,715	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	193,311	193,311	45,319,558	-19,239,610	68,110,286	159,941	118
	NONREIMBURSABLE COST CENTERS							

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMEN T GROSS SALARIES	RECON- CILIATION	A+G ACCUM COST	MAINTEN- ANCE AND REPAIRS SQUARE FEET	
		1	2	4	5A.06	5.06	6	
190	Gift, Flower, Coffee Shop & Canteen	150	150	39,227		97,113	150	190
192	Physicians' Private Offices	9,195	9,195	417,422		1,785,772	9,195	192
192.0 1	OTHER NON-REIMBURSABLE			234,101		317,518		192.0 1
192.0 2	NEPHROLOGY			285,367		779,381		192.0 2
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,741,049		8,121,801		19,239,610	2,529,988	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.460095		0.175433		0.270637	14.945052	203
204	Cost to be allocated (Per Wkst. B, Part II)			14,713		464,433	152,934	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000318		0.006533	0.903406	205

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ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY (MEALS SERVED)	CAFETERIA FULL TIME HOURS	NURSING ADMINISTRATION (FULL TIME TIME)	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant	144,298						7
8	Laundry & Linen Service	3,533	30,407					8
9	Housekeeping	1,819		138,946				9
10	Dietary	3,667		3,667	71,615			10
11	Cafeteria	5,078		5,078		1,069,290		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,547		3,547		40,379	630,535	13
14	Central Services & Supply	5,230		5,230		19,637		14
15	Pharmacy	2,892		2,892		32,864		15
16	Medical Records & Library	3,695		3,695		19,250		16
17	Social Service	998		998		19,854		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					22,862		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,145	15,316	42,145	44,215	166,168	166,168	30
31	Intensive Care Unit	5,734	2,010	5,734	3,015	37,551	37,551	31
40	Subprovider - IPF	12,607	8,709	12,607	24,385	75,041	75,041	40
43	Nursery	1,268	3,194	1,268		25,334		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,798		5,798		41,783	41,783	50
51	Recovery Room					5,680		51
52	Delivery Room & Labor Room	3,883	1,178	3,883		86,064	86,064	52
53	Anesthesiology	748		748		15,575	15,575	53
54	Radiology-Diagnostic	10,749		10,749		65,270		54
57	CT Scan					6,414		57
58	MRI					2,975		58
60	Laboratory	7,129		7,129		55,121		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					1,851		63
65	Respiratory Therapy	1,313		1,313		25,734		65
66	Physical Therapy	1,728		1,728		29,763		66
69	Electrocardiology	1,002		1,002		14,676		69
70	Electroencephalography	633		633		1,743		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)					12,994	12,994	75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,042		6,042		53,423	50,083	90
90.01	CHEMOTHERAPY					19,286	19,286	90.01
90.02	KEDZIE CLINIC					22,778		90.02
90.03	LITTLE VILLAGE CLINIC					15,393		90.03
91	Emergency	3,715		3,715		94,976	94,976	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	134,953	30,407	129,601	71,615	1,030,439	630,535	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	150		150		2,079		190

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY (MEALS SERVED)	CAFETERIA FULL TIME HOURS	NURSING ADMINISTRATION (FULL TIME TIME)	
		7	8	9	10	11	13	
192	Physicians' Private Offices	9,195		9,195		20,285		192
192.0 1	OTHER NON-REIMBURSABLE					8,394		192.0 1
192.0 2	NEPHROLOGY					8,093		192.0 2
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,745,443	862,846	2,669,028	1,454,031	1,355,022	2,434,054	202
203	Unit Cost Multiplier (Wkst. B, Part I)	32.886409	28.376558	19.209103	20.303442	1.267217	3.860300	203
204	Cost to be allocated (Per Wkst. B, Part II)	506,740	84,386	55,154	91,658	123,541	98,616	204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.511760	2.775216	0.396946	1.279872	0.115536	0.156401	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)		
	14	15	16	17	22		

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	CASHIERING						5.01
5.06	ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply	5,850,975					14
15	Pharmacy	223,320	4,319,116				15
16	Medical Records & Library	24		309,164,644			16
17	Social Service				30,407		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					1,000	22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	304,605		31,669,260	15,316	400	30
31	Intensive Care Unit	102,514		6,886,127	2,010		31
40	Subprovider - IPF	20,018		14,016,217	8,709		40
43	Nursery	32,897		4,814,710	3,194		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	153,922		17,661,624			50
51	Recovery Room	10,546		1,364,453			51
52	Delivery Room & Labor Room	244,165		10,659,273	1,178		52
53	Anesthesiology	169,277		9,306,105			53
54	Radiology-Diagnostic	75,946	79,345	21,723,386			54
57	CT Scan	64,141		16,454,119			57
58	MRI	2,671		3,545,380			58
60	Laboratory	142,842		28,050,712			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.			2,447,382			63
65	Respiratory Therapy			7,451,982			65
66	Physical Therapy	67,953		6,848,518			66
69	Electrocardiology	14,926		5,692,589			69
70	Electroencephalography	2,699		899,676			70
71	Medical Supplies Charged to Patients	2,712,621		7,329,363			71
72	Impl. Dev. Charged to Patients	1,277,288		4,045,618			72
73	Drugs Charged to Patients		4,239,771	46,978,024			73
75	ASC (Non-Distinct Part)	6,569		2,163,360			75
76	HEMODIALYSIS			694,212			76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	83,882		3,280,626		200	90
90.01	CHEMOTHERAPY			5,331,215			90.01
90.02	KEDZIE CLINIC	26,628		3,751,969			90.02
90.03	LITTLE VILLAGE CLINIC	10,600		3,909,006			90.03
91	Emergency	10,335		42,189,738		400	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	5,760,389	4,319,116	309,164,644	30,407	1,000	118

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE PATIENT DAYS 17	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22		
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	29,778						192
192.0	OTHER NON-REIMBURSABLE	102						192.0
1								1
192.0	NEPHROLOGY	60,706						192.0
2								2
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	803,696	2,259,948	1,585,257	1,136,911	1,553,541		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.137361	0.523243	0.005128	37.389779	1,553.541000		203
204	Cost to be allocated (Per Wkst. B, Part II)	126,284	86,594	95,157	31,101	11,084		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.021583	0.020049	0.000308	1.022824	11.084000		205

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET		
DESCRIPTION		PART	LINE NO.	AMOUNT
1		2	3	4

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
				1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	15,965,027		15,965,027		15,965,027	30
31	Intensive Care Unit	3,572,551		3,572,551		3,572,551	31
40	Subprovider - IPF	6,220,022		6,220,022		6,220,022	40
43	Nursery	1,925,541		1,925,541	47,894	1,973,435	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,541,773		3,541,773		3,541,773	50
51	Recovery Room	577,376		577,376		577,376	51
52	Delivery Room & Labor Room	4,894,173		4,894,173		4,894,173	52
53	Anesthesiology	1,320,718		1,320,718	155,147	1,475,865	53
54	Radiology-Diagnostic	5,231,278		5,231,278		5,231,278	54
57	CT Scan	796,826		796,826		796,826	57
58	MRI	281,481		281,481		281,481	58
60	Laboratory	5,302,492		5,302,492		5,302,492	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	670,632		670,632		670,632	63
65	Respiratory Therapy	1,247,909		1,247,909		1,247,909	65
66	Physical Therapy	1,844,931		1,844,931		1,844,931	66
69	Electrocardiology	1,036,778		1,036,778		1,036,778	69
70	Electroencephalography	143,980		143,980		143,980	70
71	Medical Supplies Charged to Patients	3,717,066		3,717,066		3,717,066	71
72	Impl. Dev. Charged to Patients	1,819,165		1,819,165		1,819,165	72
73	Drugs Charged to Patients	7,846,403		7,846,403		7,846,403	73
75	ASC (Non-Distinct Part)	742,463		742,463		742,463	75
76	HEMODIALYSIS	357,399		357,399		357,399	76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	3,504,350		3,504,350		3,504,350	90
90.01	CHEMOTHERAPY	1,134,163		1,134,163		1,134,163	90.01
90.02	KEDZIE CLINIC	1,790,292		1,790,292	97,899	1,888,191	90.02
90.03	LITTLE VILLAGE CLINIC	2,140,492		2,140,492		2,140,492	90.03
91	Emergency	6,676,464		6,676,464		6,676,464	91
92	Observation Beds (Non-Distinct Part)	1,595,844		1,595,844		1,595,844	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	85,897,589		85,897,589	300,940	86,198,529	200
201	Less Observation Beds	1,595,844		1,595,844		1,595,844	201
202	Total (line 200 minus line 201)	84,301,745		84,301,745		84,602,685	202

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	28,347,874		28,347,874				30
31	Intensive Care Unit	6,886,127		6,886,127				31
40	Subprovider - IPF	14,016,217		14,016,217				40
43	Nursery	4,814,710		4,814,710				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,963,290	10,698,334	17,661,624	0.200535	0.200535	0.200535	50
51	Recovery Room	396,117	968,336	1,364,453	0.423156	0.423156	0.423156	51
52	Delivery Room & Labor Room	8,753,846	1,905,427	10,659,273	0.459147	0.459147	0.459147	52
53	Anesthesiology	3,363,934	5,942,171	9,306,105	0.141920	0.141920	0.158591	53
54	Radiology-Diagnostic	4,040,853	17,682,533	21,723,386	0.240813	0.240813	0.240813	54
57	CT Scan	4,585,508	11,868,611	16,454,119	0.048427	0.048427	0.048427	57
58	MRI	548,311	2,997,069	3,545,380	0.079394	0.079394	0.079394	58
60	Laboratory	12,608,783	15,441,929	28,050,712	0.189032	0.189032	0.189032	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,982,975	464,407	2,447,382	0.274020	0.274020	0.274020	63
65	Respiratory Therapy	6,846,946	605,036	7,451,982	0.167460	0.167460	0.167460	65
66	Physical Therapy	616,470	6,232,048	6,848,518	0.269391	0.269391	0.269391	66
69	Electrocardiology	2,169,014	3,523,575	5,692,589	0.182128	0.182128	0.182128	69
70	Electroencephalography	178,089	721,587	899,676	0.160035	0.160035	0.160035	70
71	Medical Supplies Charged to Patients	4,479,369	2,849,994	7,329,363	0.507147	0.507147	0.507147	71
72	Impl. Dev. Charged to Patients	2,484,942	1,560,676	4,045,618	0.449663	0.449663	0.449663	72
73	Drugs Charged to Patients	20,766,623	26,211,401	46,978,024	0.167023	0.167023	0.167023	73
75	ASC (Non-Distinct Part)	125,137	2,038,223	2,163,360	0.343199	0.343199	0.343199	75
76	HEMODIALYSIS	641,004	53,208	694,212	0.514827	0.514827	0.514827	76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	462	3,280,164	3,280,626	1.068196	1.068196	1.068196	90
90.01	CHEMOTHERAPY	443	5,330,772	5,331,215	0.212740	0.212740	0.212740	90.01
90.02	KEDZIE CLINIC		3,751,969	3,751,969	0.477161	0.477161	0.503253	90.02
90.03	LITTLE VILLAGE CLINIC		3,909,006	3,909,006	0.547580	0.547580	0.547580	90.03
91	Emergency	7,067,216	35,122,522	42,189,738	0.158249	0.158249	0.158249	91
92	Observation Beds (Non-Distinct Part)	146,792	3,174,594	3,321,386	0.480475	0.480475	0.480475	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	142,831,052	166,333,592	309,164,644				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	142,831,052	166,333,592	309,164,644				202

KPMG LLP Compu-Max 2552-10

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,211,146		1,211,146	17,017	71.17	3,724	265,037	30
31	Intensive Care Unit	174,109		174,109	2,010	86.62	806	69,816	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	403,301		403,301	8,709	46.31	2,573	119,156	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	58,509		58,509	3,194	18.32			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,847,065		1,847,065	30,930		7,103	454,009	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0095

**WORKSHEET D
PART II**

Check Title v Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5	6	7	8
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	169,994	17,661,624	0.009625	1,735,552	16,705	50
51	Recovery Room	5,073	1,364,453	0.003718	101,318	377	51
52	Delivery Room & Labor Room	148,404	10,659,273	0.013923	7,282	101	52
53	Anesthesiology	33,946	9,306,105	0.003648	603,219	2,201	53
54	Radiology-Diagnostic	290,189	21,723,386	0.013358	1,287,077	17,193	54
57	CT Scan	10,891	16,454,119	0.000662	1,265,642	838	57
58	MRI	2,873	3,545,380	0.000810	168,586	137	58
60	Laboratory	208,097	28,050,712	0.007419	2,991,055	22,191	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,357	2,447,382	0.001780	514,258	915	63
65	Respiratory Therapy	41,634	7,451,982	0.005587	2,204,421	12,316	65
66	Physical Therapy	55,986	6,848,518	0.008175	251,917	2,059	66
69	Electrocardiology	31,966	5,692,589	0.005615	873,974	4,907	69
70	Electroencephalography	15,767	899,676	0.017525	52,135	914	70
71	Medical Supplies Charged to Pat	77,806	7,329,363	0.010616	1,337,353	14,197	71
72	Impl. Dev. Charged to Patients	37,159	4,045,618	0.009185	595,172	5,467	72
73	Drugs Charged to Patients	127,106	46,978,024	0.002706	4,868,798	13,175	73
75	ASC (Non-Distinct Part)	7,884	2,163,360	0.003644	29,789	109	75
76	HEMODIALYSIS	2,033	694,212	0.002929	369,500	1,082	76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	172,254	3,280,626	0.052506			90
90.01	CHEMOTHERAPY	12,266	5,331,215	0.002301			90.01
90.02	KEDZIE CLINIC	13,455	3,751,969	0.003586			90.02
90.03	LITTLE VILLAGE CLINIC	14,159	3,909,006	0.003622			90.03
91	Emergency	155,900	42,189,738	0.003695	1,416,429	5,234	91
92	Observation Beds (Non-Distinct	121,064	3,321,386	0.036450	42,010	1,531	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,760,263	255,099,716		20,715,487	121,649	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	17,017		3,724		30
31	Intensive Care Unit	2,010		806		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	8,709		2,573		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,194				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	30,930		7,103		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	17,661,624			1,735,552		1,466,760		50
51	Recovery Room	1,364,453			101,318		148,958		51
52	Delivery Room & Labor Room	10,659,273			7,282		2,290		52
53	Anesthesiology	9,306,105			603,219		920,902		53
54	Radiology-Diagnostic	21,723,386			1,287,077		1,684,949		54
57	CT Scan	16,454,119			1,265,642		1,785,223		57
58	MRI	3,545,380			168,586		502,344		58
60	Laboratory	28,050,712			2,991,055		1,546,934		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,447,382			514,258		34,034		63
65	Respiratory Therapy	7,451,982			2,204,421		168,765		65
66	Physical Therapy	6,848,518			251,917		36,409		66
69	Electrocardiology	5,692,589			873,974		808,040		69
70	Electroencephalography	899,676			52,135		151,309		70
71	Medical Supplies Charged to Pat	7,329,363			1,337,353		504,293		71
72	Impl. Dev. Charged to Patients	4,045,618			595,172		311,142		72
73	Drugs Charged to Patients	46,978,024			4,868,798		6,486,044		73
75	ASC (Non-Distinct Part)	2,163,360			29,789		362,436		75
76	HEMODIALYSIS	694,212			369,500		14,780		76
76.01	DIABETES CENTER								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,280,626					1,122,820		90
90.01	CHEMOTHERAPY	5,331,215					1,627,798		90.01
90.02	KEDZIE CLINIC	3,751,969					22,685		90.02
90.03	LITTLE VILLAGE CLINIC	3,909,006					10,227		90.03
91	Emergency	42,189,738			1,416,429		1,896,821		91
92	Observation Beds (Non-Distinct	3,321,386			42,010		557,519		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	255,099,716			20,715,487		22,173,482		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0095

**WORKSHEET D
PART V**

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.200535	1,466,760			294,137			50
51	Recovery Room	0.423156	148,958			63,032			51
52	Delivery Room & Labor Room	0.459147	2,290			1,051			52
53	Anesthesiology	0.141920	920,902			130,694			53
54	Radiology-Diagnostic	0.240813	1,684,949			405,758			54
57	CT Scan	0.048427	1,785,223			86,453			57
58	MRI	0.079394	502,344			39,883			58
60	Laboratory	0.189032	1,546,934			292,420			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.274020	34,034			9,326			63
65	Respiratory Therapy	0.167460	168,765			28,261			65
66	Physical Therapy	0.269391	36,409			9,808			66
69	Electrocardiology	0.182128	808,040			147,167			69
70	Electroencephalography	0.160035	151,309			24,215			70
71	Medical Supplies Charged to Pat	0.507147	504,293			255,751			71
72	Impl. Dev. Charged to Patients	0.449663	311,142			139,909			72
73	Drugs Charged to Patients	0.167023	6,486,044		31,727	1,083,319		5,299	73
75	ASC (Non-Distinct Part)	0.343199	362,436			124,388			75
76	HEMODIALYSIS	0.514827	14,780			7,609			76
76.01	DIABETES CENTER								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.068196	1,122,820			1,199,392			90
90.01	CHEMOTHERAPY	0.212740	1,627,798			346,298			90.01
90.02	KEDZIE CLINIC	0.477161	22,685			10,824			90.02
90.03	LITTLE VILLAGE CLINIC	0.547580	10,227			5,600			90.03
91	Emergency	0.158249	1,896,821			300,170			91
92	Observation Beds (Non-Distinct	0.480475	557,519			267,874			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		22,173,482		31,727	5,273,339		5,299	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		22,173,482		31,727	5,273,339		5,299	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S095

**WORKSHEET D
PART II**

Check Title v Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5			
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	169,994	17,661,624	0.009625	3,691	36	50
51	Recovery Room	5,073	1,364,453	0.003718	864	3	51
52	Delivery Room & Labor Room	148,404	10,659,273	0.013923			52
53	Anesthesiology	33,946	9,306,105	0.003648	3,016	11	53
54	Radiology-Diagnostic	290,189	21,723,386	0.013358	27,192	363	54
57	CT Scan	10,891	16,454,119	0.000662	24,979	17	57
58	MRI	2,873	3,545,380	0.000810	12,558	10	58
60	Laboratory	208,097	28,050,712	0.007419	455,972	3,383	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,357	2,447,382	0.001780			63
65	Respiratory Therapy	41,634	7,451,982	0.005587	52,942	296	65
66	Physical Therapy	55,986	6,848,518	0.008175	6,749	55	66
69	Electrocardiology	31,966	5,692,589	0.005615	53,579	301	69
70	Electroencephalography	15,767	899,676	0.017525	14,056	246	70
71	Medical Supplies Charged to Pat	77,806	7,329,363	0.010616			71
72	Impl. Dev. Charged to Patients	37,159	4,045,618	0.009185			72
73	Drugs Charged to Patients	127,106	46,978,024	0.002706	592,736	1,604	73
75	ASC (Non-Distinct Part)	7,884	2,163,360	0.003644			75
76	HEMODIALYSIS	2,033	694,212	0.002929	5,912	17	76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	172,254	3,280,626	0.052506			90
90.01	CHEMOTHERAPY	12,266	5,331,215	0.002301			90.01
90.02	KEDZIE CLINIC	13,455	3,751,969	0.003586			90.02
90.03	LITTLE VILLAGE CLINIC	14,159	3,909,006	0.003622			90.03
91	Emergency	155,900	42,189,738	0.003695	291,492	1,077	91
92	Observation Beds (Non-Distinct		3,321,386				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,639,199	255,099,716		1,545,738	7,419	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	17,661,624			3,691				50
51	Recovery Room	1,364,453			864				51
52	Delivery Room & Labor Room	10,659,273							52
53	Anesthesiology	9,306,105			3,016				53
54	Radiology-Diagnostic	21,723,386			27,192				54
57	CT Scan	16,454,119			24,979				57
58	MRI	3,545,380			12,558				58
60	Laboratory	28,050,712			455,972				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,447,382							63
65	Respiratory Therapy	7,451,982			52,942				65
66	Physical Therapy	6,848,518			6,749				66
69	Electrocardiology	5,692,589			53,579				69
70	Electroencephalography	899,676			14,056				70
71	Medical Supplies Charged to Pat	7,329,363							71
72	Impl. Dev. Charged to Patients	4,045,618							72
73	Drugs Charged to Patients	46,978,024			592,736				73
75	ASC (Non-Distinct Part)	2,163,360							75
76	HEMODIALYSIS	694,212			5,912				76
76.01	DIABETES CENTER								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,280,626							90
90.01	CHEMOTHERAPY	5,331,215							90.01
90.02	KEDZIE CLINIC	3,751,969							90.02
90.03	LITTLE VILLAGE CLINIC	3,909,006							90.03
91	Emergency	42,189,738			291,492				91
92	Observation Beds (Non-Distinct)	3,321,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	255,099,716			1,545,738				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S095

**WORKSHEET D
PART V**

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.200535							50
51	Recovery Room	0.423156							51
52	Delivery Room & Labor Room	0.459147							52
53	Anesthesiology	0.141920							53
54	Radiology-Diagnostic	0.240813							54
57	CT Scan	0.048427							57
58	MRI	0.079394							58
60	Laboratory	0.189032							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.274020							63
65	Respiratory Therapy	0.167460							65
66	Physical Therapy	0.269391							66
69	Electrocardiology	0.182128							69
70	Electroencephalography	0.160035							70
71	Medical Supplies Charged to Pat	0.507147							71
72	Impl. Dev. Charged to Patients	0.449663							72
73	Drugs Charged to Patients	0.167023							73
75	ASC (Non-Distinct Part)	0.343199							75
76	HEMODIALYSIS	0.514827							76
76.01	DIABETES CENTER								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.068196							90
90.01	CHEMOTHERAPY	0.212740							90.01
90.02	KEDZIE CLINIC	0.477161							90.02
90.03	LITTLE VILLAGE CLINIC	0.547580							90.03
91	Emergency	0.158249							91
92	Observation Beds (Non-Distinct	0.480475							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title v
 Applicable Title XVIII, Part A
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,211,146		1,211,146	17,017	71.17	4,527	322,187	30
31	Intensive Care Unit	174,109		174,109	2,010	86.62	312	27,025	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	403,301		403,301	8,709	46.31	2,798	129,575	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	58,509		58,509	3,194	18.32	2,097	38,417	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,847,065		1,847,065	30,930		9,734	517,204	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0095

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other)
 Applicable Title XVIII, Part A IPF
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	169,994	17,661,624	0.009625			50
51	Recovery Room	5,073	1,364,453	0.003718			51
52	Delivery Room & Labor Room	148,404	10,659,273	0.013923			52
53	Anesthesiology	33,946	9,306,105	0.003648			53
54	Radiology-Diagnostic	290,189	21,723,386	0.013358			54
57	CT Scan	10,891	16,454,119	0.000662			57
58	MRI	2,873	3,545,380	0.000810			58
60	Laboratory	208,097	28,050,712	0.007419			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,357	2,447,382	0.001780			63
65	Respiratory Therapy	41,634	7,451,982	0.005587			65
66	Physical Therapy	55,986	6,848,518	0.008175			66
69	Electrocardiology	31,966	5,692,589	0.005615			69
70	Electroencephalography	15,767	899,676	0.017525			70
71	Medical Supplies Charged to Pat	77,806	7,329,363	0.010616			71
72	Impl. Dev. Charged to Patients	37,159	4,045,618	0.009185			72
73	Drugs Charged to Patients	127,106	46,978,024	0.002706			73
75	ASC (Non-Distinct Part)	7,884	2,163,360	0.003644			75
76	HEMODIALYSIS	2,033	694,212	0.002929			76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	172,254	3,280,626	0.052506			90
90.01	CHEMOTHERAPY	12,266	5,331,215	0.002301			90.01
90.02	KEDZIE CLINIC	13,455	3,751,969	0.003586			90.02
90.03	LITTLE VILLAGE CLINIC	14,159	3,909,006	0.003622			90.03
91	Emergency	155,900	42,189,738	0.003695			91
92	Observation Beds (Non-Distinct	121,064	3,321,386	0.036450			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,760,263	255,099,716				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	17,017		4,527		30
31	Intensive Care Unit	2,010		312		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	8,709		2,798		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,194		2,097		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	30,930		9,734		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	17,661,624							50
51	Recovery Room	1,364,453							51
52	Delivery Room & Labor Room	10,659,273							52
53	Anesthesiology	9,306,105							53
54	Radiology-Diagnostic	21,723,386							54
57	CT Scan	16,454,119							57
58	MRI	3,545,380							58
60	Laboratory	28,050,712							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,447,382							63
65	Respiratory Therapy	7,451,982							65
66	Physical Therapy	6,848,518							66
69	Electrocardiology	5,692,589							69
70	Electroencephalography	899,676							70
71	Medical Supplies Charged to Pat	7,329,363							71
72	Impl. Dev. Charged to Patients	4,045,618							72
73	Drugs Charged to Patients	46,978,024							73
75	ASC (Non-Distinct Part)	2,163,360							75
76	HEMODIALYSIS	694,212							76
76.01	DIABETES CENTER								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,280,626							90
90.01	CHEMOTHERAPY	5,331,215							90.01
90.02	KEDZIE CLINIC	3,751,969							90.02
90.03	LITTLE VILLAGE CLINIC	3,909,006							90.03
91	Emergency	42,189,738							91
92	Observation Beds (Non-Distinct	3,321,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	255,099,716							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0095

**WORKSHEET D
PART V**

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
1	2	3	4	5	6	7			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	0.200535						50	
51	Recovery Room	0.423156						51	
52	Delivery Room & Labor Room	0.459147						52	
53	Anesthesiology	0.141920						53	
54	Radiology-Diagnostic	0.240813						54	
57	CT Scan	0.048427						57	
58	MRI	0.079394						58	
60	Laboratory	0.189032						60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.274020						63	
65	Respiratory Therapy	0.167460						65	
66	Physical Therapy	0.269391						66	
69	Electrocardiology	0.182128						69	
70	Electroencephalography	0.160035						70	
71	Medical Supplies Charged to Pat	0.507147						71	
72	Impl. Dev. Charged to Patients	0.449663						72	
73	Drugs Charged to Patients	0.167023						73	
75	ASC (Non-Distinct Part)	0.343199						75	
76	HEMODIALYSIS	0.514827						76	
76.01	DIABETES CENTER							76.01	
76.97	CARDIAC REHABILITATION							76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	1.068196						90	
90.01	CHEMOTHERAPY	0.212740						90.01	
90.02	KEDZIE CLINIC	0.477161						90.02	
90.03	LITTLE VILLAGE CLINIC	0.547580						90.03	
91	Emergency	0.158249						91	
92	Observation Beds (Non-Distinct	0.480475						92	
OTHER REIMBURSABLE COST CENTERS									
200	Subtotal (see instructions)							200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)							202	

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S095

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other)
 Applicable Title XVIII, Part A IPF
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5	6	7	8
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	169,994	17,661,624	0.009625	9,871	95	50
51	Recovery Room	5,073	1,364,453	0.003718	2,030	8	51
52	Delivery Room & Labor Room	148,404	10,659,273	0.013923			52
53	Anesthesiology	33,946	9,306,105	0.003648	5,728	21	53
54	Radiology-Diagnostic	290,189	21,723,386	0.013358	56,256	751	54
57	CT Scan	10,891	16,454,119	0.000662	34,518	23	57
58	MRI	2,873	3,545,380	0.000810	25,120	20	58
60	Laboratory	208,097	28,050,712	0.007419	909,192	6,745	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,357	2,447,382	0.001780			63
65	Respiratory Therapy	41,634	7,451,982	0.005587	69,994	391	65
66	Physical Therapy	55,986	6,848,518	0.008175	7,887	64	66
69	Electrocardiology	31,966	5,692,589	0.005615	120,648	677	69
70	Electroencephalography	15,767	899,676	0.017525			70
71	Medical Supplies Charged to Pat	77,806	7,329,363	0.010616	5,466	58	71
72	Impl. Dev. Charged to Patients	37,159	4,045,618	0.009185			72
73	Drugs Charged to Patients	127,106	46,978,024	0.002706	1,126,003	3,047	73
75	ASC (Non-Distinct Part)	7,884	2,163,360	0.003644			75
76	HEMODIALYSIS	2,033	694,212	0.002929	6,420	19	76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	172,254	3,280,626	0.052506			90
90.01	CHEMOTHERAPY	12,266	5,331,215	0.002301			90.01
90.02	KEDZIE CLINIC	13,455	3,751,969	0.003586			90.02
90.03	LITTLE VILLAGE CLINIC	14,159	3,909,006	0.003622			90.03
91	Emergency	155,900	42,189,738	0.003695	43,345	160	91
92	Observation Beds (Non-Distinct		3,321,386				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,639,199	255,099,716		2,422,478	12,079	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S095

**WORKSHEET D
PART IV**

Check Title v Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	17,661,624			9,871				50
51	Recovery Room	1,364,453			2,030				51
52	Delivery Room & Labor Room	10,659,273							52
53	Anesthesiology	9,306,105			5,728				53
54	Radiology-Diagnostic	21,723,386			56,256				54
57	CT Scan	16,454,119			34,518				57
58	MRI	3,545,380			25,120				58
60	Laboratory	28,050,712			909,192				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,447,382							63
65	Respiratory Therapy	7,451,982			69,994				65
66	Physical Therapy	6,848,518			7,887				66
69	Electrocardiology	5,692,589			120,648				69
70	Electroencephalography	899,676							70
71	Medical Supplies Charged to Pat	7,329,363			5,466				71
72	Impl. Dev. Charged to Patients	4,045,618							72
73	Drugs Charged to Patients	46,978,024			1,126,003				73
75	ASC (Non-Distinct Part)	2,163,360							75
76	HEMODIALYSIS	694,212			6,420				76
76.01	DIABETES CENTER								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,280,626							90
90.01	CHEMOTHERAPY	5,331,215							90.01
90.02	KEDZIE CLINIC	3,751,969							90.02
90.03	LITTLE VILLAGE CLINIC	3,909,006							90.03
91	Emergency	42,189,738			43,345				91
92	Observation Beds (Non-Distinct	3,321,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	255,099,716			2,422,478				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S095

**WORKSHEET D
PART V**

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges			Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	0.200535					50
51	Recovery Room	0.423156					51
52	Delivery Room & Labor Room	0.459147					52
53	Anesthesiology	0.141920					53
54	Radiology-Diagnostic	0.240813					54
57	CT Scan	0.048427					57
58	MRI	0.079394					58
60	Laboratory	0.189032					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	0.274020					63
65	Respiratory Therapy	0.167460					65
66	Physical Therapy	0.269391					66
69	Electrocardiology	0.182128					69
70	Electroencephalography	0.160035					70
71	Medical Supplies Charged to Pat	0.507147					71
72	Impl. Dev. Charged to Patients	0.449663					72
73	Drugs Charged to Patients	0.167023					73
75	ASC (Non-Distinct Part)	0.343199					75
76	HEMODIALYSIS	0.514827					76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1.068196					90
90.01	CHEMOTHERAPY	0.212740					90.01
90.02	KEDZIE CLINIC	0.477161					90.02
90.03	LITTLE VILLAGE CLINIC	0.547580					90.03
91	Emergency	0.158249					91
92	Observation Beds (Non-Distinct	0.480475					92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (see instructions)						200
201	Less PBP Clinic Lab. Services-Program Only Charges						201
202	Net Charges (line 200 - line 201)						202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0095

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,017	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,017	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	15,316	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,724	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 XIX only)		15
16	Nursery days (title V or 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)	15,965,027	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 (line 21 minus line 26)	15,965,027	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	15,965,027	37

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0095

**WORKSHEET D-1
PART II**

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					938.18	38	
39	Program general inpatient routine service cost (line 9 x line 38)					3,493,782	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					3,493,782	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	3,572,551	2,010	1,777.39	806	1,432,576	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,389,247	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					9,315,605	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					334,853	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					121,649	51
52	Total Program excludable cost (sum of lines 50 and 51)					456,502	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					8,859,103	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						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 (line 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

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0095

**WORKSHEET D-1
PARTS III & IV**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,701	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					938.18	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,595,844	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,211,146	15,965,027	0.075862	1,595,844	121,064	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S095

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,709	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,709	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	8,709	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,573	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 XIX only)		15
16	Nursery days (title V or 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)	6,220,022	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 (line 21 minus line 26)	6,220,022	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	6,220,022	37

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S095

**WORKSHEET D-1
PART II**

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	714.21	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,837,662	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,837,662	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	267,396	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,105,058	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	119,156	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,419	51
52	Total Program excludable cost (sum of lines 50 and 51)	126,575	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,978,483	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 (line 56 minus line 53)		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 (line 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

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0095

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,017	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,017	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	15,316	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,527	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 XIX only)	3,194	15
16	Nursery days (title V or XIX only)	2,097	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)	15,965,027	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 (line 21 minus line 26)	15,965,027	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	15,965,027	37

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0095

**WORKSHEET D-1
PART II**

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						938.18	38
39	Program general inpatient routine service cost (line 9 x line 38)						4,247,141	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						4,247,141	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)	1,925,541	3,194	602.86	2,097	1,264,197		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	3,572,551	2,010	1,777.39	312	554,546		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						6,065,884	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						387,629	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51
52	Total Program excludable cost (sum of lines 50 and 51)						387,629	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 (line 56 minus line 53)							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 (line 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

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0095

**WORKSHEET D-1
PARTS III & IV**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,701	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S095

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,709	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,709	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	8,709	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,798	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 XIX only)		15
16	Nursery days (title V or 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)	6,220,022	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 (line 21 minus line 26)	6,220,022	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	6,220,022	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S095

**WORKSHEET D-1
PART II**

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	714.21	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,998,360	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,998,360	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	429,553	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,427,913	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	129,575	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,079	51
52	Total Program excludable cost (sum of lines 50 and 51)	141,654	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 (line 56 minus line 53)		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 (line 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

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0095

WORKSHEET D-3

Check Title v Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		7,878,368		30
31	Intensive Care Unit		2,722,218		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.200535	1,735,552	348,039	50
51	Recovery Room	0.423156	101,318	42,873	51
52	Delivery Room & Labor Room	0.459147	7,282	3,344	52
53	Anesthesiology	0.158591	603,219	95,665	53
54	Radiology-Diagnostic	0.240813	1,287,077	309,945	54
57	CT Scan	0.048427	1,265,642	61,291	57
58	MRI	0.079394	168,586	13,385	58
60	Laboratory	0.189032	2,991,055	565,405	60
62.30	BLOOD CLOTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.274020	514,258	140,917	63
65	Respiratory Therapy	0.167460	2,204,421	369,152	65
66	Physical Therapy	0.269391	251,917	67,864	66
69	Electrocardiology	0.182128	873,974	159,175	69
70	Electroencephalography	0.160035	52,135	8,343	70
71	Medical Supplies Charged to Patients	0.507147	1,337,353	678,235	71
72	Impl. Dev. Charged to Patients	0.449663	595,172	267,627	72
73	Drugs Charged to Patients	0.167023	4,868,798	813,201	73
75	ASC (Non-Distinct Part)	0.343199	29,789	10,224	75
76	HEMODIALYSIS	0.514827	369,500	190,229	76
76.01	DIABETES CENTER				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.068196			90
90.01	CHEMOTHERAPY	0.212740			90.01
90.02	KEDZIE CLINIC	0.503253			90.02
90.03	LITTLE VILLAGE CLINIC	0.547580			90.03
91	Emergency	0.158249	1,416,429	224,148	91
92	Observation Beds (Non-Distinct Part)	0.480475	42,010	20,185	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		20,715,487	4,389,247	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		20,715,487		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S095

WORKSHEET D-3

Check Title v Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		4,105,328		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.200535	3,691	740	50
51	Recovery Room	0.423156	864	366	51
52	Delivery Room & Labor Room	0.459147			52
53	Anesthesiology	0.158591	3,016	478	53
54	Radiology-Diagnostic	0.240813	27,192	6,548	54
57	CT Scan	0.048427	24,979	1,210	57
58	MRI	0.079394	12,558	997	58
60	Laboratory	0.189032	455,972	86,193	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.274020			63
65	Respiratory Therapy	0.167460	52,942	8,866	65
66	Physical Therapy	0.269391	6,749	1,818	66
69	Electrocardiology	0.182128	53,579	9,758	69
70	Electroencephalography	0.160035	14,056	2,249	70
71	Medical Supplies Charged to Patients	0.507147			71
72	Impl. Dev. Charged to Patients	0.449663			72
73	Drugs Charged to Patients	0.167023	592,736	99,001	73
75	ASC (Non-Distinct Part)	0.343199			75
76	HEMODIALYSIS	0.514827	5,912	3,044	76
76.01	DIABETES CENTER				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.068196			90
90.01	CHEMOTHERAPY	0.212740			90.01
90.02	KEDZIE CLINIC	0.503253			90.02
90.03	LITTLE VILLAGE CLINIC	0.547580			90.03
91	Emergency	0.158249	291,492	46,128	91
92	Observation Beds (Non-Distinct Part)	0.480475			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,545,738	267,396	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,545,738		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0095

WORKSHEET D-3

Check Title v Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.200535			50
51	Recovery Room	0.423156			51
52	Delivery Room & Labor Room	0.459147			52
53	Anesthesiology	0.141920			53
54	Radiology-Diagnostic	0.240813			54
57	CT Scan	0.048427			57
58	MRI	0.079394			58
60	Laboratory	0.189032			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.274020			63
65	Respiratory Therapy	0.167460			65
66	Physical Therapy	0.269391			66
69	Electrocardiology	0.182128			69
70	Electroencephalography	0.160035			70
71	Medical Supplies Charged to Patients	0.507147			71
72	Impl. Dev. Charged to Patients	0.449663			72
73	Drugs Charged to Patients	0.167023			73
75	ASC (Non-Distinct Part)	0.343199			75
76	HEMODIALYSIS	0.514827			76
76.01	DIABETES CENTER				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.068196			90
90.01	CHEMOTHERAPY	0.212740			90.01
90.02	KEDZIE CLINIC	0.477161			90.02
90.03	LITTLE VILLAGE CLINIC	0.547580			90.03
91	Emergency	0.158249			91
92	Observation Beds (Non-Distinct Part)	0.480475			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S095

WORKSHEET D-3

Check Title v Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		7,685,750		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.200535	9,871	1,979	50
51	Recovery Room	0.423156	2,030	859	51
52	Delivery Room & Labor Room	0.459147			52
53	Anesthesiology	0.141920	5,728	813	53
54	Radiology-Diagnostic	0.240813	56,256	13,547	54
57	CT Scan	0.048427	34,518	1,672	57
58	MRI	0.079394	25,120	1,994	58
60	Laboratory	0.189032	909,192	171,866	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.274020			63
65	Respiratory Therapy	0.167460	69,994	11,721	65
66	Physical Therapy	0.269391	7,887	2,125	66
69	Electrocardiology	0.182128	120,648	21,973	69
70	Electroencephalography	0.160035			70
71	Medical Supplies Charged to Patients	0.507147	5,466	2,772	71
72	Impl. Dev. Charged to Patients	0.449663			72
73	Drugs Charged to Patients	0.167023	1,126,003	188,068	73
75	ASC (Non-Distinct Part)	0.343199			75
76	HEMODIALYSIS	0.514827	6,420	3,305	76
76.01	DIABETES CENTER				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.068196			90
90.01	CHEMOTHERAPY	0.212740			90.01
90.02	KEDZIE CLINIC	0.477161			90.02
90.03	LITTLE VILLAGE CLINIC	0.547580			90.03
91	Emergency	0.158249	43,345	6,859	91
92	Observation Beds (Non-Distinct Part)	0.480475			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,422,478	429,553	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,422,478		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,540,335			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,621,004			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	48,897			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	210,800			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	104.34			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	5.59			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	3.46			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.	0.04			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)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.46			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 line 8 plus lines (8.01 and 8.02) (see instructions)	2.55			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	2.51			10
11	FTE count for residents in dental and podiatric programs	0.98			11
12	Current year allowable FTE (see instructions)	3.49			12
13	Total allowable FTE count for the prior year	3.53			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	3.53			14
15	Sum of lines 12 through 14 divided by 3	3.52			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	3.52			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.033736			19
20	Prior year resident to bed ratio (see instructions)	0.033928			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.033736			21
22	IME payment adjustment (see instructions)	116,374			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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)	-0.04			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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	116,374			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1549			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5898			31
32	Sum of lines 30 and 31	0.7447			32
33	Allowable disproportionate share percentage (see instructions)	0.5065			33
34	Disproportionate share adjustment (see instructions)	780,180			34
		Prior to	On or after		
		October 1	October 1		
35	Total uncompensated care amount (see instructions)	9,046,380,143	7,647,644,885		35
35.01	Factor 3 (see instructions)	0.000400634	0.000386245		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,624,287	2,953,865		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	913,520	2,209,329		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,122,849			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
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 41.01 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 41.01)				46
47	Subtotal (see instructions)	10,229,639			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 (see instructions)	10,229,639			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	585,956			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	87,930			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 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	10,903,525			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	10,903,525			61
62	Deductibles billed to program beneficiaries	636,668			62
63	Coinsurance billed to program beneficiaries	25,767			63
64	Allowable bad debts (see instructions)	648,034			64
65	Adjusted reimbursable bad debts (see instructions)	421,222			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	471,871			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,662,312			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-1,068			70.93
70.94	HRR adjustment amount (see instructions)	-10,944			70.94
70.99	HAC adjustment amount (see instructions)	79,699			70.99
71	Amount due provider (see instructions)	10,570,601			71
71.01	Sequestration adjustment (see instructions)	211,412			71.01
72	Interim payments	9,672,208			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	686,981			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	65,110			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

HSP Bonus Payment Amount

		Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)			100

HVBP Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101
102	HVBP adjustment amount for HSP bonus payment (see instructions)			102

HRR Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)	0.0000	0.0000	103
104	HRR adjustment amount for HSP bonus payment (see instructions)			104

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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION

EXHIBIT 5

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
	(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,540,335	1,540,335			1,540,335	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	4,621,004		4,621,004		4,621,004	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1						1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1						1.04
2	Outlier payments for discharges	48,897	12,224	36,673		48,897	2
2.01	Outlier payment for discharges for Model 4 BPCI						2.01
3	Operating outlier reconciliation						3
4	Managed Care Simulated Payments	210,800	52,700	158,100		210,800	4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E Part A, line 21	0.033736	0.033736	0.033736			5
6	IME payment adjustment	116,374	29,094	87,280		116,374	6
6.01	IME payment adjustment for managed care						6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payment adjustment factor						7
8	IME add-on adjustment amount						8
8.01	IME payment adjustment add-on for managed care						8.01
9	Total IME payment (sum of lines 6 and 8)	116,374	29,094	87,280		116,374	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)						9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage	0.5065	0.5065	0.5065	0.5065	0.5065	10
11	Disproportionate share adjustment	780,180	195,045	585,135		780,180	11
11.01	Uncompensated care payments	3,122,849	913,520	2,209,329		3,122,849	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal	10,229,639	2,690,218	7,539,421		10,229,639	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)						14
15	Total payment for inpatient operating costs SCH and MDH only	10,229,639	2,690,218	7,539,421		10,229,639	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	585,956	146,489	439,467		585,956	16
17	Special add-on payments for new technologies						17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)						17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG						17.02
18	Capital outlier reconciliation adjustment amount						18
19	SUBTOTAL		2,836,707	7,978,888		10,815,595	19
20	Capital DRG other than outlier	492,541	123,135	369,406		492,541	20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments	3,083	771	2,312		3,083	21
21.01	Model 4 BPCI Capital DRG outlier payments						21.01
22	Indirect medical education percentage	2.0600	2.0600	2.0600			22
23	Indirect medical education adjustment	10,146	2,537	7,609		10,146	23
24	Allowable disproportionate share percentage	0.1628	0.1628	0.1628			24
25	Disproportionate share adjustment	80,186	20,046	60,140		80,186	25
26	Total prospective capital payments	585,956	146,489	439,467		585,956	26
27							27
28	Low volume adjustment prior to October 1						28
29	Low volume adjustment on or after October 1						29
30	HVBP payment adjustment	-1,068	-267	-801		-1,068	30
30.01	HVBP payment adjustment for HSP bonus payment						30.01
31	HRR adjustment	-10,944	-2,736	-8,208		-10,944	31
31.01	HRR adjustment for HSP bonus payment						31.01
32	HAC Reduction Program adjustment			79,699		79,699	32

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0095

**WORKSHEET E
PART B**

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,299			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,273,339			2
3	PPS payments	4,904,945			3
4	Outlier payment (see instructions)	6,297			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,299			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	31,727			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	31,727			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	31,727			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	26,428			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	5,299			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,911,242			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,040,932			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,875,609			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	40,641			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,916,250			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	3,916,250			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	577,429			34
35	Adjusted reimbursable bad debts (see instructions)	375,329			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	329,872			36
37	Subtotal (see instructions)	4,291,579			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,291,579			40
40.01	Sequestration adjustment (see instructions)	85,832			40.01
41	Interim payments	4,380,365			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-174,618			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S095

**WORKSHEET E
PART B**

Check applicable box: [] Hospital [XX] IPF [] IRF [] SUB (Other) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPI (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions))				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0095

**WORKSHEET E-1
PART I**

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT		
		1	2	3	4		
1	Total interim payments paid to provider		9,391,551		4,302,971	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					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. (1)						
		.01	02/06/2015	142,405	02/06/2015	72,641	3.01
		.02	05/28/2015	138,252	05/28/2015	4,753	3.02
		.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
		.51					3.51
		.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		280,657		77,394	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			9,672,208		4,380,365	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. (1)						
		.01					5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		686,981			6.01
		.02				-174,618	6.02
7	Total Medicare program liability (see instructions)			10,359,189		4,205,747	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S095

**WORKSHEET E-1
PART I**

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		1,907,876		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				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. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,907,876		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. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	2		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		1,907,878		7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check Hospital 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 (Wkst. S-3, Pt. I, col. 15, line 14)	4,869	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	4,530	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	181	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	17,326	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	309,164,644	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	22,584,902	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	603,611	8
9	Sequestration adjustment amount (see instructions)	12,072	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	591,539	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	764,178	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-172,639	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S095

**WORKSHEET E-3
PART II**

Check Hospital
Applicable Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	2,125,353	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	23.860274	9
10	Teaching adjustment factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,125,353	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	2,125,353	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,125,353	18
19	Deductibles	140,648	19
20	Subtotal (line 18 minus line 19)	1,984,705	20
21	Coinsurance	37,891	21
22	Subtotal (line 20 minus line 21)	1,946,814	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23
24	Adjusted reimbursable bad debts (see instructions)		24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)	1,946,814	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	1,946,814	31
31.01	Sequestration adjustment (see instructions)	38,936	31.01
32	Interim payments	1,907,876	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	2	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0095

**WORKSHEET E-3
PART VII**

Check Title V Hospital NF PPS
 Applicable Title XIX SUB (Other) ICF/IID TEFRA
 Boxes: SNF Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	6,065,884		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	6,065,884		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	6,065,884		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	18,085,285		8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	18,085,285		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)	18,085,285		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	12,019,401		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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	6,065,884		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	Titles V or XIX (sum of lines 21 and 27)	6,065,884		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)	6,065,884		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)	6,065,884		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	6,065,884		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)	6,065,884		40
41	Interim payments	12,500,212		41
42	Balance due provider/program (line 40 minus line 41)	-6,434,328		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S095

**WORKSHEET E-3
PART VII**

Check Title V Hospital NF PPS
 Applicable Title XIX Subprovider IPF ICF/IID TEFRA
 Boxes: SNF Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	2,427,913		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,427,913		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,427,913		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	8,134,192		8
9	Ancillary service charges	2,422,478		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)	10,556,670		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге 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)	10,556,670		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,128,757		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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	2,427,913		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	Titles V or XIX (sum of lines 21 and 27)	2,427,913		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)	2,427,913		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)	2,427,913		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	2,427,913		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)	2,427,913		40
41	Interim payments	2,495,776		41
42	Balance due provider/program (line 40 minus line 41)	-67,863		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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

WORKSHEET E-4

Check [] Title V
 Applicable [XX] Title XVIII
 Box: [] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996		5.59	1	
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2	
3	Amount of reduction to Direct GME cap under §422 of MMA		3.46	3	
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)		0.04	3.01	
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))		0.46	4	
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)			4.01	
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02	
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)		2.55	5	
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)		3.51	6	
7	Enter the lesser of line 5 or line 6		2.55	7	
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	1.82	1.67	3.49	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	1.32	1.21	2.53	9
10	Weighted dental and podiatric resident FTE count for the current year		0.98		10
11	Total weighted FTE count	1.32	2.19		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.82	1.71		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.60	1.60		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	1.58	1.83		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	1.58	1.83		17
18	Per resident amount	142,000.00	134,000.00		18
19	Approved amount for resident costs	224,360	245,220	469,580	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)			0.96	21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			469,580	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	7,103	181	26	
27	Total inpatient days (see instructions)	26,510	26,510	27	
28	Ratio of inpatient days to total inpatient days	0.267937	0.006828	28	
29	Program direct GME amount	125,818	3,206	29	
30	Reduction for direct GME payments for Medicare Advantage		453	30	
31	Net Program direct GME amount			128,571	31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32	
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			33	
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			34	
35	Medicare outpatient ESRD charges (see instructions)			35	
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36	
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)			11,420,663	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			11,420,663	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			5,278,638	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			5,278,638	44
45	Total reasonable cost (sum of lines 41 and 44)			16,699,301	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.683901	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.316099	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			128,571	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			87,930	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			40,641	50

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

WORKSHEET E-4

Check Title V
 Applicable Title XVIII
 Box: Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1	
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2	
3	Amount of reduction to Direct GME cap under §422 of MMA			3	
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01	
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4	
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)			4.01	
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02	
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5	
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)			6	
7	Enter the lesser of line 5 or line 6			7	
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	7,949	10,281		26
27	Total inpatient days (see instructions)	26,510	26,510		27
28	Ratio of inpatient days to total inpatient days	0.299849	0.387816		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	15,856,985				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	76,888,584				4
5	Other receivables	34,470				5
6	Allowances for uncollectible notes and accounts receivable	-61,133,821				6
7	Inventory	1,429,836				7
8	Prepaid expenses					8
9	Other current assets	3,391,805				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	36,467,859				11
FIXED ASSETS						
12	Land	472,850				12
13	Land improvements	500,937				13
14	Accumulated depreciation	-212,828				14
15	Buildings	24,487,838				15
16	Accumulated depreciation	-10,403,889				16
17	Leasehold improvements	6,370,169				17
18	Accumulated depreciation	-2,706,426				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	30,287,971				23
24	Accumulated depreciation	-12,868,130				24
25	Minor equipment depreciable	7,953,312				25
26	Accumulated depreciation	-3,379,040				26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	40,502,764				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	10,004,560				34
35	Total other assets (sum of lines 31-34)	10,004,560				35
36	Total assets (sum of lines 11, 30 and 35)	86,975,183				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	1,867,516				37
38	Salaries, wages and fees payable	7,062,886				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,582,937				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,944,770				44
45	Total current liabilities (sum of lines 37 thru 44)	13,458,109				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	5,278,226				49
50	Total long term liabilities (sum of lines 46 thru 49)	5,278,226				50
51	Total liabilities (sum of lines 45 and 50)	18,736,335				51
CAPITAL ACCOUNTS						
52	General fund balance	68,238,848				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

KPMG LLP Compu-Max 2552-10

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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets					
	(Omit Cents)	1	2	3	4	
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 thru 58)	68,238,848				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	86,975,183				60

KPMG LLP Compu-Max 2552-10

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		66,038,874			1
2	Net income (loss) (from Worksheet G-3, line 29)		2,199,974			2
3	Total (sum of line 1 and line 2)		68,238,848			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		68,238,848			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		68,238,848			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	31,883,799		31,883,799	1
2	Subprovider IPF	13,887,665		13,887,665	2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	45,771,464		45,771,464	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,652,914		6,652,914	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,652,914		6,652,914	16
17	Total inpatient routine care services (sum of lines 10 and 16)	52,424,378		52,424,378	17
18	Ancillary services	90,245,484	166,497,918	256,743,402	18
19	Outpatient services		34,907,177	34,907,177	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FOHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	142,669,862	201,405,095	344,074,957	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		109,160,655	29
30	Add (specify)			30
31				31
32	CONTRIBUTION	418,369		32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		418,369	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 Worksheet G-3, line 4)		109,579,024	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	344,074,957	1
2	Less contractual allowances and discounts on patients' accounts	238,929,514	2
3	Net patient revenues (line 1 minus line 2)	105,145,443	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	109,579,024	4
5	Net income from service to patients (line 3 minus line 4)	-4,433,581	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	135,761	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	92,668	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	628,769	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	106,648	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	349,057	22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)		24
24.0	Other (HIT INCENTIVE PAYMENT)	827,232	24.0
1			1
24.0	Other (MEDICAL STUDENRT PROGRAM)	1,556,813	24.0
2			2
24.0	Other (MEDICAL STUDENT PROGRAM - MISC REV)	160,000	24.0
3			3
24.0	Other (CAPITATION BONUS - FHN)	620,664	24.0
4			4
24.0	Other (OTHER OPERATING REV)	509,818	24.0
5			5
24.0	Other (SOCIAL SERVICES OTHER REVENUE)	51,000	24.0
6			6
24.0	Other (MEDICAID ASSESSMENT REVENUE)	1,004,508	24.0
7			7
24.0	Other (COMMUNITY WELLNESS)	186,675	24.0
8			8
24.0	Other (MID WIFERY PROGRAM)	175,942	24.0
9			9
24.1		228,000	24.1
0			0
25	Total other income (sum of lines 6-24)	6,633,555	25
26	Total (line 5 plus line 25)	2,199,974	26
29	Net income (or loss) for the period (line 26 minus line 28)	2,199,974	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0095

WORKSHEET L

Check Title V Hospital PPS
 Applicable Title XVIII, Part A SUB (Other) Cost Method
 Boxes: Title XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	492,541	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	3,083	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	48.77	3
4	Number of interns & residents (see instructions)	3.52	4
5	Indirect medical education percentage (see instructions)	2.06	5
6	Indirect medical education adjustment (see instructions)	10,146	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1549	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5898	8
9	Sum of lines 7 and 8	0.7447	9
10	Allowable disproportionate share percentage (see instructions)	0.1628	10
11	Disproportionate share adjustment (see instructions)	80,186	11
12	Total prospective capital payments (see instructions)	585,956	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 (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (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 (from prior year Worksheet 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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	CASHIERING						5.01
5.06	ADMINISTRATIVE & GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
40	Subprovider - IPF						40
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
57	CT Scan						57
58	MRI						58
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.						63
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
75	ASC (Non-Distinct Part)						75
76	HEMODIALYSIS						76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.01	CHEMOTHERAPY						90.01
90.02	KEDZIE CLINIC						90.02
90.03	LITTLE VILLAGE CLINIC						90.03
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
192	Physicians' Private Offices	0	2A	24	25	26		192
192.0 1	OTHER NON-REIMBURSABLE							192.0 1
192.0 2	NEPHROLOGY							192.0 2
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	21.88		26.60				48.48	30
31	Intensive Care Unit	40.10		15.52				55.62	31
43	Nursery			65.65				65.65	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	9.83	8.30					18.13	50
51	Recovery Room	7.43	10.92					18.35	51
52	Delivery Room & Labor Room	0.07	0.02					0.09	52
53	Anesthesiology	6.48	9.90					16.38	53
54	Radiology-Diagnostic	5.92	7.76					13.68	54
57	CT Scan	7.69	10.85					18.54	57
58	MRI	4.76	14.17					18.93	58
60	Laboratory	10.66	5.51					16.17	60
63	Blood Storing, Processing & Tra	21.01	1.39					22.40	63
65	Respiratory Therapy	29.58	2.26					31.84	65
66	Physical Therapy	3.68	0.53					4.21	66
69	Electrocardiology	15.35	14.19					29.54	69
70	Electroencephalography	5.79	16.82					22.61	70
71	Medical Supplies Charged to Pat	18.25	6.88					25.13	71
72	Impl. Dev. Charged to Patients	14.71	7.69					22.40	72
73	Drugs Charged to Patients	10.36	13.87					24.23	73
75	ASC (Non-Distinct Part)	1.38	16.75					18.13	75
76	HEMODIALYSIS	53.23	2.13					55.36	76
90	Clinic		34.23					34.23	90
	CHEMOTHERAPY								
90.01			30.53					30.53	90.01
90.02	KEDZIE CLINIC		0.60					0.60	90.02
90.03	LITTLE VILLAGE CLINIC		0.26					0.26	90.03
91	Emergency	3.36	4.50					7.86	91
92	Observation Beds (Non-Distinct	1.26	16.79					18.05	92
200	TOTAL CHARGES	8.12	8.70					16.82	200

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ST ANTHONY HOSPITAL Provider CCN: 14-0095	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IPF

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
40	Subprovider - IPF	29.54		32.13				61.67	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	0.02		0.06				0.08	50
51	Recovery Room	0.06		0.15				0.21	51
53	Anesthesiology	0.03		0.06				0.09	53
54	Radiology-Diagnostic	0.13		0.26				0.39	54
57	CT Scan	0.15		0.21				0.36	57
58	MRI	0.35		0.71				1.06	58
60	Laboratory	1.63		3.24				4.87	60
65	Respiratory Therapy	0.71		0.94				1.65	65
66	Physical Therapy	0.10		0.12				0.22	66
69	Electrocardiology	0.94		2.12				3.06	69
70	Electroencephalography	1.56						1.56	70
71	Medical Supplies Charged to Pat			0.07				0.07	71
73	Drugs Charged to Patients	1.26		2.40				3.66	73
76	HEMODIALYSIS	0.85		0.92				1.77	76
91	Emergency	0.69		0.10				0.79	91
200	TOTAL CHARGES	0.61		0.95				1.56	200

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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	3,741,049	4.14	-3,741,049	-8.78			1
2	Cap Rel Costs-Mvble Equip							2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	8,107,088	8.97	-8,107,088	-19.02			4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL	17,154,930	18.99	-17,154,930	-40.25			5.06
6	Maintenance & Repairs	1,780,845	1.97	-1,780,845	-4.18			6
7	Operation of Plant	2,755,439	3.05	-2,755,439	-6.47			7
8	Laundry & Linen Service	480,850	0.53	-480,850	-1.13			8
9	Housekeeping	1,850,705	2.05	-1,850,705	-4.34			9
10	Dietary	824,627	0.91	-824,627	-1.93			10
11	Cafeteria	622,954	0.69	-622,954	-1.46			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,415,552	1.57	-1,415,552	-3.32			13
14	Central Services & Supply	185,926	0.21	-185,926	-0.44			14
15	Pharmacy	1,282,693	1.42	-1,282,693	-3.01			15
16	Medical Records & Library	861,170	0.95	-861,170	-2.02			16
17	Social Service	688,665	0.76	-688,665	-1.62			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	866,404	0.96	-866,404	-2.03			22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	6,280,325	6.95	10,306,119	24.18	16,586,444	18.36	30
31	Intensive Care Unit	1,798,802	1.99	1,773,749	4.16	3,572,551	3.96	31
40	Subprovider - IPF	2,417,369	2.68	3,802,653	8.92	6,220,022	6.89	40
43	Nursery	1,012,296	1.12	913,245	2.14	1,925,541	2.13	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,896,303	2.10	1,645,470	3.86	3,541,773	3.92	50
51	Recovery Room	366,568	0.41	210,808	0.49	577,376	0.64	51
52	Delivery Room & Labor Room	2,598,855	2.88	2,295,318	5.39	4,894,173	5.42	52
53	Anesthesiology	853,184	0.94	467,534	1.10	1,320,718	1.46	53
54	Radiology-Diagnostic	2,801,713	3.10	2,429,565	5.70	5,231,278	5.79	54
57	CT Scan	480,048	0.53	316,778	0.74	796,826	0.88	57
58	MRI	177,882	0.20	103,599	0.24	281,481	0.31	58
60	Laboratory	3,209,815	3.55	2,092,677	4.91	5,302,492	5.87	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	506,046	0.56	164,586	0.39	670,632	0.74	63
65	Respiratory Therapy	716,658	0.79	531,251	1.25	1,247,909	1.38	65
66	Physical Therapy	1,104,672	1.22	740,259	1.74	1,844,931	2.04	66
69	Electrocardiology	624,136	0.69	412,642	0.97	1,036,778	1.15	69
70	Electroencephalography	54,262	0.06	89,718	0.21	143,980	0.16	70
71	Medical Supplies Charged to Patients	2,602,532	2.88	1,114,534	2.62	3,717,066	4.11	71
72	Impl. Dev. Charged to Patients	1,277,288	1.41	541,877	1.27	1,819,165	2.01	72
73	Drugs Charged to Patients	4,239,771	4.69	3,606,632	8.46	7,846,403	8.69	73
75	ASC (Non-Distinct Part)	451,005	0.50	291,458	0.68	742,463	0.82	75
76	HEMODIALYSIS	278,474	0.31	78,925	0.19	357,399	0.40	76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,894,555	2.10	1,920,503	4.51	3,815,058	4.22	90
90.01	CHEMOTHERAPY	684,151	0.76	450,012	1.06	1,134,163	1.26	90.01
90.02	KEDZIE CLINIC	1,283,978	1.42	506,314	1.19	1,790,292	1.98	90.02
90.03	LITTLE VILLAGE CLINIC	1,568,053	1.74	572,439	1.34	2,140,492	2.37	90.03
91	Emergency	3,896,012	4.31	3,401,868	7.98	7,297,880	8.08	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen	87,462	0.10	48,624	0.11	136,086	0.15	190
192	Physicians' Private Offices	1,542,801	1.71	1,372,501	3.22	2,915,302	3.23	192
192.01	OTHER NON-REIMBURSABLE	276,449	0.31	137,652	0.32	414,101	0.46	192.01
192.02	NEPHROLOGY	729,318	0.81	279,587	0.66	1,008,905	1.12	192.02
200	Cross Foot Adjustments							200

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REPORT 98 - COST ALLOCATION SUMMARY

COST CENTERS		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
201	Negative Cost Centers							201
202	TOTAL	90,329,680	100.00			90,329,680	100.00	202

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	169,994	17,661,624	0.009625	1,735,552	16,705	50
51	Recovery Room	5,073	1,364,453	0.003718	101,318	377	51
52	Delivery Room & Labor Room	148,404	10,659,273	0.013923	7,282	101	52
53	Anesthesiology	33,946	9,306,105	0.003648	603,219	2,201	53
54	Radiology-Diagnostic	290,189	21,723,386	0.013358	1,287,077	17,193	54
57	CT Scan	10,891	16,454,119	0.000662	1,265,642	838	57
58	MRI	2,873	3,545,380	0.000810	168,586	137	58
60	Laboratory	208,097	28,050,712	0.007419	2,991,055	22,191	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,357	2,447,382	0.001780	514,258	915	63
65	Respiratory Therapy	41,634	7,451,982	0.005587	2,204,421	12,316	65
66	Physical Therapy	55,986	6,848,518	0.008175	251,917	2,059	66
69	Electrocardiology	31,966	5,692,589	0.005615	873,974	4,907	69
70	Electroencephalography	15,767	899,676	0.017525	52,135	914	70
71	Medical Supplies Charged to Pat	77,806	7,329,363	0.010616	1,337,353	14,197	71
72	Impl. Dev. Charged to Patients	37,159	4,045,618	0.009185	595,172	5,467	72
73	Drugs Charged to Patients	127,106	46,978,024	0.002706	4,868,798	13,175	73
75	ASC (Non-Distinct Part)	7,884	2,163,360	0.003644	29,789	109	75
76	HEMODIALYSIS	2,033	694,212	0.002929	369,500	1,082	76
76.01	DIABETES CENTER						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	172,254	3,280,626	0.052506			90
90.01	CHEMOTHERAPY	12,266	5,331,215	0.002301			90.01
90.02	KEDZIE CLINIC	13,455	3,751,969	0.003586			90.02
90.03	LITTLE VILLAGE CLINIC	14,159	3,909,006	0.003622			90.03
91	Emergency	155,900	42,189,738	0.003695	1,416,429	5,234	91
92	Observation Beds (Non-Distinct	121,064	3,321,386	0.036450	42,010	1,531	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	1,760,263	255,099,716		20,715,487	121,649	200

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUSTMENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	1,211,146		1,211,146	17,017	71.17	3,724	265,037	30
31	Intensive Care Unit	174,109		174,109	2,010	86.62	806	69,816	31
200	TOTAL	1,385,255		1,385,255	19,027		4,530	334,853	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	334,853
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	121,649
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	456,502
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	795
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	4,530
PER DISCHARGE CAPITAL COSTS	574.22

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ST ANTHONY HOSPITAL Provider CCN: 14-0095	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 13:04 Version: 2015.10 (11/24/2015)
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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	8,859,103
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	31,316,073
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.283

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	2,105,058
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	5,651,066
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.373

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	456,502
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.015

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	5,263,531
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	22,137,073
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.238