

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 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.	Date: 11/29/2016 Time: 07:14
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 ST ANTHONY HOSPITAL (14-0095) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII						
		TITLE V	PART A	PART B	HIT	TITLE XIX		
		1	2	3	4	5		
1	HOSPITAL		771,121	-22,784	-11,212	-40,054	1	
2	SUBPROVIDER - IPF			1		52,976	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		771,121	-22,783	-11,212	12,922	200	

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 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 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 / 2015	To: 06 / 30 / 2016	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.	2,832	1,532			5,413		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
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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N						37.01
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**

		1	2	
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)	Y	Y	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
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
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete 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 osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery 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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**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**

		V	XIX	
Title V and XIX Services		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-I, 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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

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 transition factor. (see instructions)	0.50			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 / 2015	09 / 30 / 2015		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

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

		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 relieved 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	34,404			3,105	1,911	13,763	1
2	HMO and other (see instructions)						727	5,451		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)		94	34,404			3,105	1,911	13,763	7
8	Intensive Care Unit	31	15	5,490			512	262	1,907	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						1,907	2,883	13
14	Total (see instructions)		109	39,894			3,617	4,080	18,553	14
15	CAH Visits									15
16	Subprovider - IPF	40	42	15,372			2,737	2,798	11,340	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)							246	300	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)					704	1,605	4,488	1
2	HMO and other (see instructions)					138	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)	2.70	723.02			704	1,605	4,488	14
15	CAH Visits								15
16	Subprovider - IPF		45.28			269	343	1,304	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)	2.70	768.30						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	Reclassification 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	200	57,041,225	90,082	57,131,307	1,598,146.00	35.75	1
2							2
3							3
4		3,502,930		3,502,930	25,396.00	137.93	4
4.01		159,106		159,106	1,494.00	106.50	4.01
5		6,510,605		6,510,605	58,336.00	111.61	5
6							6
7	21	1,158,548		1,158,548	10,345.00	111.99	7
7.01							7.01
8							8
9	44						9
10		4,264,166		4,264,166	127,316.00	33.49	10
OTHER WAGES & RELATED COSTS							
11		674,626		674,626	9,540.00	70.72	11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		9,118,973		9,118,973			17
18							18
19		885,478		885,478			19
20							20
21							21
22		348,342		348,342			22
22.01		18,191		18,191			22.01
23		724,905		724,905			23
24							24
25		128,750		128,750			25
OVERHEAD COSTS - DIRECT SALARIES							
26		1,003,653		1,003,653	25,637.00	39.15	26
27		10,391,010	90,082	10,481,092	278,670.00	37.61	27
28		928,765		928,765	3,898.00	238.27	28
29		343,494		343,494	10,102.00	34.00	29
30		1,347,774		1,347,774	56,455.00	23.87	30
31							31
32		878,620		878,620	60,467.00	14.53	32
33							33
34		960,120	-557,397	402,723	27,518.00	14.63	34
35							35
36			557,397	557,397	38,158.00	14.61	36
37							37
38		1,285,531		1,285,531	44,224.00	29.07	38
39		258,723		258,723	12,728.00	20.33	39
40		1,384,571		1,384,571	32,276.00	42.90	40
41		690,690		690,690	25,182.00	27.43	41
42		703,745		703,745	18,422.00	38.20	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	50,141,731	90,082	50,231,813	1,531,869.00	32.79	1
2	Excluded area salaries (see instructions)	4,264,166		4,264,166	127,316.00	33.49	2
3	Subtotal salaries (line 1 minus line 2)	45,877,565	90,082	45,967,647	1,404,553.00	32.73	3
4	Subtotal other wages & related costs (see instructions)	674,626		674,626	9,540.00	70.72	4
5	Subtotal wage-related costs (see instructions)	9,467,315		9,467,315		20.60%	5
6	Total (sum of lines 3 through 5)	56,019,506	90,082	56,109,588	1,414,093.00	39.68	6
7	Total overhead cost (see instructions)	20,176,696	90,082	20,266,778	633,737.00	31.98	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	1,271,177	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)	4,930,170	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	213,443	10
11	Life Insurance (If employee is owner or beneficiary)	69,012	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	114,311	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	396,865	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	3,897,907	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	120,000	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	211,754	23
24	Total Wage Related cost (Sum of lines 1-23)	11,224,639	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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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 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)		0.296280	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		109,252,315	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		165,792,023	6
7	Medicaid cost (line 1 times line 6)		49,120,861	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	14,443,059	1,703,573	16,146,632	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,279,190	504,735	4,783,925	21
22	Partial payment by patients approved for charity care	722,153	85,179	807,332	22
23	Cost of charity care (line 21 minus line 22)	3,557,037	419,556	3,976,593	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)			8,722,488	26
27	Medicare bad debts for the entire hospital complex (see instructions)			810,030	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			7,912,458	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,344,303	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			6,320,896	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,320,896	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- FICATIONS	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		3,143,288	3,143,288		3,143,288	336,627	3,479,915	1
2	00200	Cap Rel Costs-Mvble Equip								2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	1,003,653	7,136,055	8,139,708		8,139,708	-21,487	8,118,221	4
5.01	00580	CASHIERING								5.01
5.06	00590	ADMINISTRATIVE & GENERAL	10,391,010	18,979,258	29,370,268		29,370,268	-9,435,045	19,935,223	5.06
6	00600	Maintenance & Repairs	343,494	2,061,531	2,405,025		2,405,025		2,405,025	6
7	00700	Operation of Plant	1,347,774	1,609,171	2,956,945		2,956,945	-21,130	2,935,815	7
8	00800	Laundry & Linen Service								8
9	00900	Housekeeping	878,620	988,504	1,867,124		1,867,124		1,867,124	9
10	01000	Dietary	960,120	1,368,574	2,328,694	-1,351,921	976,773	-64,851	911,922	10
11	01100	Cafeteria				1,351,921	1,351,921	-708,240	643,681	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,285,531	116,268	1,401,799		1,401,799	-6,416	1,395,383	13
14	01400	Central Services & Supply	258,723	74,383	333,106	-113,776	219,330		219,330	14
15	01500	Pharmacy	1,384,571	4,455,806	5,840,377	-3,999,203	1,841,174	-129,288	1,711,886	15
16	01600	Medical Records & Library	690,690	900,378	1,591,068		1,591,068	-6,088	1,584,980	16
17	01700	Social Service	703,745	83,425	787,170		787,170	-17,915	769,255	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	1,158,548		1,158,548		1,158,548	-873,536	285,012	21
22	02200	I&R Services-Other Prgm Costs Apprvd	672,940	946,915	1,619,855		1,619,855	-1,619,855		22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	5,872,494	873,753	6,746,247		6,746,247	-525,239	6,221,008	30
31	03100	Intensive Care Unit	1,374,423	313,712	1,688,135		1,688,135	-74,593	1,613,542	31
40	04000	Subprovider - IPF	2,818,925	349,264	3,168,189		3,168,189	-37,610	3,130,579	40
43	04300	Nursery	1,533,055	140,151	1,673,206		1,673,206	-609,059	1,064,147	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,533,157	3,182,341	4,715,498	-2,769,991	1,945,507	-437	1,945,070	50
51	05100	Recovery Room	345,255	36,819	382,074		382,074		382,074	51
52	05200	Delivery Room & Labor Room	4,046,328	759,958	4,806,286		4,806,286	-2,187,993	2,618,293	52
53	05300	Anesthesiology	1,579,453	556,734	2,136,187		2,136,187	-1,274,083	862,104	53
54	05400	Radiology-Diagnostic	1,999,412	900,153	2,899,565		2,899,565	-3,130	2,896,435	54
57	05700	CT Scan	341,808	217,418	559,226		559,226	-22	559,204	57
58	05800	MRI	151,441	26,610	178,051		178,051		178,051	58
60	06000	Laboratory	1,522,069	1,663,972	3,186,041		3,186,041	-10,641	3,175,400	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.	60,267	474,894	535,161		535,161		535,161	63
65	06500	Respiratory Therapy	720,936	206,273	927,209	-146,314	780,895		780,895	65
66	06600	Physical Therapy	971,579	170,842	1,142,421		1,142,421	-24,915	1,117,506	66
69	06900	Electrocardiology	432,219	160,928	593,147		593,147	-102,576	490,571	69
70	07000	Electroencephalography	46,762	8,895	55,657		55,657		55,657	70
71	07100	Medical Supplies Charged to Patients				2,183,710	2,183,710		2,183,710	71
72	07200	Impl. Dev. Charged to Patients				1,287,836	1,287,836		1,287,836	72
73	07300	Drugs Charged to Patients				3,999,203	3,999,203		3,999,203	73
75	07500	ASC (Non-Distinct Part)	413,250	43,958	457,208		457,208		457,208	75
76	03950	HEMODIALYSIS		218,082	218,082		218,082		218,082	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	1,458,253	624,803	2,083,056		2,083,056	-392,161	1,690,895	90
90.01	09001	CHEMOTHERAPY	622,780	173,536	796,316		796,316	-98,644	697,672	90.01
90.02	09002	KEDZIE CLINIC	1,010,294	469,433	1,479,727		1,479,727	-246,006	1,233,721	90.02
90.03	09003	LITTLE VILLAGE CLINIC	537,837	1,062,825	1,600,662		1,600,662	-124,718	1,475,944	90.03
91	09100	Emergency	5,124,568	1,575,317	6,699,885	-441,465	6,258,420	-2,428,034	3,830,386	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
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	55,595,984	56,074,227	111,670,211		111,670,211	-20,707,085	90,963,126	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	32,996	42,515	75,511		75,511		75,511	190
192	19200	Physicians' Private Offices	790,365	319,869	1,110,234		1,110,234		1,110,234	192
192.01	19210	OTHER NON-REIMBURSABLE	224,718	41,049	265,767		265,767		265,767	192.01
192.02	19202	NEPHROLOGY	397,162	661,998	1,059,160		1,059,160		1,059,160	192.02

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSI- FICATIONS 4	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6) 7	
200		TOTAL (sum of lines 118-199)	57,041,225	57,139,658	114,180,883		114,180,883	-20,707,085	93,473,798	200

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1		1	2	3	4	5	
1	CAFETERIA RECLASS	B	Cafeteria	11	557,397	794,524	1
500	Total reclassifications				557,397	794,524	500
	Code Letter - B						
1	COST OF MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		2,183,710	1
2			Impl. Dev. Charged to Patient	72		1,287,836	2
3							3
4							4
500	Total reclassifications					3,471,546	500
	Code Letter - C						
1	COST OF DRUGS SOLD	D	Drugs Charged to Patients	73		3,999,203	1
500	Total reclassifications					3,999,203	500
	Code Letter - D						
1	HIRING INCENTIVES	E	ADMINISTRATIVE & GENERAL	5.06	90,082		1
500	Total reclassifications				90,082		500
	Code Letter - E						
	GRAND TOTAL (Increases)				647,479	8,265,273	

(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	557,397	794,524	1	
500	Total reclassifications				557,397	794,524	500	
	Code letter - B							
1	COST OF MEDICAL SUPPLIES	C	Operating Room	50		2,769,991	1	
2			Respiratory Therapy	65		146,314	2	
3			Emergency	91		441,465	3	
4			Central Services & Supply	14		113,776	4	
500	Total reclassifications					3,471,546	500	
	Code letter - C							
1	COST OF DRUGS SOLD	D	Pharmacy	15		3,999,203	1	
500	Total reclassifications					3,999,203	500	
	Code letter - D							
1	HIRING INCENTIVES	E	ADMINISTRATIVE & GENERAL	5.06		90,082	1	
500	Total reclassifications					90,082	500	
	Code letter - E							
	GRAND TOTAL (Decreases)				557,397	8,355,355		

(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	30,858,004	286,488		286,488		31,144,492		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	38,241,281	407,227		407,227		38,648,508		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	70,073,072	693,715		693,715		70,766,787		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	70,073,072	693,715		693,715		70,766,787		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	3,143,288						3,143,288	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	3,143,288						3,143,288	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 line 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 Equip	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							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	3,479,915						3,479,915	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	3,479,915						3,479,915	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	-14,295	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	-9,055,773			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	-708,240	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients	B	-129,288	Pharmacy	15	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	502,058	Cap Rel Costs-Bldg & Fixt	1	9
36	OTHER REVENUE	B	-511	Intensive Care Unit	31	36
36.01	OTHER REVENUE	B	-32,578	ADMINISTRATIVE & GENERAL	5.06	36.01
36.02	OTHER REVENUE	B	-21,130	Operation of Plant	7	36.02
36.03	OTHER REVENUE	B	-2,101	Nursing Administration	13	36.03
36.04	OTHER REVENUE	B	-195	Subprovider - IPF	40	36.04
36.05	OTHER REVENUE	B	-25	Nursery	43	36.05
36.06	INTERNS RESIDENTS REVENUE	B	-393,120	I&R Services-Salary & Fringes Apprvd	21	36.06
36.08	OTHER REVENUE	B	-6,088	Medical Records & Library	16	36.08
36.09	OTHER REVENUE	B	-1,233,160	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	-23	Delivery Room & Labor Room	52	36.11
36.12	OTHER REVENUE	B	-437	Operating Room	50	36.12
36.13	OTHER REVENUE	B	-4,726	Laboratory	60	36.13
36.14	OTHER REVENUE	B	-22	CT Scan	57	36.14
36.15	OTHER REVENUE	B	-3,130	Radiology-Diagnostic	54	36.15
36.16	OTHER REVENUE- NEGATIVE REV	B	-615	Emergency	91	36.16
36.17	OTHER REVENUE	B	-24,375	Clinic	90	36.17
36.18	SPONSORSHIP	A	-144,570	ADMINISTRATIVE & GENERAL	5.06	36.18
36.19	MARKETING	A	-370,088	ADMINISTRATIVE & GENERAL	5.06	36.19
36.20	MEDICAID TAX	A	-7,024,968	ADMINISTRATIVE & GENERAL	5.06	36.20
36.21	TELECOMMUNICATIONS REVENUE	B	-3,300	ADMINISTRATIVE & GENERAL	5.06	36.21
36.22	DIETARY OTHER REVENUE	B	-64,851	Dietary	10	36.22
36.23	RENTAL REVENUE	B	-165,431	Cap Rel Costs-Bldg & Fixt	1	9
36.24	OTHER REVENUE	B	-23,553	CHEMOTHERAPY	90.01	36.24
36.25	OTHER REVENUE	B	-12	KEDZIE CLINIC	90.02	36.25
36.26	OTHER REVENUE	B	-2,561	LITTLE VILLAGE CLINIC	90.03	36.26
36.27	LOBBYING	A	-14,938	ADMINISTRATIVE & GENERAL	5.06	36.27
36.28	OTHER REVENUE ADMIN	B	-258,037	ADMINISTRATIVE & GENERAL	5.06	36.28
36.29	MIDWIFERY PROGRAM	A	-992,463	Delivery Room & Labor Room	52	36.29
36.30	COMMUNITY WELLNESS REVENUE	B	-158,746	ADMINISTRATIVE & GENERAL	5.06	36.30

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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		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
37						37
37.31	OTHER CARD REVENUE	B	-102,576	Electrocardiology	69	37.31
38						38
39						39
40						40
41						41
42						42
43						43
44	MILLENUM 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)		-20,707,085			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 subscripts 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:

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	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	2,663,157	105,210	2,557,947	177,200	17,357	1,478,683	73,934	1
2	4	Employee Benefits De	21,572		21,572	177,200	1	85	4	2
3	13	Nursing Administrati	4,400		4,400	177,200	1	85	4	3
4	17	Social Service	18,000		18,000	177,200	1	85	4	4
5										5
6	21	I&R Services-Salary AGGREGATE	480,416	480,416						6
7	22	I&R Services-Other P AGGREGATE	387,140	167,596	219,543	620	1,494	445	22	7
8										8
9	30	Adults & Pediatrics AGGREGATE	501,158	483,658	17,500	177,200	1	85	4	9
10	31	Intensive Care Unit	74,167		74,167	177,200	1	85	4	10
11	40	Subprovider - IPF	37,500		37,500	177,200	1	85	4	11
12										12
13	43	Nursery AGGREGATE	766,725	562,752	203,972	177,200	1,851	157,691	7,885	13
14										14
15										15
16										16
17	52	Delivery Room & Labo AGGREGATE	1,195,507	1,195,507						17
18										18
19	53	Anesthesiology AGGREGATE	1,448,046	1,113,750	334,296	177,200	2,042	173,963	8,698	19
20	60	Laboratory	6,000		6,000	177,200	1	85	4	20
21	66	Physical Therapy	25,000		25,000	177,200	1	85	4	21
22	90	Clinic AGGREGATE	367,871	225,808	142,062	177,200	1	85	4	22
23	90.01	CHEMOTHERAPY	75,176		75,176	177,200	1	85	4	23
24	90.02	KEDZIE CLINIC AGGREGATE	419,957	144,012	275,945	177,200	2,042	173,963	8,698	24
25	90.03	LITTLE VILLAGE CLINI AGGREGATE	122,157	122,157						25
32	91	Emergency AGGREGATE	2,427,419	2,427,419						32
200		TOTAL	11,041,368	7,028,285	4,013,080		24,796	1,985,595	99,277	200

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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 Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.06	ADMINISTRATIVE & GEN AGGREGATE					1,478,683	1,079,264	1,184,474	1
2	4	Employee Benefits De					85	21,487	21,487	2
3	13	Nursing Administrati					85	4,315	4,315	3
4	17	Social Service					85	17,915	17,915	4
5										5
6	21	I&R Services-Salary AGGREGATE							480,416	6
7	22	I&R Services-Other P AGGREGATE					445	219,098	386,695	7
8										8
9	30	Adults & Pediatrics AGGREGATE					85	17,415	501,073	9
10	31	Intensive Care Unit					85	74,082	74,082	10
11	40	Subprovider - IPF					85	37,415	37,415	11
12										12
13	43	Nursery AGGREGATE					157,691	46,281	609,034	13
14										14
15										15
16										16
17	52	Delivery Room & Labo AGGREGATE							1,195,507	17
18										18
19	53	Anesthesiology AGGREGATE					173,963	160,333	1,274,083	19
20	60	Laboratory					85	5,915	5,915	20
21	66	Physical Therapy					85	24,915	24,915	21
22	90	Clinic AGGREGATE					85	141,977	367,786	22
23	90.01	CHEMOTHERAPY					85	75,091	75,091	23
24	90.02	KEDZIE CLINIC AGGREGATE					173,963	101,982	245,994	24
25	90.03	LITTLE VILLAGE CLINI AGGREGATE							122,157	25
32	91	Emergency AGGREGATE							2,427,419	32
200		TOTAL					1,985,595	2,027,485	9,055,773	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	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	3,479,915	3,479,915					1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	8,118,221	13,686	8,131,907				4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL	19,935,223	429,288	1,625,177	21,989,688	21,989,688		5.06
6	Maintenance & Repairs	2,405,025	130,040	70,563	2,605,628	801,533	3,407,161	6
7	Operation of Plant	2,935,815	429,082	224,350	3,589,247	1,104,110	502,925	7
8	Laundry & Linen Service		60,667		60,667	18,662	71,107	8
9	Housekeeping	1,867,124	31,235	147,970	2,046,329	629,484	36,610	9
10	Dietary	911,922	62,968	58,609	1,033,499	317,921	73,804	10
11	Cafeteria	643,681	87,197	81,897	812,775	250,023	102,203	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,395,383	60,907	207,430	1,663,720	511,787	71,389	13
14	Central Services & Supply	219,330	89,807	54,584	363,721	111,886	105,262	14
15	Pharmacy	1,711,886	49,660	233,303	1,994,849	613,647	58,206	15
16	Medical Records & Library	1,584,980	63,449	104,204	1,752,633	539,138	74,368	16
17	Social Service	769,255	17,137	115,356	901,748	277,392	20,086	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	285,012			285,012	87,674		21
22	I&R Services-Other Prgm Costs Apprvd			333,859	333,859	102,700		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,221,008	723,695	953,279	7,897,982	2,429,577	848,240	30
31	Intensive Care Unit	1,613,542	98,462	262,147	1,974,151	607,280	115,406	31
40	Subprovider - IPF	3,130,579	216,482	378,453	3,725,514	1,146,028	253,737	40
43	Nursery	1,064,147	21,774	122,425	1,208,346	371,707	25,521	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,945,070	99,561	221,902	2,266,533	697,222	116,694	50
51	Recovery Room	382,074		58,335	440,409	135,477		51
52	Delivery Room & Labor Room	2,618,293	66,677	499,273	3,184,243	979,524	78,152	52
53	Anesthesiology	862,104	12,844	14,267	889,215	273,537	15,055	53
54	Radiology-Diagnostic	2,896,435	184,577	356,574	3,437,586	1,057,456	216,341	54
57	CT Scan	559,204		67,408	626,612	192,756		57
58	MRI	178,051		26,113	204,164	62,804		58
60	Laboratory	3,175,400	122,416	272,264	3,570,080	1,098,214	143,483	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	535,161		10,036	545,197	167,711		63
65	Respiratory Therapy	780,895	22,546	116,346	919,787	282,941	26,426	65
66	Physical Therapy	1,117,506	29,672	159,762	1,306,940	402,036	34,779	66
69	Electrocardiology	490,571	17,206	81,328	589,105	181,218	20,167	69
70	Electroencephalography	55,657	10,870	8,317	74,844	23,023	12,740	70
71	Medical Supplies Charged to Patients	2,183,710			2,183,710	671,744		71
72	Impl. Dev. Charged to Patients	1,287,836			1,287,836	396,159		72
73	Drugs Charged to Patients	3,999,203			3,999,203	1,230,219		73
75	ASC (Non-Distinct Part)	457,208		71,531	528,739	162,649		75
76	HEMODIALYSIS	218,082			218,082	67,086		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	1,690,895	103,750	205,585	2,000,230	615,303	121,605	90
90.01	CHEMOTHERAPY	697,672		109,237	806,909	248,218		90.01
90.02	KEDZIE CLINIC	1,233,721		84,361	1,318,082	405,463		90.02
90.03	LITTLE VILLAGE CLINIC	1,475,944		84,361	1,560,305	479,975		90.03
91	Emergency	3,830,386	63,792	539,845	4,434,023	1,363,976	74,771	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)	90,963,126	3,319,447	7,960,451	90,631,202	21,115,260	3,219,077	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	75,511	2,576	6,890	84,977	26,140	3,019	190
192	Physicians' Private Offices	1,110,234	157,892	73,321	1,341,447	412,651	185,065	192
192.01	OTHER NON-REIMBURSABLE	265,767		41,120	306,887	94,403		192.01
192.02	NEPHROLOGY	1,059,160		50,125	1,109,285	341,234		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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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	SUBTOTAL (cols.0-4)	A+G	MAINTEN- ANCE AND REPAIRS	
		0	1	4	4A	5.06	6	
202	TOTAL (sum of lines 118-201)	93,473,798	3,479,915	8,131,907	93,473,798	21,989,688	3,407,161	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	5,196,282						7
8	Laundry & Linen Service	127,226	277,662					8
9	Housekeeping	65,504		2,777,927				9
10	Dietary	132,051		73,314	1,630,589			10
11	Cafeteria	182,863		101,524		1,449,388		11
12	Maintenance of Personnel							12
13	Nursing Administration	127,730		70,915		58,214	2,503,755	13
14	Central Services & Supply	188,336		104,563		16,754		14
15	Pharmacy	104,143		57,819		42,486		15
16	Medical Records & Library	133,060		73,874		33,148		16
17	Social Service	35,939		19,953		24,250		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					22,203		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,517,672	129,327	842,597	870,036	221,441	622,311	30
31	Intensive Care Unit	206,486	17,537	114,639	58,980	55,592	156,229	31
40	Subprovider - IPF	453,988	104,285	252,050	701,573	123,986	348,437	40
43	Nursery	45,662	26,513	25,351		33,716	94,750	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	208,790		115,919		54,301	152,600	50
51	Recovery Room					9,226	25,928	51
52	Delivery Room & Labor Room	139,830		77,632		118,838	333,969	52
53	Anesthesiology	26,936		14,955		16,123	45,309	53
54	Radiology-Diagnostic	387,080		214,903		84,133		54
57	CT Scan					10,408		57
58	MRI					5,122		58
60	Laboratory	256,721		142,529		75,238		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					2,422		63
65	Respiratory Therapy	47,282		26,251		29,953		65
66	Physical Therapy	62,227		34,548		35,693		66
69	Electrocardiology	36,083		20,033		16,904		69
70	Electroencephalography	22,795		12,655		2,409		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)					15,522	43,622	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	217,577		120,797		86,767	243,839	90
90.01	CHEMOTHERAPY					22,604	63,524	90.01
90.02	KEDZIE CLINIC					34,378		90.02
90.03	LITTLE VILLAGE CLINIC					21,140		90.03
91	Emergency	133,780		74,273		132,811	373,237	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)	4,859,761	277,662	2,591,094	1,630,589	1,405,782	2,503,755	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,402		2,999		1,477		190
192	Physicians' Private Offices	331,119		183,834		22,502		192
192.01	OTHER NON-REIMBURSABLE					2,654		192.01
192.02	NEPHROLOGY					16,973		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,196,282	277,662	2,777,927	1,630,589	1,449,388	2,503,755	202

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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-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
		14	15	16	17	21	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	890,522						14
15	Pharmacy	38,513	2,909,663					15
16	Medical Records & Library	4		2,606,225				16
17	Social Service				1,279,368			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					394,889		21
22	I&R Services-Other Prgm Costs Apprvd						436,559	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	48,686		236,159	644,418	157,955	174,623	30
31	Intensive Care Unit	18,883		57,898	84,570			31
40	Subprovider - IPF	5,103		159,880	366,429			40
43	Nursery	4,588		38,099	134,387			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			132,568				50
51	Recovery Room	1,969		10,278				51
52	Delivery Room & Labor Room	36,283		77,153	49,564			52
53	Anesthesiology	21,850		70,043				53
54	Radiology-Diagnostic	25,446	45,308	172,194				54
57	CT Scan	16,280		168,990				57
58	MRI	541		28,920				58
60	Laboratory	23,015		232,857				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			25,036				63
65	Respiratory Therapy			59,197				65
66	Physical Therapy	6,597		62,344				66
69	Electrocardiology	2,810		50,591				69
70	Electroencephalography	479		9,133				70
71	Medical Supplies Charged to Patients	376,607		59,438				71
72	Impl. Dev. Charged to Patients	222,096		32,656				72
73	Drugs Charged to Patients		2,864,355	400,364				73
75	ASC (Non-Distinct Part)	1,256		14,525				75
76	HEMODIALYSIS			4,196				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	14,441		40,840		78,978	87,312	90
90.01	CHEMOTHERAPY	8,991		40,883				90.01
90.02	KEDZIE CLINIC	2,880		31,631				90.02
90.03	LITTLE VILLAGE CLINIC	847		40,153				90.03
91	Emergency	2,545		350,199		157,956	174,624	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)	880,710	2,909,663	2,606,225	1,279,368	394,889	436,559	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	2,463						192
192.01	OTHER NON-REIMBURSABLE	7						192.01
192.02	NEPHROLOGY	7,342						192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	890,522	2,909,663	2,606,225	1,279,368	394,889	436,559	202

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		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 SERV COST CENTERS					
30	Adults & Pediatrics	16,641,024	-332,578	16,308,446		30
31	Intensive Care Unit	3,467,651		3,467,651		31
40	Subprovider - IPF	7,641,010		7,641,010		40
43	Nursery	2,008,640		2,008,640		43
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	3,744,627		3,744,627		50
51	Recovery Room	623,287		623,287		51
52	Delivery Room & Labor Room	5,075,188		5,075,188		52
53	Anesthesiology	1,373,023		1,373,023		53
54	Radiology-Diagnostic	5,640,447		5,640,447		54
57	CT Scan	1,015,046		1,015,046		57
58	MRI	301,551		301,551		58
60	Laboratory	5,542,137		5,542,137		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	Blood Storing, Processing & Trans.	740,366		740,366		63
65	Respiratory Therapy	1,391,837		1,391,837		65
66	Physical Therapy	1,945,164		1,945,164		66
69	Electrocardiology	916,911		916,911		69
70	Electroencephalography	158,078		158,078		70
71	Medical Supplies Charged to Patients	3,291,499		3,291,499		71
72	Impl. Dev. Charged to Patients	1,938,747		1,938,747		72
73	Drugs Charged to Patients	8,494,141		8,494,141		73
75	ASC (Non-Distinct Part)	766,313		766,313		75
76	HEMODIALYSIS	289,364		289,364		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	3,627,689	-166,290	3,461,399		90
90.01	CHEMOTHERAPY	1,191,129		1,191,129		90.01
90.02	KEDZIE CLINIC	1,792,434		1,792,434		90.02
90.03	LITTLE VILLAGE CLINIC	2,102,420		2,102,420		90.03
91	Emergency	7,272,195	-332,580	6,939,615		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)	88,991,918	-831,448	88,160,470		118
	NONREIMBURSABLE COST CENTERS					
190	Gift, Flower, Coffee Shop & Canteen	124,014		124,014		190
192	Physicians' Private Offices	2,479,081		2,479,081		192
192.01	OTHER NON-REIMBURSABLE	403,951		403,951		192.01
192.02	NEPHROLOGY	1,474,834		1,474,834		192.02
200	Cross Foot Adjustments					200
201	Negative Cost Centers					201
202	TOTAL (sum of lines 118-201)	93,473,798	-831,448	92,642,350		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 DEPARTMENT	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		13,686	13,686	13,686			4
5.01	CASHIERING							5.01
5.06	ADMINISTRATIVE & GENERAL		429,288	429,288	2,721	432,009		5.06
6	Maintenance & Repairs		130,040	130,040	119	15,746	145,905	6
7	Operation of Plant		429,082	429,082	378	21,690	21,537	7
8	Laundry & Linen Service		60,667	60,667		367	3,045	8
9	Housekeeping		31,235	31,235	249	12,366	1,568	9
10	Dietary		62,968	62,968	99	6,245	3,161	10
11	Cafeteria		87,197	87,197	138	4,912	4,377	11
12	Maintenance of Personnel							12
13	Nursing Administration		60,907	60,907	350	10,054	3,057	13
14	Central Services & Supply		89,807	89,807	92	2,198	4,508	14
15	Pharmacy		49,660	49,660	393	12,055	2,493	15
16	Medical Records & Library		63,449	63,449	176	10,591	3,185	16
17	Social Service		17,137	17,137	194	5,449	860	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					1,722		21
22	I&R Services-Other Prgm Costs Apprvd				563	2,018		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		723,695	723,695	1,606	47,758	36,321	30
31	Intensive Care Unit		98,462	98,462	442	11,930	4,942	31
40	Subprovider - IPF		216,482	216,482	638	22,513	10,866	40
43	Nursery		21,774	21,774	206	7,302	1,093	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		99,561	99,561	374	13,697	4,997	50
51	Recovery Room				98	2,661		51
52	Delivery Room & Labor Room		66,677	66,677	841	19,242	3,347	52
53	Anesthesiology		12,844	12,844	24	5,374	645	53
54	Radiology-Diagnostic		184,577	184,577	601	20,773	9,264	54
57	CT Scan				114	3,787		57
58	MRI				44	1,234		58
60	Laboratory		122,416	122,416	459	21,574	6,144	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.				17	3,295		63
65	Respiratory Therapy		22,546	22,546	196	5,558	1,132	65
66	Physical Therapy		29,672	29,672	269	7,898	1,489	66
69	Electrocardiology		17,206	17,206	137	3,560	864	69
70	Electroencephalography		10,870	10,870	14	452	546	70
71	Medical Supplies Charged to Patients					13,196		71
72	Impl. Dev. Charged to Patients					7,782		72
73	Drugs Charged to Patients					24,167		73
75	ASC (Non-Distinct Part)				121	3,195		75
76	HEMODIALYSIS					1,318		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		103,750	103,750	346	12,087	5,208	90
90.01	CHEMOTHERAPY				184	4,876		90.01
90.02	KEDZIE CLINIC				142	7,965		90.02
90.03	LITTLE VILLAGE CLINIC				142	9,429		90.03
91	Emergency		63,792	63,792	910	26,795	3,202	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)		3,319,447	3,319,447	13,397	414,831	137,851	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,576	2,576	12	514	129	190
192	Physicians' Private Offices		157,892	157,892	124	8,106	7,925	192
192.01	OTHER NON-REIMBURSABLE				69	1,855		192.01
192.02	NEPHROLOGY				84	6,703		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,479,915	3,479,915	13,686	432,009	145,905	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	472,687						7
8	Laundry & Linen Service	11,573	75,652					8
9	Housekeeping	5,959		51,377				9
10	Dietary	12,012		1,356	85,841			10
11	Cafeteria	16,634		1,878		115,136		11
12	Maintenance of Personnel							12
13	Nursing Administration	11,619		1,312		4,624	91,923	13
14	Central Services & Supply	17,132		1,934		1,331		14
15	Pharmacy	9,474		1,069		3,375		15
16	Medical Records & Library	12,104		1,366		2,633		16
17	Social Service	3,269		369		1,926		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					1,764		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	138,058	35,236	15,582	45,802	17,594	22,847	30
31	Intensive Care Unit	18,783	4,778	2,120	3,105	4,416	5,736	31
40	Subprovider - IPF	41,298	28,414	4,662	36,934	9,849	12,793	40
43	Nursery	4,154	7,224	469		2,678	3,479	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,993		2,144		4,313	5,603	50
51	Recovery Room					733	952	51
52	Delivery Room & Labor Room	12,720		1,436		9,440	12,261	52
53	Anesthesiology	2,450		277		1,281	1,663	53
54	Radiology-Diagnostic	35,211		3,975		6,683		54
57	CT Scan					827		57
58	MRI					407		58
60	Laboratory	23,353		2,636		5,977		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					192		63
65	Respiratory Therapy	4,301		485		2,379		65
66	Physical Therapy	5,661		639		2,835		66
69	Electrocardiology	3,282		371		1,343		69
70	Electroencephalography	2,074		234		191		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)					1,233	1,602	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	19,792		2,234		6,893	8,952	90
90.01	CHEMOTHERAPY					1,796	2,332	90.01
90.02	KEDZIE CLINIC					2,731		90.02
90.03	LITTLE VILLAGE CLINIC					1,679		90.03
91	Emergency	12,169		1,374		10,550	13,703	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)	442,075	75,652	47,922	85,841	111,673	91,923	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	491		55		117		190
192	Physicians' Private Offices	30,121		3,400		1,787		192
192.01	OTHER NON-REIMBURSABLE					211		192.01
192.02	NEPHROLOGY					1,348		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	472,687	75,652	51,377	85,841	115,136	91,923	202

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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-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
		14	15	16	17	21	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	117,002						14
15	Pharmacy	5,060	83,579					15
16	Medical Records & Library	1		93,505				16
17	Social Service				29,204			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					3,486		21
22	I&R Services-Other Prgm Costs Apprvd						2,581	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,397		8,466	14,711			30
31	Intensive Care Unit	2,481		2,076	1,930			31
40	Subprovider - IPF	670		5,732	8,364			40
43	Nursery	603		1,366	3,068			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			4,752				50
51	Recovery Room	259		368				51
52	Delivery Room & Labor Room	4,767		2,766	1,131			52
53	Anesthesiology	2,871		2,511				53
54	Radiology-Diagnostic	3,343	1,301	6,173				54
57	CT Scan	2,139		6,058				57
58	MRI	71		1,037				58
60	Laboratory	3,024		8,348				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			897				63
65	Respiratory Therapy			2,122				65
66	Physical Therapy	867		2,235				66
69	Electrocardiology	369		1,814				69
70	Electroencephalography	63		327				70
71	Medical Supplies Charged to Patients	49,481		2,131				71
72	Impl. Dev. Charged to Patients	29,180		1,171				72
73	Drugs Charged to Patients		82,278	14,427				73
75	ASC (Non-Distinct Part)	165		521				75
76	HEMODIALYSIS			150				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	1,897		1,464				90
90.01	CHEMOTHERAPY	1,181		1,466				90.01
90.02	KEDZIE CLINIC	378		1,134				90.02
90.03	LITTLE VILLAGE CLINIC	111		1,439				90.03
91	Emergency	334		12,554				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)	115,712	83,579	93,505	29,204			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	324						192
192.01	OTHER NON-REIMBURSABLE	1						192.01
192.02	NEPHROLOGY	965						192.02
200	Cross Foot Adjustments					3,486	2,581	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	117,002	83,579	93,505	29,204	3,486	2,581	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		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 SERV COST CENTERS						
30	Adults & Pediatrics	1,114,073		1,114,073			30
31	Intensive Care Unit	161,201		161,201			31
40	Subprovider - IPF	399,215		399,215			40
43	Nursery	53,416		53,416			43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	154,434		154,434			50
51	Recovery Room	5,071		5,071			51
52	Delivery Room & Labor Room	134,628		134,628			52
53	Anesthesiology	29,940		29,940			53
54	Radiology-Diagnostic	271,901		271,901			54
57	CT Scan	12,925		12,925			57
58	MRI	2,793		2,793			58
60	Laboratory	193,931		193,931			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	4,401		4,401			63
65	Respiratory Therapy	38,719		38,719			65
66	Physical Therapy	51,565		51,565			66
69	Electrocardiology	28,946		28,946			69
70	Electroencephalography	14,771		14,771			70
71	Medical Supplies Charged to Patients	64,808		64,808			71
72	Impl. Dev. Charged to Patients	38,133		38,133			72
73	Drugs Charged to Patients	120,872		120,872			73
75	ASC (Non-Distinct Part)	6,837		6,837			75
76	HEMODIALYSIS	1,468		1,468			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	162,623		162,623			90
90.01	CHEMOTHERAPY	11,835		11,835			90.01
90.02	KEDZIE CLINIC	12,350		12,350			90.02
90.03	LITTLE VILLAGE CLINIC	12,800		12,800			90.03
91	Emergency	145,383		145,383			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)	3,249,039		3,249,039			118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	3,894		3,894			190
192	Physicians' Private Offices	209,679		209,679			192
192.01	OTHER NON-REIMBURSABLE	2,136		2,136			192.01
192.02	NEPHROLOGY	9,100		9,100			192.02
200	Cross Foot Adjustments	6,067		6,067			200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	3,479,915		3,479,915			202

KPMG LLP Compu-Max 2552-10

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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 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	-21,989,688	71,484,110		5.06
6	Maintenance & Repairs	7,573	7,573	401,718		2,605,628	169,286	6
7	Operation of Plant	24,988	24,988	1,277,244		3,589,247	24,988	7
8	Laundry & Linen Service	3,533	3,533			60,667	3,533	8
9	Housekeeping	1,819	1,819	842,406		2,046,329	1,819	9
10	Dietary	3,667	3,667	333,663		1,033,499	3,667	10
11	Cafeteria	5,078	5,078	466,247		812,775	5,078	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,547	3,547	1,180,917		1,663,720	3,547	13
14	Central Services & Supply	5,230	5,230	310,753		363,721	5,230	14
15	Pharmacy	2,892	2,892	1,328,212		1,994,849	2,892	15
16	Medical Records & Library	3,695	3,695	593,243		1,752,633	3,695	16
17	Social Service	998	998	656,728		901,748	998	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					285,012		21
22	I&R Services-Other Prgm Costs Apprvd			1,900,685		333,859		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,145	42,145	5,427,089		7,897,982	42,145	30
31	Intensive Care Unit	5,734	5,734	1,492,424		1,974,151	5,734	31
40	Subprovider - IPF	12,607	12,607	2,154,562		3,725,514	12,607	40
43	Nursery	1,268	1,268	696,972		1,208,346	1,268	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,798	5,798	1,263,307		2,266,533	5,798	50
51	Recovery Room			332,103		440,409		51
52	Delivery Room & Labor Room	3,883	3,883	2,842,400		3,184,243	3,883	52
53	Anesthesiology	748	748	81,221		889,215	748	53
54	Radiology-Diagnostic	10,749	10,749	2,030,001		3,437,586	10,749	54
57	CT Scan			383,759		626,612		57
58	MRI			148,664		204,164		58
60	Laboratory	7,129	7,129	1,550,018		3,570,080	7,129	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			57,134		545,197		63
65	Respiratory Therapy	1,313	1,313	662,369		919,787	1,313	65
66	Physical Therapy	1,728	1,728	909,537		1,306,940	1,728	66
69	Electrocardiology	1,002	1,002	463,008		589,105	1,002	69
70	Electroencephalography	633	633	47,350		74,844	633	70
71	Medical Supplies Charged to Patients					2,183,710		71
72	Impl. Dev. Charged to Patients					1,287,836		72
73	Drugs Charged to Patients					3,999,203		73
75	ASC (Non-Distinct Part)			407,234		528,739		75
76	HEMODIALYSIS					218,082		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	6,042	6,042	1,170,413		2,000,230	6,042	90
90.01	CHEMOTHERAPY			621,893		806,909		90.01
90.02	KEDZIE CLINIC			480,275		1,318,082		90.02
90.03	LITTLE VILLAGE CLINIC			480,275		1,560,305		90.03
91	Emergency	3,715	3,715	3,073,378		4,434,023	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	-21,989,688	68,641,514	159,941	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	150	150	39,227		84,977	150	190
192	Physicians' Private Offices	9,195	9,195	417,422		1,341,447	9,195	192
192.01	OTHER NON-REIMBURSABLE			234,101		306,887		192.01
192.02	NEPHROLOGY			285,367		1,109,285		192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,479,915		8,131,907		21,989,688	3,407,161	202

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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 GROSS SALARIES	RECON-CILIATION	A+G ACCUM COST	MAINTEN-ANCE AND REPAIRS SQUARE FEET	
		1	2	4	5A.06	5.06	6	
203	Unit Cost Multiplier (Wkst. B, Part I)	17.171537		0.175652		0.307616	20.126655	203
204	Cost to be allocated (Per Wkst. B, Part II)			13,686		432,009	145,905	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000296		0.006043	0.861885	205

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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	30,193					8
9	Housekeeping	1,819		138,946				9
10	Dietary	3,667		3,667	79,069			10
11	Cafeteria	5,078		5,078		1,101,071		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,547		3,547		44,224	676,819	13
14	Central Services & Supply	5,230		5,230		12,728		14
15	Pharmacy	2,892		2,892		32,276		15
16	Medical Records & Library	3,695		3,695		25,182		16
17	Social Service	998		998		18,422		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					16,867		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,145	14,063	42,145	42,189	168,224	168,224	30
31	Intensive Care Unit	5,734	1,907	5,734	2,860	42,232	42,232	31
40	Subprovider - IPF	12,607	11,340	12,607	34,020	94,190	94,190	40
43	Nursery	1,268	2,883	1,268		25,613	25,613	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,798		5,798		41,251	41,251	50
51	Recovery Room					7,009	7,009	51
52	Delivery Room & Labor Room	3,883		3,883		90,279	90,279	52
53	Anesthesiology	748		748		12,248	12,248	53
54	Radiology-Diagnostic	10,749		10,749		63,914		54
57	CT Scan					7,907		57
58	MRI					3,891		58
60	Laboratory	7,129		7,129		57,157		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					1,840		63
65	Respiratory Therapy	1,313		1,313		22,755		65
66	Physical Therapy	1,728		1,728		27,115		66
69	Electrocardiology	1,002		1,002		12,842		69
70	Electroencephalography	633		633		1,830		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)					11,792	11,792	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		65,915	65,915	90
90.01	CHEMOTHERAPY					17,172	17,172	90.01
90.02	KEDZIE CLINIC					26,116		90.02
90.03	LITTLE VILLAGE CLINIC					16,060		90.03
91	Emergency	3,715		3,715		100,894	100,894	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	30,193	129,601	79,069	1,067,945	676,819	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	150		150		1,122		190
192	Physicians' Private Offices	9,195		9,195		17,094		192
192.01	OTHER NON-REIMBURSABLE					2,016		192.01
192.02	NEPHROLOGY					12,894		192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	5,196,282	277,662	2,777,927	1,630,589	1,449,388	2,503,755	202

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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 ADMINI- STRATION (FULL TIME TIME)	
		7	8	9	10	11	13	
203	Unit Cost Multiplier (Wkst. B, Part I)	36.010769	9.196238	19.992853	20.622355	1.316344	3.699298	203
204	Cost to be allocated (Per Wkst. B, Part II)	472.687	75.652	51.377	85.841	115,136	91,923	204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.275770	2.505614	0.369762	1.085647	0.104567	0.135816	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-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	
		14	15	16	17	21	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	5,163,728						14
15	Pharmacy	223,320	4,420,039					15
16	Medical Records & Library	24		297,558,145				16
17	Social Service				30,407			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					1,000		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	282,308		26,961,816	15,316	400	400	30
31	Intensive Care Unit	109,492		6,610,150	2,010			31
40	Subprovider - IPF	29,592		18,253,265	8,709			40
43	Nursery	26,603		4,349,750	3,194			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			15,135,107				50
51	Recovery Room	11,419		1,173,430				51
52	Delivery Room & Labor Room	210,388		8,808,373	1,178			52
53	Anesthesiology	126,698		7,996,689				53
54	Radiology-Diagnostic	147,547	68,827	19,659,112				54
57	CT Scan	94,398		19,293,264				57
58	MRI	3,139		3,301,708				58
60	Laboratory	133,456		26,584,935				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			2,858,265				63
65	Respiratory Therapy			6,758,449				65
66	Physical Therapy	38,254		7,117,754				66
69	Electrocardiology	16,295		5,775,861				69
70	Electroencephalography	2,776		1,042,711				70
71	Medical Supplies Charged to Patients	2,183,764		6,785,941				71
72	Impl. Dev. Charged to Patients	1,287,836		3,728,289				72
73	Drugs Charged to Patients		4,351,212	45,718,611				73
75	ASC (Non-Distinct Part)	7,284		1,658,274				75
76	HEMODIALYSIS			479,106				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	83,738		4,662,658		200	200	90
90.01	CHEMOTHERAPY	52,133		4,667,587				90.01
90.02	KEDZIE CLINIC	16,699		3,611,223				90.02
90.03	LITTLE VILLAGE CLINIC	4,913		4,584,236				90.03
91	Emergency	14,755		39,981,581		400	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)	5,106,831	4,420,039	297,558,145	30,407	1,000	1,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	14,283						192
192.01	OTHER NON-REIMBURSABLE	39						192.01
192.02	NEPHROLOGY	42,575						192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	890,522	2,909,663	2,606,225	1,279,368	394,889	436,559	202

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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-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)	
		14	15	16	17	21	22	
203	Unit Cost Multiplier (Wkst. B, Part I)	0.172457	0.658289	0.008759	42.074785	394.889000	436.559000	203
204	Cost to be allocated (Per Wkst. B, Part II)	117.002	83.579	93.505	29.204	3,486	2,581	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.022658	0.018909	0.000314	0.960437	3.486000	2.581000	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
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	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							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
192	Physicians' Private Offices							192
192.01	OTHER NON-REIMBURSABLE							192.01
192.02	NEPHROLOGY							192.02
200	Cross foot adjustments							200

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	16,308,446		16,308,446	17,415	16,325,861	30
31	Intensive Care Unit	3,467,651		3,467,651	74,082	3,541,733	31
40	Subprovider - IPF	7,641,010		7,641,010	37,415	7,678,425	40
43	Nursery	2,008,640		2,008,640	46,281	2,054,921	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,744,627		3,744,627		3,744,627	50
51	Recovery Room	623,287		623,287		623,287	51
52	Delivery Room & Labor Room	5,075,188		5,075,188		5,075,188	52
53	Anesthesiology	1,373,023		1,373,023	160,333	1,533,356	53
54	Radiology-Diagnostic	5,640,447		5,640,447		5,640,447	54
57	CT Scan	1,015,046		1,015,046		1,015,046	57
58	MRI	301,551		301,551		301,551	58
60	Laboratory	5,542,137		5,542,137	5,915	5,548,052	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	740,366		740,366		740,366	63
65	Respiratory Therapy	1,391,837		1,391,837		1,391,837	65
66	Physical Therapy	1,945,164		1,945,164	24,915	1,970,079	66
69	Electrocardiology	916,911		916,911		916,911	69
70	Electroencephalography	158,078		158,078		158,078	70
71	Medical Supplies Charged to Patients	3,291,499		3,291,499		3,291,499	71
72	Impl. Dev. Charged to Patients	1,938,747		1,938,747		1,938,747	72
73	Drugs Charged to Patients	8,494,141		8,494,141		8,494,141	73
75	ASC (Non-Distinct Part)	766,313		766,313		766,313	75
76	HEMODIALYSIS	289,364		289,364		289,364	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	3,461,399		3,461,399	141,977	3,603,376	90
90.01	CHEMOTHERAPY	1,191,129		1,191,129	75,091	1,266,220	90.01
90.02	KEDZIE CLINIC	1,792,434		1,792,434	101,982	1,894,416	90.02
90.03	LITTLE VILLAGE CLINIC	2,102,420		2,102,420		2,102,420	90.03
91	Emergency	6,939,615		6,939,615		6,939,615	91
92	Observation Beds (Non-Distinct Part)	1,795,797		1,795,797		1,795,797	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)	89,956,267		89,956,267	685,406	90,641,673	200
201	Less Observation Beds	1,795,797		1,795,797		1,795,797	201
202	Total (line 200 minus line 201)	88,160,470		88,160,470		88,845,876	202

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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				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	23,908,766		23,908,766				30
31	Intensive Care Unit	6,610,150		6,610,150				31
40	Subprovider - IPF	18,253,265		18,253,265				40
43	Nursery	4,349,750		4,349,750				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,205,608	8,929,499	15,135,107	0.247413	0.247413	0.247413	50
51	Recovery Room	350,034	823,396	1,173,430	0.531167	0.531167	0.531167	51
52	Delivery Room & Labor Room	7,219,072	1,589,301	8,808,373	0.576178	0.576178	0.576178	52
53	Anesthesiology	2,887,814	5,108,875	7,996,689	0.171699	0.171699	0.191749	53
54	Radiology-Diagnostic	3,594,720	16,064,392	19,659,112	0.286913	0.286913	0.286913	54
57	CT Scan	4,963,173	14,330,091	19,293,264	0.052611	0.052611	0.052611	57
58	MRI	563,182	2,738,526	3,301,708	0.091332	0.091332	0.091332	58
60	Laboratory	11,616,208	14,968,727	26,584,935	0.208469	0.208469	0.208692	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	2,406,639	451,626	2,858,265	0.259026	0.259026	0.259026	63
65	Respiratory Therapy	6,276,751	481,698	6,758,449	0.205940	0.205940	0.205940	65
66	Physical Therapy	675,328	6,442,426	7,117,754	0.273283	0.273283	0.276784	66
69	Electrocardiology	2,152,337	3,623,524	5,775,861	0.158749	0.158749	0.158749	69
70	Electroencephalography	183,353	859,358	1,042,711	0.151603	0.151603	0.151603	70
71	Medical Supplies Charged to Patients	4,131,212	2,654,729	6,785,941	0.485047	0.485047	0.485047	71
72	Impl. Dev. Charged to Patients	2,454,221	1,274,068	3,728,289	0.520010	0.520010	0.520010	72
73	Drugs Charged to Patients	18,605,360	27,113,251	45,718,611	0.185792	0.185792	0.185792	73
75	ASC (Non-Distinct Part)	81,827	1,576,447	1,658,274	0.462115	0.462115	0.462115	75
76	HEMODIALYSIS	439,200	39,906	479,106	0.603967	0.603967	0.603967	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		4,662,658	4,662,658	0.742366	0.742366	0.772816	90
90.01	CHEMOTHERAPY	20,366	4,647,221	4,667,587	0.255192	0.255192	0.271279	90.01
90.02	KEDZIE CLINIC		3,611,223	3,611,223	0.496351	0.496351	0.524591	90.02
90.03	LITTLE VILLAGE CLINIC		4,584,236	4,584,236	0.458619	0.458619	0.458619	90.03
91	Emergency	7,119,565	32,862,016	39,981,581	0.173570	0.173570	0.173570	91
92	Observation Beds (Non-Distinct Part)	322,807	2,730,243	3,053,050	0.588198	0.588198	0.588198	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)	135,390,708	162,167,437	297,558,145				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	135,390,708	162,167,437	297,558,145				202

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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)	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)		
(A)	1	2	3	4	5	6	7		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,114,073		1,114,073	15,464	72.04	3,105	223,684	30
31	Intensive Care Unit	161,201		161,201	1,907	84.53	512	43,279	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	399,215		399,215	11,340	35.20	2,737	96,342	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	53,416		53,416	2,883	18.53			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,727,905		1,727,905	31,594		6,354	363,305	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0095

WORKSHEET D
PART II

Check [] Title V [XX] Hospital [] SUB (Other) [XX] PPS
 Applicable [XX] 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	154,434	15,135,107	0.010204	1,406,700	14,354	50
51	Recovery Room	5,071	1,173,430	0.004322	84,450	365	51
52	Delivery Room & Labor Room	134,628	8,808,373	0.015284	12,137	186	52
53	Anesthesiology	29,940	7,996,689	0.003744	511,590	1,915	53
54	Radiology-Diagnostic	271,901	19,659,112	0.013831	963,030	13,320	54
57	CT Scan	12,925	19,293,264	0.000670	1,155,031	774	57
58	MRI	2,793	3,301,708	0.000846	150,597	127	58
60	Laboratory	193,931	26,584,935	0.007295	2,230,911	16,274	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,401	2,858,265	0.001540	412,958	636	63
65	Respiratory Therapy	38,719	6,758,449	0.005729	1,486,615	8,517	65
66	Physical Therapy	51,565	7,117,754	0.007245	233,728	1,693	66
69	Electrocardiology	28,946	5,775,861	0.005012	635,153	3,183	69
70	Electroencephalography	14,771	1,042,711	0.014166	60,684	860	70
71	Medical Supplies Charged to Pat	64,808	6,785,941	0.009550	1,098,419	10,490	71
72	Impl. Dev. Charged to Patients	38,133	3,728,289	0.010228	633,033	6,475	72
73	Drugs Charged to Patients	120,872	45,718,611	0.002644	3,803,624	10,057	73
75	ASC (Non-Distinct Part)	6,837	1,658,274	0.004123	21,268	88	75
76	HEMODIALYSIS	1,468	479,106	0.003064	208,398	639	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	162,623	4,662,658	0.034878			90
90.01	CHEMOTHERAPY	11,835	4,667,587	0.002536	19,409	49	90.01
90.02	KEDZIE CLINIC	12,350	3,611,223	0.003420			90.02
90.03	LITTLE VILLAGE CLINIC	12,800	4,584,236	0.002792			90.03
91	Emergency	145,383	39,981,581	0.003636	1,237,371	4,499	91
92	Observation Beds (Non-Distinct	122,545	3,053,050	0.040139	52,261	2,098	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,643,679	244,436,214		16,417,367	96,599	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check [] Title V [XX] PPS
Applicable [XX] 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)	15,464		3,105		30
31	Intensive Care Unit	1,907		512		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	11,340		2,737		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,883				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	31,594		6,354		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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	15,135,107			1,406,700		938,637		50
51	Recovery Room	1,173,430			84,450		111,888		51
52	Delivery Room & Labor Room	8,808,373			12,137		5,159		52
53	Anesthesiology	7,996,689			511,590		728,434		53
54	Radiology-Diagnostic	19,659,112			963,030		1,473,880		54
57	CT Scan	19,293,264			1,155,031		1,911,195		57
58	MRI	3,301,708			150,597		439,048		58
60	Laboratory	26,584,935			2,230,911		1,491,530		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,858,265			412,958		18,490		63
65	Respiratory Therapy	6,758,449			1,486,615		98,442		65
66	Physical Therapy	7,117,754			233,728		39,571		66
69	Electrocardiology	5,775,861			635,153		693,636		69
70	Electroencephalography	1,042,711			60,684		115,818		70
71	Medical Supplies Charged to Pat	6,785,941			1,098,419		320,834		71
72	Impl. Dev. Charged to Patients	3,728,289			633,033		217,722		72
73	Drugs Charged to Patients	45,718,611			3,803,624		8,731,945		73
75	ASC (Non-Distinct Part)	1,658,274			21,268		242,347		75
76	HEMODIALYSIS	479,106			208,398		19,214		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	4,662,658					836,519		90
90.01	CHEMOTHERAPY	4,667,587			19,409		1,755,949		90.01
90.02	KEDZIE CLINIC	3,611,223					16,888		90.02
90.03	LITTLE VILLAGE CLINIC	4,584,236					39,573		90.03
91	Emergency	39,981,581			1,237,371		1,777,727		91
92	Observation Beds (Non-Distinct	3,053,050			52,261		446,167		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	244,436,214			16,417,367		22,470,613		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] 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	0.247413	938,637			232,231			50
51	Recovery Room	0.531167	111,888			59,431			51
52	Delivery Room & Labor Room	0.576178	5,159			2,973			52
53	Anesthesiology	0.171699	728,434			125,071			53
54	Radiology-Diagnostic	0.286913	1,473,880			422,875			54
57	CT Scan	0.052611	1,911,195			100,550			57
58	MRI	0.091332	439,048			40,099			58
60	Laboratory	0.208469	1,491,530			310,938			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.259026	18,490			4,789			63
65	Respiratory Therapy	0.205940	98,442			20,273			65
66	Physical Therapy	0.273283	39,571			10,814			66
69	Electrocardiology	0.158749	693,636			110,114			69
70	Electroencephalography	0.151603	115,818			17,558			70
71	Medical Supplies Charged to Pat	0.485047	320,834			155,620			71
72	Impl. Dev. Charged to Patients	0.520010	217,722			113,218			72
73	Drugs Charged to Patients	0.185792	8,731,945		34,983	1,622,326		6,500	73
75	ASC (Non-Distinct Part)	0.462115	242,347			111,992			75
76	HEMODIALYSIS	0.603967	19,214			11,605			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	0.742366	836,519			621,003			90
90.01	CHEMOTHERAPY	0.255192	1,755,949			448,104			90.01
90.02	KEDZIE CLINIC	0.496351	16,888			8,382			90.02
90.03	LITTLE VILLAGE CLINIC	0.458619	39,573			18,149			90.03
91	Emergency	0.173570	1,777,727			308,560			91
92	Observation Beds (Non-Distinct	0.588198	446,167			262,435			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		22,470,613		34,983	5,139,110		6,500	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		22,470,613		34,983	5,139,110		6,500	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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) [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] 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	154,434	15,135,107	0.010204	7,125	73	50
51	Recovery Room	5,071	1,173,430	0.004322	864	4	51
52	Delivery Room & Labor Room	134,628	8,808,373	0.015284			52
53	Anesthesiology	29,940	7,996,689	0.003744	3,653	14	53
54	Radiology-Diagnostic	271,901	19,659,112	0.013831	28,823	399	54
57	CT Scan	12,925	19,293,264	0.000670	26,221	18	57
58	MRI	2,793	3,301,708	0.000846			58
60	Laboratory	193,931	26,584,935	0.007295	492,551	3,593	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,401	2,858,265	0.001540			63
65	Respiratory Therapy	38,719	6,758,449	0.005729	7,565	43	65
66	Physical Therapy	51,565	7,117,754	0.007245	2,598	19	66
69	Electrocardiology	28,946	5,775,861	0.005012	51,005	256	69
70	Electroencephalography	14,771	1,042,711	0.014166	10,330	146	70
71	Medical Supplies Charged to Pat	64,808	6,785,941	0.009550	1,891	18	71
72	Impl. Dev. Charged to Patients	38,133	3,728,289	0.010228			72
73	Drugs Charged to Patients	120,872	45,718,611	0.002644	485,358	1,283	73
75	ASC (Non-Distinct Part)	6,837	1,658,274	0.004123			75
76	HEMODIALYSIS	1,468	479,106	0.003064			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	162,623	4,662,658	0.034878			90
90.01	CHEMOTHERAPY	11,835	4,667,587	0.002536			90.01
90.02	KEDZIE CLINIC	12,350	3,611,223	0.003420			90.02
90.03	LITTLE VILLAGE CLINIC	12,800	4,584,236	0.002792			90.03
91	Emergency	145,383	39,981,581	0.003636	341,150	1,240	91
92	Observation Beds (Non-Distinct		3,053,050				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,521,134	244,436,214		1,459,134	7,106	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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	15,135,107			7,125				50
51	Recovery Room	1,173,430			864				51
52	Delivery Room & Labor Room	8,808,373							52
53	Anesthesiology	7,996,689			3,653				53
54	Radiology-Diagnostic	19,659,112			28,823				54
57	CT Scan	19,293,264			26,221				57
58	MRI	3,301,708							58
60	Laboratory	26,584,935			492,551				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,858,265							63
65	Respiratory Therapy	6,758,449			7,565				65
66	Physical Therapy	7,117,754			2,598				66
69	Electrocardiology	5,775,861			51,005				69
70	Electroencephalography	1,042,711			10,330				70
71	Medical Supplies Charged to Pat	6,785,941			1,891				71
72	Impl. Dev. Charged to Patients	3,728,289							72
73	Drugs Charged to Patients	45,718,611			485,358				73
75	ASC (Non-Distinct Part)	1,658,274							75
76	HEMODIALYSIS	479,106							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	4,662,658					244,025		90
90.01	CHEMOTHERAPY	4,667,587							90.01
90.02	KEDZIE CLINIC	3,611,223							90.02
90.03	LITTLE VILLAGE CLINIC	4,584,236							90.03
91	Emergency	39,981,581			341,150				91
92	Observation Beds (Non-Distinct	3,053,050							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	244,436,214			1,459,134		244,025		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 [XX] Title XVIII, Part B [XX] 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	0.247413						50
51	Recovery Room	0.531167						51
52	Delivery Room & Labor Room	0.576178						52
53	Anesthesiology	0.171699						53
54	Radiology-Diagnostic	0.286913						54
57	CT Scan	0.052611						57
58	MRI	0.091332						58
60	Laboratory	0.208469						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.259026						63
65	Respiratory Therapy	0.205940						65
66	Physical Therapy	0.273283						66
69	Electrocardiology	0.158749						69
70	Electroencephalography	0.151603						70
71	Medical Supplies Charged to Pat	0.485047						71
72	Impl. Dev. Charged to Patients	0.520010						72
73	Drugs Charged to Patients	0.185792						73
75	ASC (Non-Distinct Part)	0.462115						75
76	HEMODIALYSIS	0.603967						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	0.742366	244,025			181,156		90
90.01	CHEMOTHERAPY	0.255192						90.01
90.02	KEDZIE CLINIC	0.496351						90.02
90.03	LITTLE VILLAGE CLINIC	0.458619						90.03
91	Emergency	0.173570						91
92	Observation Beds (Non-Distinct	0.588198						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)		244,025			181,156		200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		244,025			181,156		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,114,073		1,114,073	15,464	72.04	1,911	137,668	30
31	Intensive Care Unit	161,201		161,201	1,907	84.53	262	22,147	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	399,215		399,215	11,340	35.20	2,798	98,490	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	53,416		53,416	2,883	18.53	1,907	35,337	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,727,905		1,727,905	31,594		6,878	293,642	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0095

WORKSHEET D
PART II

Check [] Title V [XX] Hospital [] SUB (Other)
 Applicable [] Title XVIII, Part A [] IPF
 Boxes: [XX] 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	154,434	15,135,107	0.010204			50
51	Recovery Room	5,071	1,173,430	0.004322			51
52	Delivery Room & Labor Room	134,628	8,808,373	0.015284			52
53	Anesthesiology	29,940	7,996,689	0.003744			53
54	Radiology-Diagnostic	271,901	19,659,112	0.013831			54
57	CT Scan	12,925	19,293,264	0.000670			57
58	MRI	2,793	3,301,708	0.000846			58
60	Laboratory	193,931	26,584,935	0.007295			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,401	2,858,265	0.001540			63
65	Respiratory Therapy	38,719	6,758,449	0.005729			65
66	Physical Therapy	51,565	7,117,754	0.007245			66
69	Electrocardiology	28,946	5,775,861	0.005012			69
70	Electroencephalography	14,771	1,042,711	0.014166			70
71	Medical Supplies Charged to Pat	64,808	6,785,941	0.009550			71
72	Impl. Dev. Charged to Patients	38,133	3,728,289	0.010228			72
73	Drugs Charged to Patients	120,872	45,718,611	0.002644			73
75	ASC (Non-Distinct Part)	6,837	1,658,274	0.004123			75
76	HEMODIALYSIS	1,468	479,106	0.003064			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	162,623	4,662,658	0.034878			90
90.01	CHEMOTHERAPY	11,835	4,667,587	0.002536			90.01
90.02	KEDZIE CLINIC	12,350	3,611,223	0.003420			90.02
90.03	LITTLE VILLAGE CLINIC	12,800	4,584,236	0.002792			90.03
91	Emergency	145,383	39,981,581	0.003636			91
92	Observation Beds (Non-Distinct	122,545	3,053,050	0.040139			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,643,679	244,436,214				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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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: [XX] Title XIX [XX] 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)	15,464		1,911		30
31	Intensive Care Unit	1,907		262		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	11,340		2,798		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,883		1,907		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	31,594		6,878		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 Anesthetist 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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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	15,135,107							50
51	Recovery Room	1,173,430							51
52	Delivery Room & Labor Room	8,808,373							52
53	Anesthesiology	7,996,689							53
54	Radiology-Diagnostic	19,659,112							54
57	CT Scan	19,293,264							57
58	MRI	3,301,708							58
60	Laboratory	26,584,935							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,858,265							63
65	Respiratory Therapy	6,758,449							65
66	Physical Therapy	7,117,754							66
69	Electrocardiology	5,775,861							69
70	Electroencephalography	1,042,711							70
71	Medical Supplies Charged to Pat	6,785,941							71
72	Impl. Dev. Charged to Patients	3,728,289							72
73	Drugs Charged to Patients	45,718,611							73
75	ASC (Non-Distinct Part)	1,658,274							75
76	HEMODIALYSIS	479,106							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	4,662,658							90
90.01	CHEMOTHERAPY	4,667,587							90.01
90.02	KEDZIE CLINIC	3,611,223							90.02
90.03	LITTLE VILLAGE CLINIC	4,584,236							90.03
91	Emergency	39,981,581							91
92	Observation Beds (Non-Distinct	3,053,050							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	244,436,214							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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] 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	0.247413						50
51	Recovery Room	0.531167						51
52	Delivery Room & Labor Room	0.576178						52
53	Anesthesiology	0.171699						53
54	Radiology-Diagnostic	0.286913						54
57	CT Scan	0.052611						57
58	MRI	0.091332						58
60	Laboratory	0.208469						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.259026						63
65	Respiratory Therapy	0.205940						65
66	Physical Therapy	0.273283						66
69	Electrocardiology	0.158749						69
70	Electroencephalography	0.151603						70
71	Medical Supplies Charged to Pat	0.485047						71
72	Impl. Dev. Charged to Patients	0.520010						72
73	Drugs Charged to Patients	0.185792						73
75	ASC (Non-Distinct Part)	0.462115						75
76	HEMODIALYSIS	0.603967						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	0.742366						90
90.01	CHEMOTHERAPY	0.255192						90.01
90.02	KEDZIE CLINIC	0.496351						90.02
90.03	LITTLE VILLAGE CLINIC	0.458619						90.03
91	Emergency	0.173570						91
92	Observation Beds (Non-Distinct	0.588198						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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 [XX] IPF
 Boxes: [XX] 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	154,434	15,135,107	0.010204	9,871	101	50
51	Recovery Room	5,071	1,173,430	0.004322	2,030	9	51
52	Delivery Room & Labor Room	134,628	8,808,373	0.015284			52
53	Anesthesiology	29,940	7,996,689	0.003744	5,728	21	53
54	Radiology-Diagnostic	271,901	19,659,112	0.013831	56,256	778	54
57	CT Scan	12,925	19,293,264	0.000670	34,518	23	57
58	MRI	2,793	3,301,708	0.000846	25,120	21	58
60	Laboratory	193,931	26,584,935	0.007295	909,192	6,633	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,401	2,858,265	0.001540			63
65	Respiratory Therapy	38,719	6,758,449	0.005729	69,994	401	65
66	Physical Therapy	51,565	7,117,754	0.007245	7,887	57	66
69	Electrocardiology	28,946	5,775,861	0.005012	120,648	605	69
70	Electroencephalography	14,771	1,042,711	0.014166			70
71	Medical Supplies Charged to Pat	64,808	6,785,941	0.009550	5,466	52	71
72	Impl. Dev. Charged to Patients	38,133	3,728,289	0.010228			72
73	Drugs Charged to Patients	120,872	45,718,611	0.002644	1,126,003	2,977	73
75	ASC (Non-Distinct Part)	6,837	1,658,274	0.004123			75
76	HEMODIALYSIS	1,468	479,106	0.003064	6,420	20	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	162,623	4,662,658	0.034878			90
90.01	CHEMOTHERAPY	11,835	4,667,587	0.002536			90.01
90.02	KEDZIE CLINIC	12,350	3,611,223	0.003420			90.02
90.03	LITTLE VILLAGE CLINIC	12,800	4,584,236	0.002792			90.03
91	Emergency	145,383	39,981,581	0.003636	43,345	158	91
92	Observation Beds (Non-Distinct		3,053,050				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,521,134	244,436,214		2,422,478	11,856	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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	15,135,107			9,871				50
51	Recovery Room	1,173,430			2,030				51
52	Delivery Room & Labor Room	8,808,373							52
53	Anesthesiology	7,996,689			5,728				53
54	Radiology-Diagnostic	19,659,112			56,256				54
57	CT Scan	19,293,264			34,518				57
58	MRI	3,301,708			25,120				58
60	Laboratory	26,584,935			909,192				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,858,265							63
65	Respiratory Therapy	6,758,449			69,994				65
66	Physical Therapy	7,117,754			7,887				66
69	Electrocardiology	5,775,861			120,648				69
70	Electroencephalography	1,042,711							70
71	Medical Supplies Charged to Pat	6,785,941			5,466				71
72	Impl. Dev. Charged to Patients	3,728,289							72
73	Drugs Charged to Patients	45,718,611			1,126,003				73
75	ASC (Non-Distinct Part)	1,658,274							75
76	HEMODIALYSIS	479,106			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	4,662,658							90
90.01	CHEMOTHERAPY	4,667,587							90.01
90.02	KEDZIE CLINIC	3,611,223							90.02
90.03	LITTLE VILLAGE CLINIC	4,584,236							90.03
91	Emergency	39,981,581			43,345				91
92	Observation Beds (Non-Distinct	3,053,050							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	244,436,214			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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 [XX] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] 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	0.247413						50
51	Recovery Room	0.531167						51
52	Delivery Room & Labor Room	0.576178						52
53	Anesthesiology	0.171699						53
54	Radiology-Diagnostic	0.286913						54
57	CT Scan	0.052611						57
58	MRI	0.091332						58
60	Laboratory	0.208469						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.259026						63
65	Respiratory Therapy	0.205940						65
66	Physical Therapy	0.273283						66
69	Electrocardiology	0.158749						69
70	Electroencephalography	0.151603						70
71	Medical Supplies Charged to Pat	0.485047						71
72	Impl. Dev. Charged to Patients	0.520010						72
73	Drugs Charged to Patients	0.185792						73
75	ASC (Non-Distinct Part)	0.462115						75
76	HEMODIALYSIS	0.603967						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	0.742366						90
90.01	CHEMOTHERAPY	0.255192						90.01
90.02	KEDZIE CLINIC	0.496351						90.02
90.03	LITTLE VILLAGE CLINIC	0.458619						90.03
91	Emergency	0.173570						91
92	Observation Beds (Non-Distinct	0.588198						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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0095

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] 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)	15,464	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,464	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)	13,763	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)	3,105	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)	16,325,861	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)	16,325,861	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)	16,325,861	37

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)						1,055.73	38				
39	Program general inpatient routine service cost (line 9 x line 38)						3,278,042	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)						3,278,042	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)							42				
	Intensive Care Type Inpatient Hospital Units											
43	Intensive Care Unit						3,541,733	1,907	1,857.23	512	950,902	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)						3,857,345	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						8,086,289	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						266,963	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						96,599	51
52	Total Program excludable cost (sum of lines 50 and 51)						363,562	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						7,722,727	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)					1,055.73	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,795,797	89
		Cost	Routine Cost (from line 21)	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	1,114,073	16,325,861	0.068240	1,795,797	122,545	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)	11,340	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,340	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)	11,340	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)	2,737	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)	7,678,425	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)	7,678,425	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)	7,678,425	37

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)	15,464	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,464	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)	13,763	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)	1,911	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)	2,883	15
16	Nursery days (title V or XIX only)	1,907	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)	16,308,446	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)	16,308,446	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)	16,308,446	37

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)					1,054.61	38	
39	Program general inpatient routine service cost (line 9 x line 38)					2,015,360	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)					2,015,360	41	
42	Nursery (Titles V and XIX only)	2,008,640	2,883	696.72	1,907	1,328,645	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	3,467,651	1,907	1,818.38	262	476,416	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)					3,820,421	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					195,152	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)					195,152	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

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 21)	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)	11,340	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,340	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)	11,340	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)	7,641,010	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)	7,641,010	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)	7,641,010	37

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)	673.81	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,885,320	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)	1,885,320	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	473,268	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,358,588	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	98,490	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,856	51
52	Total Program excludable cost (sum of lines 50 and 51)	110,346	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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [XX] 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		6,032,271		30
31	Intensive Care Unit		1,732,851		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.247413	1,406,700	348,036	50
51	Recovery Room	0.531167	84,450	44,857	51
52	Delivery Room & Labor Room	0.576178	12,137	6,993	52
53	Anesthesiology	0.191749	511,590	98,097	53
54	Radiology-Diagnostic	0.286913	963,030	276,306	54
57	CT Scan	0.052611	1,155,031	60,767	57
58	MRI	0.091332	150,597	13,754	58
60	Laboratory	0.208692	2,230,911	465,573	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.259026	412,958	106,967	63
65	Respiratory Therapy	0.205940	1,486,615	306,153	65
66	Physical Therapy	0.276784	233,728	64,692	66
69	Electrocardiology	0.158749	635,153	100,830	69
70	Electroencephalography	0.151603	60,684	9,200	70
71	Medical Supplies Charged to Patients	0.485047	1,098,419	532,785	71
72	Impl. Dev. Charged to Patients	0.520010	633,033	329,183	72
73	Drugs Charged to Patients	0.185792	3,803,624	706,683	73
75	ASC (Non-Distinct Part)	0.462115	21,268	9,828	75
76	HEMODIALYSIS	0.603967	208,398	125,866	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	0.772816			90
90.01	CHEMOTHERAPY	0.271279	19,409	5,265	90.01
90.02	KEDZIE CLINIC	0.524591			90.02
90.03	LITTLE VILLAGE CLINIC	0.458619			90.03
91	Emergency	0.173570	1,237,371	214,770	91
92	Observation Beds (Non-Distinct Part)	0.588198	52,261	30,740	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		16,417,367	3,857,345	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		16,417,367		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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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/ID 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		4,365,530		40
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.247413	7,125	1,763	50
51	Recovery Room	0.531167	864	459	51
52	Delivery Room & Labor Room	0.576178			52
53	Anesthesiology	0.191749	3,653	700	53
54	Radiology-Diagnostic	0.286913	28,823	8,270	54
57	CT Scan	0.052611	26,221	1,380	57
58	MRI	0.091332			58
60	Laboratory	0.208692	492,551	102,791	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.259026			63
65	Respiratory Therapy	0.205940	7,565	1,558	65
66	Physical Therapy	0.276784	2,598	719	66
69	Electrocardiology	0.158749	51,005	8,097	69
70	Electroencephalography	0.151603	10,330	1,566	70
71	Medical Supplies Charged to Patients	0.485047	1,891	917	71
72	Impl. Dev. Charged to Patients	0.520010			72
73	Drugs Charged to Patients	0.185792	485,358	90,176	73
75	ASC (Non-Distinct Part)	0.462115			75
76	HEMODIALYSIS	0.603967			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	0.772816			90
90.01	CHEMOTHERAPY	0.271279			90.01
90.02	KEDZIE CLINIC	0.524591			90.02
90.03	LITTLE VILLAGE CLINIC	0.458619			90.03
91	Emergency	0.173570	341,150	59,213	91
92	Observation Beds (Non-Distinct Part)	0.588198			92
OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-94, and 96-98)		1,459,134	277,609	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,459,134		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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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	0.247413			50
51	Recovery Room	0.531167			51
52	Delivery Room & Labor Room	0.576178			52
53	Anesthesiology	0.171699			53
54	Radiology-Diagnostic	0.286913			54
57	CT Scan	0.052611			57
58	MRI	0.091332			58
60	Laboratory	0.208469			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.259026			63
65	Respiratory Therapy	0.205940			65
66	Physical Therapy	0.273283			66
69	Electrocardiology	0.158749			69
70	Electroencephalography	0.151603			70
71	Medical Supplies Charged to Patients	0.485047			71
72	Impl. Dev. Charged to Patients	0.520010			72
73	Drugs Charged to Patients	0.185792			73
75	ASC (Non-Distinct Part)	0.462115			75
76	HEMODIALYSIS	0.603967			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	0.742366			90
90.01	CHEMOTHERAPY	0.255192			90.01
90.02	KEDZIE CLINIC	0.496351			90.02
90.03	LITTLE VILLAGE CLINIC	0.458619			90.03
91	Emergency	0.173570			91
92	Observation Beds (Non-Distinct Part)	0.588198			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

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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/ID 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	0.247413	9,871	2,442	50
51	Recovery Room	0.531167	2,030	1,078	51
52	Delivery Room & Labor Room	0.576178			52
53	Anesthesiology	0.171699	5,728	983	53
54	Radiology-Diagnostic	0.286913	56,256	16,141	54
57	CT Scan	0.052611	34,518	1,816	57
58	MRI	0.091332	25,120	2,294	58
60	Laboratory	0.208469	909,192	189,538	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.259026			63
65	Respiratory Therapy	0.205940	69,994	14,415	65
66	Physical Therapy	0.273283	7,887	2,155	66
69	Electrocardiology	0.158749	120,648	19,153	69
70	Electroencephalography	0.151603			70
71	Medical Supplies Charged to Patients	0.485047	5,466	2,651	71
72	Impl. Dev. Charged to Patients	0.520010			72
73	Drugs Charged to Patients	0.185792	1,126,003	209,202	73
75	ASC (Non-Distinct Part)	0.462115			75
76	HEMODIALYSIS	0.603967	6,420	3,877	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	0.742366			90
90.01	CHEMOTHERAPY	0.255192			90.01
90.02	KEDZIE CLINIC	0.496351			90.02
90.03	LITTLE VILLAGE CLINIC	0.458619			90.03
91	Emergency	0.173570	43,345	7,523	91
92	Observation Beds (Non-Distinct Part)	0.588198			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,422,478	473,268	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)	1,306,222			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,918,667			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)	117,074			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	36,895			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	104.35			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	1.72			10
11	FTE count for residents in dental and podiatric programs	0.98			11
12	Current year allowable FTE (see instructions)	2.70			12
13	Total allowable FTE count for the prior year	3.49			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	3.24			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	3.24			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.031049			19
20	Prior year resident to bed ratio (see instructions)	0.033448			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.031049			21
22	IME payment adjustment (see instructions)	87,893			22
22.01	IME payment adjustment - Managed Care (see instructions)	621			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)	-0.83			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)	87,893			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	621			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1494			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5186			31
32	Sum of lines 30 and 31	0.6680			32
33	Allowable disproportionate share percentage (see instructions)	0.4477			33
34	Disproportionate share adjustment (see instructions)	584,796			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	7,647,644,885		6,406,145,534	35
35.01	Factor 3 (see instructions)	0.000386245		0.000381790	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,953,865		2,445,802	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	744,536		1,831,011	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,575,547			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
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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	8,590,199			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)	8,590,820			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	492,657			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)	74,815			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)	9,158,292			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	9,158,292			61
62	Deductibles billed to program beneficiaries	553,488			62
63	Coinsurance billed to program beneficiaries	71,316			63
64	Allowable bad debts (see instructions)	705,555			64
65	Adjusted reimbursable bad debts (see instructions)	458,611			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	547,673			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,992,099			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)	4,934			70.93
70.94	HRR adjustment amount (see instructions)	-27,270			70.94
70.99	HAC adjustment amount (see instructions)	90,611			70.99
71	Amount due provider (see instructions)	8,879,152			71
71.01	Sequestration adjustment (see instructions)	177,583			71.01
72	Interim payments	7,930,448			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	771,121			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	38,403			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
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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	1,306,222	1,306,222			1,306,222	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,918,667		3,918,667		3,918,667	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	117,074	29,269		87,805	117,074	2
2.01	Outlier payment for discharges for Model 4 BPCI						2.01
3	Operating outlier reconciliation						3
4	Managed Care Simulated Payments	36,895	9,224		27,671	36,895	4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E Part A, line 21	0.031049	0.031049		0.031049		5
6	IME payment adjustment	87,893	21,973		65,920	87,893	6
6.01	IME payment adjustment for managed care	621	155		466	621	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)	87,893	21,973		65,920	87,893	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	621	155		466	621	9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage	0.4477	0.4477	0.4477	0.4477	0.4477	10
11	Disproportionate share adjustment	584,796	146,199		438,597	584,796	11
11.01	Uncompensated care payments	2,575,547	744,536		1,831,011	2,575,547	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal	8,590,199	2,248,199		6,342,000	8,590,199	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	8,590,820	2,248,354		6,342,466	8,590,820	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	492,657	123,164		369,493	492,657	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		2,371,518		6,711,959	9,083,477	19
20	Capital DRG other than outlier	418,741	104,685		314,056	418,741	20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments	4,363	1,091		3,272	4,363	21
21.01	Model 4 BPCI Capital DRG outlier payments						21.01
22	Indirect medical education percentage	2,1200	2,1200		2,1200		22
23	Indirect medical education adjustment	8,877	2,219		6,658	8,877	23
24	Allowable disproportionate share percentage	0.1449	0.1449		0.1449		24
25	Disproportionate share adjustment	60,676	15,169		45,507	60,676	25
26	Total prospective capital payments	492,657	123,164		369,493	492,657	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	4,934	1,234		3,700	4,934	30
30.01	HVBP payment adjustment for HSP bonus payment						30.01
31	HRR adjustment	-27,270	-6,818		-20,452	-27,270	31
31.01	HRR adjustment for HSP bonus payment						31.01
32	HAC Reduction Program adjustment		23,659		66,952	90,611	32

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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)	6,500			1
2	Medical and other services reimbursed under OPPTS (see instructions)	5,139,110			2
3	PPS payments	4,788,802			3
4	Outlier payment (see instructions)	7,996			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)	6,500			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	34,983			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)	34,983			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)	34,983			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	28,483			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)	6,500			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)	4,796,798			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	983,732			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)	3,819,566			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	39,004			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,858,570			30
31	Primary payer payments	207			31
32	Subtotal (line 30 minus line 31)	3,858,363			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)	540,645			34
35	Adjusted reimbursable bad debts (see instructions)	351,419			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	382,863			36
37	Subtotal (see instructions)	4,209,782			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)	4,209,782			40
40.01	Sequestration adjustment (see instructions)	84,196			40.01
41	Interim payments	4,148,370			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-22,784			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 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 OPPTS (see instructions)	181,156			2
3	PPS payments	110,523			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)	110,523			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	22,300			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)	88,223			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)	88,223			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	88,223			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)	88,223			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)	88,223			40
40.01	Sequestration adjustment (see instructions)	1,764			40.01
41	Interim payments	86,458			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	1			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

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	Total interim payments paid to provider		8,131,960		4,256,258	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)						
						3.01	
						3.02	
		Program				3.03	
		to				3.04	
		Provider				3.05	
						3.06	
						3.07	
						3.08	
						3.09	
						3.10	
						3.50	
			02/16/2016	201,512	02/16/2016	107,888	3.51
		Provider					3.52
		to					3.53
		Program					3.54
							3.55
							3.56
							3.57
							3.58
							3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			-201,512		-107,888	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)			7,930,448		4,148,370	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)						
							5.01
							5.02
		Program					5.03
		to					5.04
		Provider					5.05
							5.06
							5.07
							5.08
							5.09
							5.10
							5.50
							5.51
		Provider					5.52
		to					5.53
		Program					5.54
							5.55
							5.56
							5.57
							5.58
							5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)						5.99
6	Determined net settlement amount (balance due) based on the cost report (1)			771,121		-22,784	6.01
							6.02
7	Total Medicare program liability (see instructions)			8,701,569		4,125,586	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

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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		2,022,892		86,458	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)					
						3.01
						3.02
		Program				3.03
		to				3.04
		Provider				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		Provider				3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					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)		2,022,892		86,458	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)					
						5.01
						5.02
		Program				5.03
		to				5.04
		Provider				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		Provider				5.52
		to				5.53
		Program				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)					6.01
						6.02
7	Total Medicare program liability (see instructions)		2,022,892		86,459	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

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

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)	4,488	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	3,617	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	727	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	15,670	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	297,558,145	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	16,146,632	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)	390,966	8
9	Sequestration adjustment amount (see instructions)	7,819	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	383,147	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	394,359	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-11,212	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 [XX] 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)	2,322,525	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)	30.983607	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)	2,322,525	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)	2,322,525	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,322,525	18
19	Deductibles	146,468	19
20	Subtotal (line 18 minus line 19)	2,176,057	20
21	Coinsurance	111,881	21
22	Subtotal (line 20 minus line 21)	2,064,176	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)	2,064,176	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)	2,064,176	31
31.01	Sequestration adjustment (see instructions)	41,284	31.01
32	Interim payments	2,022,892	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 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	3,820,421	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	3,820,421	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	3,820,421	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 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(c)		14
15	Ratio of line 13 to line 14 (not to exceed 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)	14,264,864	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)	3,820,421	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)	3,820,421	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)	3,820,421	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)	3,820,421	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)	3,820,421	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)	3,820,421	40
41	Interim payments	3,860,475	41
42	Balance due provider/program (line 40 minus line 41)	-40,054	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 cap (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 the current year from your records (see instructions)			1.72	6
7	Enter the lesser of line 5 or line 6			1.72	7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	1.10	0.62	1.72	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	1.10	0.62	1.72	9
10	Weighted dental and podiatric resident FTE count for the current year		0.98		10
11	Total weighted FTE count	1.10	1.60		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.32	2.19		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.82	1.71		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	1.41	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	1.41	1.83		17
18	Per resident amount	142,000.00	134,000.00		18
19	Approved amount for resident costs	200,220	245,220	445,440	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)			445,440	25
COMPUTATION OF PROGRAM PATIENT LOAD					
26	Inpatient days (see instructions)	Inpatient Part A 6,354	Managed Care 727		26
27	Total inpatient days (see instructions)	27,310	27,310		27
28	Ratio of inpatient days to total inpatient days	0.232662	0.026620		28
29	Program direct GME amount	103,637	11,858		29
30	Reduction for direct GME payments for Medicare Advantage		1,676		30
31	Net Program direct GME amount			113,819	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)			10,217,148	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)			10,217,148	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			5,326,766	42
43	Primary payer payments (see instructions)			207	43
44	Total Part B reasonable cost (line 42 minus line 43)			5,326,559	44
45	Total reasonable cost (sum of lines 41 and 44)			15,543,707	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.657317	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.342683	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			113,819	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			74,815	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			39,004	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 cap (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 the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00
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
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
COMPUTATION OF PROGRAM PATIENT LOAD				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	5,217	5,451	
27	Total inpatient days (see instructions)	27,310	27,310	
28	Ratio of inpatient days to total inpatient days	0.191029	0.199597	
29	Program direct GME amount			
30	Reduction for direct GME payments for Medicare Advantage			
31	Net Program direct GME amount			
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)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
Part A Reasonable Cost				
37	Reasonable cost (see instructions)			
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			
Part B Reasonable Cost				
42	Reasonable cost (see instructions)			
43	Primary payer payments (see instructions)			
44	Total Part B reasonable cost (line 42 minus line 43)			
45	Total reasonable cost (sum of lines 41 and 44)			
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			

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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	4,809,926				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	94,486,042				4
5	Other receivables	112,138				5
6	Allowances for uncollectible notes and accounts receivable	-74,923,880				6
7	Inventory	1,452,121				7
8	Prepaid expenses					8
9	Other current assets	3,065,503				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	29,001,850				11
FIXED ASSETS						
12	Land	472,850				12
13	Land improvements	500,937				13
14	Accumulated depreciation	-237,875				14
15	Buildings	24,573,575				15
16	Accumulated depreciation	-21,369,000				16
17	Leasehold improvements	6,370,169				17
18	Accumulated depreciation	-2,919,242				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	38,849,261				23
24	Accumulated depreciation	-24,953,701				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	21,286,974				30
OTHER ASSETS						
31	Investments	26,163,927				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	952,371				34
35	Total other assets (sum of lines 31-34)	27,116,298				35
36	Total assets (sum of lines 11, 30 and 35)	77,405,122				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	2,026,727				37
38	Salaries, wages and fees payable	8,644,043				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,732,753				44
45	Total current liabilities (sum of lines 37 thru 44)	13,403,523				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	5,330,700				49
50	Total long term liabilities (sum of lines 46 thru 49)	5,330,700				50
51	Total liabilities (sum of lines 45 and 50)	18,734,223				51
CAPITAL ACCOUNTS						
52	General fund balance	58,670,899				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
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)	58,670,899				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	77,405,122				60

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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		68,523,451		1
2	Net income (loss) (from Worksheet G-3, line 29)		-9,852,552		2
3	Total (sum of line 1 and line 2)		58,670,899		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)		58,670,899		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)		58,670,899		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	28,167,352		28,167,352	1
2	Subprovider IPF	18,253,265		18,253,265	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)	46,420,617		46,420,617	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,580,129		6,580,129	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)	6,580,129		6,580,129	16
17	Total inpatient routine care services (sum of lines 10 and 16)	53,000,746		53,000,746	17
18	Ancillary services	82,245,576	162,319,841	244,565,417	18
19	Outpatient services		40,181,687	40,181,687	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	135,246,322	202,501,528	337,747,850	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		114,180,883	29
30	Add (specify)			30
31				31
32	CONTRIBUTION	389,199		32
33	OTHER NON OPER EXPENSES	6,000		33
34				34
35				35
36	Total additions (sum of lines 30-35)		395,199	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)		114,576,082	43

KPMG LLP Compu-Max 2552-10

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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)	337,747,850	1
2	Less contractual allowances and discounts on patients' accounts	237,818,996	2
3	Net patient revenues (line 1 minus line 2)	99,928,854	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	114,576,082	4
5	Net income from service to patients (line 3 minus line 4)	-14,647,228	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	94,223	7
8	Revenues from telephone and other miscellaneous communication services	3,180	8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	14,295	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	708,240	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	129,287	17
18	Revenue from sale of medical records and abstracts	6,088	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen	34,782	20
21	Rental of vending machines		21
22	Rental of hosptial space	166,656	22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	1,129,237	24
24.01	Other (HIT INCENTIVE PAYMENT)		24.01
24.02	Other (MEDICAL STUDENRT PROGRAM)	1,626,280	24.02
24.03	Other (RADIOLOGY REVENUE)	3,970	24.03
24.04	Other (CAPITATION BONUS - FHN)		24.04
24.05	Other (PHYSICIAN BILLING REVENUE)	21,115	24.05
24.06	Other (CHEMOTHERAPY OTHER REVENUE)	23,553	24.06
24.07	Other (SECURITY OTHER REVENUE)	21,130	24.07
24.08	Other (COMMUNITY WELLNESS)	158,746	24.08
24.09	Other (MID WIFERY PROGRAM)	233,034	24.09
24.10	Other (OTHER RENTAL REVENUE)	176,959	24.10
24.11	Other (DIETARY OTHER REVENUE)	63,351	24.11
24.12	Other (LAB REVENUE)	4,726	24.12
24.13	Other (CARDIOLOGY REVENUE)	102,576	24.13
24.14	Other (ARCHER CLINIC OTHER REVENUE)	46,963	24.14
24.15	Other (MISCELLANEOUS REVENUE)	26,285	24.15
25	Total other income (sum of lines 6-24)	4,794,676	25
26	Total (line 5 plus line 25)	-9,852,552	26
29	Net income (or loss) for the period (line 26 minus line 28)	-9,852,552	29

KPMG LLP Compu-Max 2552-10

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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	418,741	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	4,363	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)	43.63	3
4	Number of interns & residents (see instructions)	3.24	4
5	Indirect medical education percentage (see instructions)	2.12	5
6	Indirect medical education adjustment (see instructions)	8,877	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1494	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5186	8
9	Sum of lines 7 and 8	0.6680	9
10	Allowable disproportionate share percentage (see instructions)	0.1449	10
11	Disproportionate share adjustment (see instructions)	60,676	11
12	Total prospective capital payments (see instructions)	492,657	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

KPMG LLP Compu-Max 2552-10

ST ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 07:14 Version: 2016.05 (11/15/2016)
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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
192	Physicians' Private Offices						192
192.01	OTHER NON-REIMBURSABLE						192.01
192.02	NEPHROLOGY						192.02
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202