

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 01-30-2012 TIME: 15:15____
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. ANTHONY'S MEMORIAL HOSPITAL (14-0032) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		1,209,721	121,275		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					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		1,209,721	121,275		200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 503 N MAPLE P.O.BOX: 1
 2 CITY: EFFINGHAM STATE: IL ZIP CODE: 62401- COUNTY: EFFINGHAM 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			3
						V	XVIII	XIX	
3	HOSPITAL	14-0032	41180	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	14-5940		N	06/27/1997	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA	14-7661		N	02/17/1997	N	P	N	12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2010			TO: 06/30/2011				20
21	TYPE OF CONTROL			1					21

INPATIENT PPS INFORMATION

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

24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPHS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	IN-STATE MEDICAID		OUT-OF-STATE MEDICAID		MEDICAID HMO DAYS	OTHER MEDICAID DAYS	24
		PAID DAYS	ELIGIBLE DAYS	PAID DAYS	ELIGIBLE DAYS			
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPHS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,236	265			1	34	24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
			3	4	5
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)					
	PROGRAM NAME 1	PROGRAM CODE 2			
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
			3	4	5

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5			
INPATIENT PSYCHIATRIC FACILITY PPS							
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	70		
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71		
INPATIENT REHABILITATION FACILITY PPS							
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	75		
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76		
LONG TERM CARE HOSPITAL PPS							
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	80		
TEFRA PROVIDERS							
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N	85		
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	86		
TITLE V AND XIX INPATIENT SERVICES							
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 2 N Y	XIX 2 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	N 92		
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 94		
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				95		
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N 96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				97		
RURAL PROVIDERS							
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N	105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.				106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.				107		
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N	108		
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- N	OCCUP- N	SPEECH N	RESPI- RATORY N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N 120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	2 140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.			
141	NAME: HOSPITAL SISTERS HEALTH SYSTEM CONTRACTOR'S NAME:		CONTRACTOR'S NUMBER: 141
142	STREET: 4936 LAVERNA ROAD P.O. BOX:		142
143	CITY: SPRINGFIELD, IL 62707 STATE:		ZIP CODE: 143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149

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

155	HOSPITAL	1	2
156	SUBPROVIDER - IPF	N	N 155
157	SUBPROVIDER - IRF	N	N 156
158	SUBPROVIDER - (OTHER)	N	N 157
159	SNF	N	N 158
160	HHA	N	N 159
161	CMHC	N	N 160

MULTICAMPUS

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1	2	1	2	3	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
2	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)	Y		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4	5	1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
6	7	1	2	3	
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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
16	17	Y/N	DATE	Y/N	DATE
1	2	1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	31,676,062	31,676,062	1,405,661.00	22.53	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A						4
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44	750,436	750,436	36,314.00	20.67	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		834,345	834,345	33,463.00	24.93	10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		104,895	104,895	2,192.00	47.85	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,664,791	1,664,791	21,213.00	78.48	14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		13,546,432	13,546,432			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		713,433	713,433			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A						22
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		159,686	206,696	14,136.00	25.92	26
27	ADMINISTRATIVE & GENERAL		4,096,382	-206,696	3,889,686	184,241.00	21.11
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		281,606	281,606	1,990.00	141.51	28
29	MAINTENANCE & REPAIRS		605,730	605,730	27,419.00	22.09	29
30	OPERATION OF PLANT		152,838	152,838	10,509.00	14.54	30
31	LAUNDRY & LINEN SERVICE		133,555	133,555	11,662.00	11.45	31
32	HOUSEKEEPING		729,370	729,370	64,657.00	11.28	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		634,537	-200,283	434,254	29,074.00	14.94
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA		64,335	200,283	264,618	18,464.00	14.33
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		727,637	727,637	16,996.00	42.81	38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY		1,207,691	1,207,691	31,543.00	38.29	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,845,206	1,845,206	83,190.00	22.18	41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	31,957,668		31,957,668	1,407,651.00	22.70	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	1,584,781		1,584,781	69,777.00	22.71	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	30,372,887		30,372,887	1,337,874.00	22.70	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,769,686		1,769,686	23,405.00	75.61	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	13,546,432		13,546,432		44.60%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	45,689,005		45,689,005	1,361,279.00	33.56	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	10,638,573		10,638,573	493,881.00	21.54	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	3
4 PRIOR YEAR PENSION SERVICE COST	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/30/2012 15:15

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7661

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		1,264	13		1,277	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		371.00	54.00	99.00	506.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL 3	
	STAFF 1	CONTRACT 2			
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)					3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)					4
5 OTHER ADMINISTRATIVE PERSONNEL			1.99	1.99	5
6 DIRECT NURSING SERVICE			9.58	9.58	6
7 NURSING SUPERVISOR					7
8 PHYSICAL THERAPY SERVICE			1.23	1.23	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE			0.12	0.12	10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE			0.04	0.04	12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE			0.08	0.08	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE			1.55	1.55	16
17 HOME HEALTH AIDE SUPERVISOR					17
18 OTHER (SPECIFY)					18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).	00014	20

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4)	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	3,540	361	139	87	4,127	21
22 SKILLED NURSING VISIT CHARGES	446,040	45,486	17,514	10,962	520,002	22
23 PHYSICAL THERAPY VISITS	718	6	9	1	734	23
24 PHYSICAL THERAPY VISIT CHARGES	105,546	882	1,323	147	107,898	24
25 OCCUPATIONAL THERAPY VISITS	247		3	1	251	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	36,309		441	147	36,897	26
27 SPEECH PATHOLOGY VISITS	15				15	27
28 SPEECH PATHOLOGY VISIT CHARGES	2,205				2,205	28
29 MEDICAL SOCIAL SERVICE VISITS	31	1			32	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	5,696	184			5,880	30
31 HOME HEALTH AIDE VISITS	446	36	1		483	31
32 HOME HEALTH AIDE VISIT CHARGES	32,781	2,646	74		35,501	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	4,997	404	152	89	5,642	33
34 OTHER CHARGES	34,618	2,489	1,321	646	39,074	34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	663,195	51,687	20,673	11,902	747,457	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	369		43	14	426	36
37 TOTAL NUMBER OF OUTLIER EPISODES		9			9	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES						38

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE			
		1	2			
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1		
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N		2		
						TOTAL (COLS. 2 + 3)
	GROUP				SNF DAYS	SWING BED SNF DAYS
	1				2	3
3	RUX					3
4	RUL					4
5	RVX					5
6	RVL			7		6
7	RHX					7
8	RHL			15		8
9	RMX			72		9
10	RML			816		10
11	RLX					11
12	RUC					12
13	RUB					13
14	RUA					14
15	RVC					15
16	RVB					16
17	RVA			12		17
18	RHC			74		18
19	RHB			47		19
20	RHA			372		20
21	RMC			94		21
22	RMB			57		22
23	RMA			870		23
24	RLB					24
25	RLA					25
26	ES3					26
27	ES2			26		27
28	ES1			67		28
29	HE2					29
30	HE1					30
31	HD2					31
32	HD1			3		32
33	HC2					33
34	HC1					34
35	HB2					35
36	HB1			8		36
37	LE2					37
38	LE1					38
39	LD2					39
40	LD1					40
41	LC2					41
42	LC1			14		42
43	LB2					43
44	LB1			20		44
45	CE2					45
46	CE1					46
47	CD2					47
48	CD1			48		48
49	CC2					49
50	CC1			18		50
51	CB2			2		51
52	CB1			280		52
53	CA2					53
54	CA1			117		54
55	SE3					55
56	SE2			12		56
57	SE1					57
58	SSC					58
59	SSB					59
60	SSA			21		60
61	IB2					61
62	IB1					62
63	IA1					63
64	IA2					64
65	BB2					65
66	BB1			34		66
67	BA2					67
68	BA1					68

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
 01/30/2012 15:15

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1		20		20 74
75	PB2				75
76	PB1		55		55 76
77	PA2				77
78	PA1		27		27 78
199	AAA				199
200	TOTAL		3,208		3,208 200

		CBSA	
		BEGINNING	ON/AFTER
		OF COST	OF THE COST
		REPORTING	REPORTING
		PERIOD	PERIOD (IF
		1	APPLICABLE)
			2
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).		00014 201

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

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?
		1	2	3
202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	922,053		207

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.363719	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID					2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES					6
7	MEDICAID COST (LINE 1 TIMES LINE 6)					7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)					8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)					19
			UNINSURED PATIENTS	INSURED PATIENTS		TOTAL
			1	2		3
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY					20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)					21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE					22
23	COST OF CHARITY CARE					23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)					26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				726,341	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				-726,341	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				-264,184	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				-264,184	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				-264,184	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,845,346	1,845,346	391,735	1
2	00200		4,743,617	4,743,617	38,760	2
3	00300					3
4	00400	159,686	14,332,465	14,492,151	308,580	4
5	00500	4,096,382	12,803,858	16,900,240	-368,927	5
6	00600	605,730	429,839	1,035,569		6
7	00700	152,838	1,622,338	1,775,176		7
8	00800	133,555	78,836	212,391		8
9	00900	729,370	155,569	884,939		9
10	01000	634,537	280,372	914,909	-234,843	10
11	01100	64,335	117,176	181,511	234,843	11
12	01200					12
13	01300	727,637	20,402	748,039		13
14	01400		1,447,018	1,447,018	-1,443,302	14
15	01500		2,836,137	4,043,828	-2,661,547	15
16	01600	1,207,691	761,690	2,606,896		16
17	01700		2,268	2,268		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	6,494,125	238,807	6,732,932		30
31	03100	1,340,518	46,861	1,387,379		31
43	04300		20,603	20,603		43
44	04400	750,436	34,853	785,289		44
ANCILLARY SERVICE COST CENTERS						
50	05000	3,305,394	14,303,138	17,608,532		50
52	05200	142,590	98,773	241,363		52
53	05300		1,247,687	1,247,687		53
54	05400	1,529,733	812,160	2,341,893		54
54.01	03630	166,672	51,320	217,992		54.01
54.02	03450	247,539	508,272	755,811		54.02
54.04	03480					54.04
54.06	05401		215,172	215,172		54.06
57	05700	241,857	357,538	599,395		57
58	05800	195,864	399,498	595,362		58
59	05900	199,186	128,207	327,393		59
60	06000	1,205,152	2,659,424	3,864,576		60
62.30	06250					62.30
65	06500	1,149,207	119,890	1,269,097		65
66	06600	803,610	80,646	884,256		66
67	06700	162,735	22,346	185,081		67
69	06900	490,378	298,995	789,373		69
70	07000	133,105	328,491	461,596		70
71	07100				1,443,302	71
73	07300				2,661,547	73
74	07400		34,691	34,691		74
76	03050					76
76.01	03650	157,869	29,270	187,139		76.01
76.02	03651	66,295	2,279	68,574		76.02
76.03	03950	184,118	633,297	817,415		76.03
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	1,518,367	906,336	2,424,703		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	765,221	160,462	925,683		101
SPECIAL PURPOSE COST CENTERS						
113	11300		370,148	370,148	-370,148	113
118		31,606,938	65,586,095	97,193,033		118
NONREIMBURSABLE COST CENTERS						
190	19000		24,147	24,147		190
192	19200		19,378	19,378		192
194	07950	61,921	39,461	101,382		194
194.01	07951					194.01
194.02	07952					194.02
194.03	07953	7,203	2,337,835	2,345,038		194.03
200		31,676,062	68,006,916	99,682,978		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	2,237,081	496,285	2,733,366	1
2	00200	4,782,377	-41,307	4,741,070	2
3	00300				3
4	00400	14,800,731	-599,660	14,201,071	4
5	00500	16,531,313	-1,419,700	15,111,613	5
6	00600	1,035,569	-14,769	1,020,800	6
7	00700	1,775,176	-3,338	1,771,838	7
8	00800	212,391		212,391	8
9	00900	884,939	-74	884,865	9
10	01000	680,066	-74,241	605,825	10
11	01100	416,354	-278,275	138,079	11
12	01200				12
13	01300	748,039		748,039	13
14	01400	3,716		3,716	14
15	01500	1,382,281	-4,900	1,377,381	15
16	01600	2,606,896	-67,706	2,539,190	16
17	01700	2,268		2,268	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	6,732,932		6,732,932	30
31	03100	1,387,379		1,387,379	31
43	04300	20,603		20,603	43
44	04400	785,289		785,289	44
ANCILLARY SERVICE COST CENTERS					
50	05000	17,608,532	-1,176,321	16,432,211	50
52	05200	241,363		241,363	52
53	05300	1,247,687	-1,110,117	137,570	53
54	05400	2,341,893	-8,576	2,333,317	54
54.01	03630	217,992		217,992	54.01
54.02	03450	755,811	-6,545	749,266	54.02
54.04	03480				54.04
54.06	05401	215,172		215,172	54.06
57	05700	599,395		599,395	57
58	05800	595,362		595,362	58
59	05900	327,393		327,393	59
60	06000	3,864,576	-27,513	3,837,063	60
62.30	06250				62.30
65	06500	1,269,097	-25,617	1,243,480	65
66	06600	884,256	-1,164	883,092	66
67	06700	185,081		185,081	67
69	06900	789,373	-174,324	615,049	69
70	07000	461,596	-282,545	179,051	70
71	07100	1,443,302	-79,501	1,363,801	71
73	07300	2,661,547	-179,864	2,481,683	73
74	07400	34,691		34,691	74
76	03050				76
76.01	03650	187,139	-23,728	163,411	76.01
76.02	03651	68,574		68,574	76.02
76.03	03950	817,415	-76,494	740,921	76.03
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
91	09100	2,424,703	-753,351	1,671,352	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
101	10100	925,683		925,683	101
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		97,193,033	-5,933,345	91,259,688	118
NONREIMBURSABLE COST CENTERS					
190	19000	24,147		24,147	190
192	19200	19,378		19,378	192
194	07950	101,382		101,382	194
194.01	07951				194.01
194.02	07952				194.02
194.03	07953	2,345,038		2,345,038	194.03
200		99,682,978	-5,933,345	93,749,633	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	-----		INCREASE		-----	
		COST CENTER	LINE #	SALARY	OTHER		
	1	2	3	4	5		
1 PERSONNELCOSTS	A	EMPLOYEE BENEFITS	4	206,696	101,884	1	
500 TOTAL RECLASSIFICATIONS				206,696	101,884	500	
CODE LETTER - A							
1 CAFETERIA COSTS	B	CAFETERIA	11	200,283	34,560	1	
500 TOTAL RECLASSIFICATIONS				200,283	34,560	500	
CODE LETTER - B							
1 PHARMACY DRUGS	C	DRUGS CHARGED TO PATIENTS	73		2,661,547	1	
500 TOTAL RECLASSIFICATIONS					2,661,547	500	
CODE LETTER - C							
1 CENTRAL SUPPLY	D	MEDICAL SUPPLIES CHRGED TO PA	71		1,443,302	1	
500 TOTAL RECLASSIFICATIONS					1,443,302	500	
CODE LETTER - D							
1 BUSINESS PROPERTY INSURANCE	E	CAP REL COSTS-BLDG & FIXT	1		60,347	1	
500 TOTAL RECLASSIFICATIONS					60,347	500	
CODE LETTER - E							
1 INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		331,388	1	
2 INTEREST EXPENSE	F	CAP REL COSTS-MVBLE EQUIP	2		38,760	2	
500 TOTAL RECLASSIFICATIONS					370,148	500	
CODE LETTER - F							
GRAND TOTAL (INCREASES)				406,979	4,671,788		

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE		OTHER 9	WKST A-7	
			LINE # 7	SALARY 8		REF. 10	
1 PERSONNELCOSTS	A	ADMINISTRATIVE & GENERAL	5	206,696	101,884		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				206,696	101,884		500
1 CAFETERIA COSTS	B	DIETARY	10	200,283	34,560		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B				200,283	34,560		500
1 PHARMACY DRUGS	C	PHARMACY	15		2,661,547		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					2,661,547		500
1 CENTRAL SUPPLY	D	CENTRAL SERVICES & SUPPLY	14		1,443,302		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					1,443,302		500
1 BUSINESS PROPERTY INSURANCE	E	ADMINISTRATIVE & GENERAL	5		60,347		9 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					60,347		500
1 INTEREST EXPENSE	F						9 1
2 INTEREST EXPENSE	F	INTEREST EXPENSE	113		370,148		9 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					370,148		500
GRAND TOTAL (DECREASES)				406,979	4,671,788		

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	1,047,531	48,000		48,000		1,095,531		1
2 LAND IMPROVEMENTS	1,854,132	45,360		45,360		1,899,492	1,482,625	2
3 BUILDINGS AND FIXTURES	56,634,014	3,139,108		3,139,108	242,220	59,530,902	20,597,710	3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	14,223,505	366,251		366,251		14,589,756	12,956,521	5
6 MOVABLE EQUIPMENT	54,513,705	6,016,488		6,016,488	456,134	60,074,059	44,849,542	6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	128,272,887	9,615,207		9,615,207	698,354	137,189,740	79,886,398	8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	128,272,887	9,615,207		9,615,207	698,354	137,189,740	79,886,398	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	1,845,346						1,845,346	1
2 CAP REL COSTS-MVBLE EQUIP	3,724,443	1,019,174					4,743,617	2
3 TOTAL (SUM OF LINES 1-2)	5,569,789	1,019,174					6,588,963	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	3,064,754		-331,388				2,733,366	1
2 CAP REL COSTS-MVBLE EQUIP	3,760,656	1,019,174	-38,760				4,741,070	2
3 TOTAL	6,825,410	1,019,174	-370,148				7,474,436	3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-331,388	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	A		CAP REL COSTS-MVBLE EQUIP	2	2 3
3 INVESTMENT INCOME-OTHER (CHAPTER 2) TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-8,393	ADMINISTRATIVE & GENERAL	5	4 5
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					6 6
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					7 7
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-2,547	CAP REL COSTS-MVBLE EQUIP	2	9 8
8 TELEVISION AND RADIO SERVICE (CHAPTER 21) PARKING LOT (CHAPTER 21)					9 9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,561,582			10 10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-3,995	RADIOLOGY-DIAGNOSTIC	54	11 11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-1,197,324			12 12
13 LAUNDRY AND LINEN SERVICE					13 13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-278,275	CAFETERIA	11	14 14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15 15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16 16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17 17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-67,706	MEDICAL RECORDS & LIBRARY	16	18 18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.) VENDING MACHINES					19 19
20 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					20 20
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					21 21
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				22 22
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23 23
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	24 24
26 DEPRECIATION--BUILDINGS & FIXTURES	A	827,673	CAP REL COSTS-BLDG & FIXT	1	9 25
27 DEPRECIATION--MOVABLE EQUIPMENT	A		CAP REL COSTS-MVBLE EQUIP	2	9 26
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	27 27
29 PHYSICIANS' ASSISTANT					28 28
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				29 29
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30 30
32 CAH HIT ADJ FOR DEPRECIATION AND					31 31
33 TELEPHONE EMPLOYEE BENEFITS	A	-2,170	EMPLOYEE BENEFITS	4	32 32
34 TELEPHONE A&G SALARIES	A	-4,800	ADMINISTRATIVE & GENERAL	5	33 33
35 TELEPHONE A&G EXPENSES	A	-6,226	ADMINISTRATIVE & GENERAL	5	34 34
36 TELEVISION EMPLOYEE BENEFITS	A	-822	EMPLOYEE BENEFITS	4	35 35
37 TELEVISION MAINTENANCE SALARIES	A	-1,818	MAINTENANCE & REPAIRS	6	36 36
38 TELEVISION MAINTENANCE CABLE	A	-12,951	MAINTENANCE & REPAIRS	6	37 37
39 TELEVISION PLANT ELECTRIC	A	-721	OPERATION OF PLANT	7	38 38
40 RECYCLING	B	-1,927	OPERATION OF PLANT	7	39 39
41 BOND INDENTURE FEES	A	-9,681	ADMINISTRATIVE & GENERAL	5	40 40
42 NON-OPERATING BUILDINGS	A	-18,752	ADMINISTRATIVE & GENERAL	5	41 41
43 PHYSICIAN EXPENSE	A	-103,754	ADMINISTRATIVE & GENERAL	5	42 42
44 COMMUNITY RELATION ADVERTISING	A	-471,398	ADMINISTRATIVE & GENERAL	5	43 43
45 HOUSEKEEPING	B	-74	HOUSEKEEPING	9	44 44
45.02 INTEREST NEW EQUIP	A	-38,760	CAP REL COSTS-MVBLE EQUIP	2	11 45
45.03 UNCLAIMED PROPERTY	B	-2,445	ADMINISTRATIVE & GENERAL	5	45 45.02
45.04 LOBBYING EXPENSE	A	-25,776	ADMINISTRATIVE & GENERAL	5	46 46
45.05 COUNTRY CLUB DUES	A	-2,340	ADMINISTRATIVE & GENERAL	5	47 47
45.06 NAME BADGES	B	-135	EMPLOYEE BENEFITS	4	48 48
45.07 PHYSICIAN APPLICATIONS	B	-2,000	ADMINISTRATIVE & GENERAL	5	49 49
45.08 GUEST MEALS	B	-510	DIETARY	10	50 50
45.09 DIETARY SUPPLIES	B	-39,459	DIETARY	10	51 51
45.10 PHYSICIAN RECRUITMENT	A	-79,615	ADMINISTRATIVE & GENERAL	5	52 52
45.11 REBATES	B	-1,275	ADMINISTRATIVE & GENERAL	5	53 53
45.12 REBATES	B	-11,744	DIETARY	10	54 54
45.13 REBATES	B	-179,864	DRUGS CHARGED TO PATIENTS	73	55 55
45.14 REBATES	B	-2,319	MEDICAL SUPPLIES CHRGED TO PATI	71	56 56
45.15 REBATES	B	-1,988	LABORATORY	60	57 57
45.16 REBATES	B	-5	ELECTROCARDIOLOGY	69	58 58
45.17 REBATES	B	-77,182	MEDICAL SUPPLIES CHRGED TO PATI	71	59 59

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
45.18 REBATES	B	-58,457	OPERATING ROOM	50	45.18
45.19 REBATES	B	-690	OPERATION OF PLANT	7	45.19
45.20 REBATES	B	-4,581	RADIOLOGY-DIAGNOSTIC	54	45.20
45.21 REBATES	B	-29	RESPIRATORY THERAPY	65	45.21
45.22 ALCOHOLIC BEVERAGES	A	-3,400	ADMINISTRATIVE & GENERAL	5	45.22
45.26 IN-SERVICE	B	-2,413	ADMINISTRATIVE & GENERAL	5	45.26
45.27 EEG'S RICHLAND MEMORIAL	B	-1,265	ELECTROENCEPHALOGRAPHY	70	45.27
45.28 MISC INCOME - SPIRIT COMMITTEE	B	-33,296	EMPLOYEE BENEFITS	4	45.28
45.30 IN-SERVICE	B	-1,045	PHYSICAL THERAPY	66	45.30
45.40 MISC INC	B	-525	LABORATORY	60	45.40
45.43 DRUGS NON PATIENT	B	-4,900	PHARMACY	15	45.43
45.46 IHA GRANT-T1	B	-13,175	ADMINISTRATIVE & GENERAL	5	45.46
45.47 PHYSICIAN DUES	B	-20,300	ADMINISTRATIVE & GENERAL	5	45.47
45.48 DIABETES INSTRUCTION	B	-22,528	DIETARY	10	45.48
45.50 HOUSEKEEPING 900 W TEMPLE	B	-9,870	ADMINISTRATIVE & GENERAL	5	45.50
45.51 ALLIANCE IMAGING SALARIES	B	-6,545	NUCLEAR MEDICINE-DIAGNOSTIC	54.02	45.51
45.52 ASPR GRANT	B	-26,278	EMERGENCY	91	45.52
46					46
47					47
48					48
49					49
50					50
TOTAL (SUM OF LINES 1 THRU 49)		-5,933,345			
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,553,881	4,692,000	-3,138,119	1
2	5	ADMINISTRATIVE & GENERAL	CCC (FAMIS) FEE	2,504,032		2,504,032	2
3	4	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS	10,634,045	11,197,282	-563,237	3
4							4
5		TOTALS (SUM OF LINES 1-4)		14,691,958	15,889,282	-1,197,324	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	91 EMERGENCY	EMERGENCY	727,073	727,073				1
2	53 ANESTHESIOLOGY	ANESTHESIA	1,110,117	1,110,117				2
3	69 ELECTROCARDIOLOGY	CARDIOLOGY	174,319	174,319				3
4	65 RESPIRATORY THERAPY	RESPIRATORY CAR	25,588	25,588				4
5	76.01 VASCULAR LAB	VASCULAR LAB	23,728	23,728				5
6	60 LABORATORY	LABORATORY	25,000	25,000				6
7	76.03 WOUND CARE	WOUND CARE	76,494	76,494				7
8	54 RADIOLOGY-DIAGNOSTIC	WOMENS WELLNESS						8
9	70 ELECTROENCEPHALOGRAPHY	NEUROLOGY	281,280	281,280				9
10	69 ELECTROCARDIOLOGY	PRAIRIE CARDIOV						10
11	50 OPERATING ROOM	HSHS MEDICAL GR	1,117,864	1,117,864				11
12	66 PHYSICAL THERAPY	SPEECH THERAPIS	119	119				12
200	TOTAL		3,561,582	3,561,582				200

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.		12	13	14	15	16	17	18	
10	11								
1	91 EMERGENCY	EMERGENCY						727,073	1
2	53 ANESTHESIOLOGY	ANESTHESIA						1,110,117	2
3	69 ELECTROCARDIOLOGY	CARDIOLOGY						174,319	3
4	65 RESPIRATORY THERAPY	RESPIRATORY CAR						25,588	4
5	76.01 VASCULAR LAB	VASCULAR LAB						23,728	5
6	60 LABORATORY	LABORATORY						25,000	6
7	76.03 WOUND CARE	WOUND CARE						76,494	7
8	54 RADIOLOGY-DIAGNOSTIC	WOMENS WELLNESS							8
9	70 ELECTROENCEPHALOGRAPHY	NEUROLOGY						281,280	9
10	69 ELECTROCARDIOLOGY	PRAIRIE CARDIOV							10
11	50 OPERATING ROOM	HSHS MEDICAL GR						1,117,864	11
12	66 PHYSICAL THERAPY	SPEECH THERAPIS						119	12
200	TOTAL							3,561,582	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,733,366	2,733,366				1
2 CAP REL COSTS-MVBLE EQUIP	4,741,070		4,741,070			2
4 EMPLOYEE BENEFITS	14,201,071			14,201,071		4
5 ADMINISTRATIVE & GENERAL	15,111,613	6,869	569,256	1,762,433	17,450,171	5
6 MAINTENANCE & REPAIRS	1,020,800	738,281	12,204	273,973	2,045,258	6
7 OPERATION OF PLANT	1,771,838	478,536	1,539,756	69,337	3,859,467	7
8 LAUNDRY & LINEN SERVICE	212,391	27,732	3,158	60,589	303,870	8
9 HOUSEKEEPING	884,865	29,907	5,334	330,889	1,250,995	9
10 DIETARY	605,825	39,479	12,259	197,005	854,568	10
11 CAFETERIA	138,079	14,142	5,815	120,048	278,084	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	748,039	13,984	3,993	330,103	1,096,119	13
14 CENTRAL SERVICES & SUPPLY	3,716	53,130			56,846	14
15 PHARMACY	1,377,381	14,853	206,531	547,886	2,146,651	15
16 MEDICAL RECORDS & LIBRARY	2,539,190	47,190	14,786	837,104	3,438,270	16
17 SOCIAL SERVICE	2,268				2,268	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,732,932	355,467	126,800	2,946,148	10,161,347	30
31 INTENSIVE CARE UNIT	1,387,379	37,558	63,029	608,145	2,096,111	31
43 NURSERY	20,603	6,992	3,184		30,779	43
44 SKILLED NURSING FACILITY	785,289	52,410	2,185	340,446	1,180,330	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,432,211	260,025	646,765	1,499,538	18,838,539	50
52 DELIVERY ROOM & LABOR ROOM	241,363	41,040	1,244	64,688	348,335	52
53 ANESTHESIOLOGY	137,570	1,720	71,702		210,992	53
54 RADIOLOGY-DIAGNOSTIC	2,333,317	99,197	761,921	693,985	3,888,420	54
54.01 ULTRASOUND	217,992	3,772	1,202	75,613	298,579	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	749,266	18,967	88,834	112,300	969,367	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN	215,172	1,755			216,927	54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	599,395	11,151	134,389	109,722	854,657	57
58 MAGNETIC RESONANCE IMAGING (MRI)	595,362	42,532		88,856	726,750	58
59 CARDIAC CATHETERIZATION	327,393	16,248	184,585	90,364	618,590	59
60 LABORATORY	3,837,063	65,456	69,129	546,734	4,518,382	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,243,480	6,720	30,875	521,354	1,802,429	65
66 PHYSICAL THERAPY	883,092	31,776	23,795	364,569	1,303,232	66
67 OCCUPATIONAL THERAPY	185,081	6,203		73,827	265,111	67
69 ELECTROCARDIOLOGY	615,049	40,970	55,769	222,467	934,255	69
70 ELECTROENCEPHALOGRAPHY	179,051	5,992	922	60,385	246,350	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,363,801				1,363,801	71
73 DRUGS CHARGED TO PATIENTS	2,481,683				2,481,683	73
74 RENAL DIALYSIS	34,691				34,691	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	163,411	3,343	11,386	71,619	249,759	76.01
76.02 CARDIAC REHAB	68,574	4,062	10,225	30,076	112,937	76.02
76.03 WOUND CARE	740,921	16,353	1,144	83,528	841,946	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,671,352	81,870	27,188	688,828	2,469,238	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	925,683	11,738	13,674	347,153	1,298,248	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	91,259,688	2,687,420	4,703,039	14,169,712	91,144,352	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,147	4,852	352		29,351	190
192 PHYSICIANS' PRIVATE OFFICES	19,378	14,941	37,679		71,998	192
194 PHILANTHROPY DEVELOPMENT	101,382	1,860		28,091	131,333	194
194.01 VENDING		1,404			1,404	194.01

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	2,345,038	22,889		3,268	2,371,195	194.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	93,749,633	2,733,366	4,741,070	14,201,071	93,749,633	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	17,450,171					5
6 MAINTENANCE & REPAIRS	467,763	2,513,021				6
7 OPERATION OF PLANT	882,683	1,155,586	5,897,736			7
8 LAUNDRY & LINEN SERVICE	69,497	91,635	108,337	573,339		8
9 HOUSEKEEPING	286,110	14,525	116,837		1,668,467	9
10 DIETARY	195,445	58,740	154,229	3,887	46,577	10
11 CAFETERIA	63,599	214	55,248		16,685	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	250,689	12,175	54,631		16,498	13
14 CENTRAL SERVICES & SUPPLY	13,001		207,557		62,681	14
15 PHARMACY	490,952	8,971	58,024		17,523	15
16 MEDICAL RECORDS & LIBRARY	786,353	27,127	184,355		55,674	16
17 SOCIAL SERVICE	519					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,323,961	219,155	1,388,674	277,179	419,376	30
31 INTENSIVE CARE UNIT	479,393	71,556	146,723	25,117	44,310	31
43 NURSERY	7,039	12,389	27,316		8,249	43
44 SKILLED NURSING FACILITY	269,949	36,739	204,747	25,636	61,832	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,308,514	242,865	1,015,818	134,712	306,776	50
52 DELIVERY ROOM & LABOR ROOM	79,666	50,410	160,329		48,419	52
53 ANESTHESIOLOGY	48,255	12,389	6,718		2,029	53
54 RADIOLOGY-DIAGNOSTIC	889,305	170,240	387,525	17,984	117,033	54
54.01 ULTRASOUND	68,287	427	14,737	1,348	4,450	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	221,700	11,748	74,098	2,745	22,380	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN	49,613		6,855		2,070	54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	195,465		43,561	5,675	13,156	57
58 MAGNETIC RESONANCE IMAGING (MRI)	166,212	641	166,156	7,222	50,174	58
59 CARDIAC CATHETERIZATION	141,475	1,495	63,474		19,168	59
60 LABORATORY	1,033,381	82,450	255,711	272	77,224	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	412,226	57,459	26,253	8,511	7,928	65
66 PHYSICAL THERAPY	298,057	31,186	124,137	3,279	37,492	66
67 OCCUPATIONAL THERAPY	60,632	854	24,231	709	7,318	67
69 ELECTROCARDIOLOGY	213,670	16,447	160,055	2,311	48,336	69
70 ELECTROENCEPHALOGRAPHY	56,342		23,408	131	7,069	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	311,909					71
73 DRUGS CHARGED TO PATIENTS	567,576					73
74 RENAL DIALYSIS	7,934					74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	57,121	8,971	13,058	384	3,943	76.01
76.02 CARDIAC REHAB	25,829	2,990	15,868	506	4,793	76.02
76.03 WOUND CARE	192,558	36,953	63,885	601	19,295	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	564,730	74,120	319,836	54,492	96,585	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	296,917	2,350	45,857		13,849	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	16,854,327	2,512,807	5,718,248	572,701	1,658,892	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,713		18,953		5,724	190
192 PHYSICIANS' PRIVATE OFFICES	16,466	214	58,367			192
194 PHILANTHROPY DEVELOPMENT	30,037		7,266		2,195	194
194.01 VENDING	321		5,484		1,656	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	542,307		89,418	638		194.03

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION		ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	17,450,171	2,513,021	5,897,736	573,339	1,668,467	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	1,313,446					10
11 CAFETERIA		413,830				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		6,711	1,436,823			13
14 CENTRAL SERVICES & SUPPLY				340,085		14
15 PHARMACY		12,456		184	2,734,761	15
16 MEDICAL RECORDS & LIBRARY		32,827				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,018,682	114,834	678,252	2,958	11,253	30
31 INTENSIVE CARE UNIT	82,801	19,997	118,132	613	1,799	31
43 NURSERY				368		43
44 SKILLED NURSING FACILITY	164,892	14,334	84,662	237	302	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		57,058	336,978	268,755	2,056	50
52 DELIVERY ROOM & LABOR ROOM				1,898		52
53 ANESTHESIOLOGY				779	56,223	53
54 RADIOLOGY-DIAGNOSTIC		25,944		1,836	3,170	54
54.01 ULTRASOUND		2,237		273		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC		3,172		49	8,562	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN		3,688		426		57
58 MAGNETIC RESONANCE IMAGING (MRI)		3,022		149	95	58
59 CARDIAC CATHETERIZATION				666	213	59
60 LABORATORY		23,603		19,819		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		22,241		1,811	51	65
66 PHYSICAL THERAPY		10,945		1,373	122	66
67 OCCUPATIONAL THERAPY		1,870		335		67
69 ELECTROCARDIOLOGY		13,054		646		69
70 ELECTROENCEPHALOGRAPHY		2,087		593		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				29,041	110	71
73 DRUGS CHARGED TO PATIENTS					2,646,545	73
74 RENAL DIALYSIS				4		74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB		2,170		1		76.01
76.02 CARDIAC REHAB		868		25		76.02
76.03 WOUND CARE		3,494		4,123	1,047	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		25,121	148,398	2,295	3,013	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		11,917	70,401	827	200	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,266,375	413,650	1,436,823	340,084	2,734,761	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 PHILANTHROPY DEVELOPMENT						194
194.01 VENDING						194.01
194.02 MEALS ON WHEELS	47,071					194.02
194.03 PRAIRIE CARDIOVASCULAR		180		1		194.03

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION		DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,313,446	413,830	1,436,823	340,085	2,734,761	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	4,524,606					16
17 SOCIAL SERVICE		2,787				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,622,852	2,232	20,240,755		20,240,755	30
31 INTENSIVE CARE UNIT	315,365	194	3,402,111		3,402,111	31
43 NURSERY			86,140		86,140	43
44 SKILLED NURSING FACILITY	586,389	361	2,630,410		2,630,410	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			25,512,071		25,512,071	50
52 DELIVERY ROOM & LABOR ROOM			689,057		689,057	52
53 ANESTHESIOLOGY			337,385		337,385	53
54 RADIOLOGY-DIAGNOSTIC			5,501,457		5,501,457	54
54.01 ULTRASOUND			390,338		390,338	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC			1,313,821		1,313,821	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN			275,465		275,465	54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN			1,116,628		1,116,628	57
58 MAGNETIC RESONANCE IMAGING (MRI)			1,120,421		1,120,421	58
59 CARDIAC CATHETERIZATION			845,081		845,081	59
60 LABORATORY			6,010,842		6,010,842	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			2,338,909		2,338,909	65
66 PHYSICAL THERAPY			1,809,823		1,809,823	66
67 OCCUPATIONAL THERAPY			361,060		361,060	67
69 ELECTROCARDIOLOGY			1,388,774		1,388,774	69
70 ELECTROENCEPHALOGRAPHY			335,980		335,980	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,704,861		1,704,861	71
73 DRUGS CHARGED TO PATIENTS			5,695,804		5,695,804	73
74 RENAL DIALYSIS			42,629		42,629	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB			335,407		335,407	76.01
76.02 CARDIAC REHAB			163,816		163,816	76.02
76.03 WOUND CARE			1,163,902		1,163,902	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY			3,757,828		3,757,828	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			1,740,566		1,740,566	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	4,524,606	2,787	90,311,341		90,311,341	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			60,741		60,741	190
192 PHYSICIANS' PRIVATE OFFICES			147,045		147,045	192
194 PHILANTHROPY DEVELOPMENT			170,831		170,831	194
194.01 VENDING			8,865		8,865	194.01
194.02 MEALS ON WHEELS			47,071		47,071	194.02
194.03 PRAIRIE CARDIOVASCULAR			3,003,739		3,003,739	194.03

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PART I

COST CENTER DESCRIPTION		MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	4,524,606	2,787	93,749,633		93,749,633 202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL		6,869	569,256	576,125	576,125	5
6 MAINTENANCE & REPAIRS		738,281	12,204	750,485	15,444	6
7 OPERATION OF PLANT		478,536	1,539,756	2,018,292	29,143	7
8 LAUNDRY & LINEN SERVICE		27,732	3,158	30,890	2,295	8
9 HOUSEKEEPING		29,907	5,334	35,241	9,446	9
10 DIETARY		39,479	12,259	51,738	6,453	10
11 CAFETERIA		14,142	5,815	19,957	2,100	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		13,984	3,993	17,977	8,277	13
14 CENTRAL SERVICES & SUPPLY		53,130		53,130	429	14
15 PHARMACY		14,853	206,531	221,384	16,209	15
16 MEDICAL RECORDS & LIBRARY		47,190	14,786	61,976	25,962	16
17 SOCIAL SERVICE					17	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		355,467	126,800	482,267	76,728	30
31 INTENSIVE CARE UNIT		37,558	63,029	100,587	15,828	31
43 NURSERY		6,992	3,184	10,176	232	43
44 SKILLED NURSING FACILITY		52,410	2,185	54,595	8,913	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		260,025	646,765	906,790	142,235	50
52 DELIVERY ROOM & LABOR ROOM		41,040	1,244	42,284	2,630	52
53 ANESTHESIOLOGY		1,720	71,702	73,422	1,593	53
54 RADIOLOGY-DIAGNOSTIC		99,197	761,921	861,118	29,361	54
54.01 ULTRASOUND		3,772	1,202	4,974	2,255	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC		18,967	88,834	107,801	7,320	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN		1,755		1,755	1,638	54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN		11,151	134,389	145,540	6,454	57
58 MAGNETIC RESONANCE IMAGING (MRI)		42,532		42,532	5,488	58
59 CARDIAC CATHETERIZATION		16,248	184,585	200,833	4,671	59
60 LABORATORY		65,456	69,129	134,585	34,118	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		6,720	30,875	37,595	13,610	65
66 PHYSICAL THERAPY		31,776	23,795	55,571	9,841	66
67 OCCUPATIONAL THERAPY		6,203		6,203	2,002	67
69 ELECTROCARDIOLOGY		40,970	55,769	96,739	7,055	69
70 ELECTROENCEPHALOGRAPHY		5,992	922	6,914	1,860	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					10,298	71
73 DRUGS CHARGED TO PATIENTS					18,739	73
74 RENAL DIALYSIS					262	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB		3,343	11,386	14,729	1,886	76.01
76.02 CARDIAC REHAB		4,062	10,225	14,287	853	76.02
76.03 WOUND CARE		16,353	1,144	17,497	6,358	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		81,870	27,188	109,058	18,645	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		11,738	13,674	25,412	9,803	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		2,687,420	4,703,039	7,390,459	556,451	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		4,852	352	5,204	222	190
192 PHYSICIANS' PRIVATE OFFICES		14,941	37,679	52,620	544	192
194 PHILANTHROPY DEVELOPMENT		1,860		1,860	992	194
194.01 VENDING		1,404		1,404	11	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR		22,889		22,889	17,905	194.03

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ALLOCATION OF CAPITAL-RELATED COSTS

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PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)		2,733,366	4,741,070	7,474,436	576,125 202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	765,929					6
7 OPERATION OF PLANT	352,203	2,399,638				7
8 LAUNDRY & LINEN SERVICE	27,929	44,080	105,194			8
9 HOUSEKEEPING	4,427	47,538		96,652		9
10 DIETARY	17,903	62,752	713	2,698	142,257	10
11 CAFETERIA	65	22,479		967		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,711	22,228		956		13
14 CENTRAL SERVICES & SUPPLY		84,450		3,631		14
15 PHARMACY	2,734	23,609		1,015		15
16 MEDICAL RECORDS & LIBRARY	8,268	75,009		3,225		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	66,795	565,018	50,855	24,294	110,332	30
31 INTENSIVE CARE UNIT	21,809	59,698	4,608	2,567	8,968	31
43 NURSERY	3,776	11,114		478		43
44 SKILLED NURSING FACILITY	11,198	83,306	4,704	3,582	17,859	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	74,021	413,310	24,716	17,771		50
52 DELIVERY ROOM & LABOR ROOM	15,364	65,234		2,805		52
53 ANESTHESIOLOGY	3,776	2,733		118		53
54 RADIOLOGY-DIAGNOSTIC	51,887	157,674	3,300	6,779		54
54.01 ULTRASOUND	130	5,996	247	258		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	3,581	30,149	504	1,296		54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN		2,789		120		54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN		17,724	1,041	762		57
58 MAGNETIC RESONANCE IMAGING (MRI)	195	67,604	1,325	2,907		58
59 CARDIAC CATHETERIZATION	456	25,826		1,110		59
60 LABORATORY	25,130	104,042	50	4,473		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	17,513	10,682	1,562	459		65
66 PHYSICAL THERAPY	9,505	50,508	602	2,172		66
67 OCCUPATIONAL THERAPY	260	9,859	130	424		67
69 ELECTROCARDIOLOGY	5,013	65,122	424	2,800		69
70 ELECTROENCEPHALOGRAPHY		9,524	24	409		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	2,734	5,313	71	228		76.01
76.02 CARDIAC REHAB	911	6,456	93	278		76.02
76.03 WOUND CARE	11,263	25,993	110	1,118		76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	22,591	130,133	9,998	5,595		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	716	18,658		802		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	765,864	2,326,610	105,077	96,097	137,159	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,711		332		190
192 PHYSICIANS' PRIVATE OFFICES	65	23,748				192
194 PHILANTHROPY DEVELOPMENT		2,956		127		194
194.01 VENDING		2,231		96		194.01
194.02 MEALS ON WHEELS					5,098	194.02
194.03 PRAIRIE CARDIOVASCULAR		36,382	117			194.03

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WORKSHEET B
PART II

COST CENTER DESCRIPTION		MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	765,929	2,399,638	105,194	96,652	142,257	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	45,568					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	739	53,888				13
14 CENTRAL SERVICES & SUPPLY			141,640			14
15 PHARMACY	1,372		77	266,400		15
16 MEDICAL RECORDS & LIBRARY	3,615				178,055	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,644	25,438	1,232	1,096	142,569	30
31 INTENSIVE CARE UNIT	2,202	4,431	255	175	12,410	31
43 NURSERY			153			43
44 SKILLED NURSING FACILITY	1,578	3,175	99	29	23,076	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,283	12,638	111,931	200		50
52 DELIVERY ROOM & LABOR ROOM			790			52
53 ANESTHESIOLOGY			324	5,477		53
54 RADIOLOGY-DIAGNOSTIC	2,857		765	309		54
54.01 ULTRASOUND	246		114			54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	349		21	834		54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	406		178			57
58 MAGNETIC RESONANCE IMAGING (MRI)	333		62	9		58
59 CARDIAC CATHETERIZATION			278	21		59
60 LABORATORY	2,599		8,254			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,449		754	5		65
66 PHYSICAL THERAPY	1,205		572	12		66
67 OCCUPATIONAL THERAPY	206		139			67
69 ELECTROCARDIOLOGY	1,437		269			69
70 ELECTROENCEPHALOGRAPHY	230		247			70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			12,095	11		71
73 DRUGS CHARGED TO PATIENTS				257,807		73
74 RENAL DIALYSIS			2			74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	239					76.01
76.02 CARDIAC REHAB	96		11			76.02
76.03 WOUND CARE	385		1,717	102		76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,766	5,566	956	293		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,312	2,640	345	20		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	45,548	53,888	141,640	266,400	178,055	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 PHILANTHROPY DEVELOPMENT						194
194.01 VENDING						194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	20					194.03

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION		CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	45,568	53,888	141,640	266,400	178,055	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	17				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	14	1,559,282		1,559,282	30
31 INTENSIVE CARE UNIT	1	233,539		233,539	31
43 NURSERY		25,929		25,929	43
44 SKILLED NURSING FACILITY	2	212,116		212,116	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		1,709,895		1,709,895	50
52 DELIVERY ROOM & LABOR ROOM		129,107		129,107	52
53 ANESTHESIOLOGY		87,443		87,443	53
54 RADIOLOGY-DIAGNOSTIC		1,114,050		1,114,050	54
54.01 ULTRASOUND		14,220		14,220	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC		151,855		151,855	54.02
54.04 RADIATION ONC					54.04
54.06 PET SCAN		6,302		6,302	54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN		172,105		172,105	57
58 MAGNETIC RESONANCE IMAGING (MRI)		120,455		120,455	58
59 CARDIAC CATHETERIZATION		233,195		233,195	59
60 LABORATORY		313,251		313,251	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		84,629		84,629	65
66 PHYSICAL THERAPY		129,988		129,988	66
67 OCCUPATIONAL THERAPY		19,223		19,223	67
69 ELECTROCARDIOLOGY		178,859		178,859	69
70 ELECTROENCEPHALOGRAPHY		19,208		19,208	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		22,404		22,404	71
73 DRUGS CHARGED TO PATIENTS		276,546		276,546	73
74 RENAL DIALYSIS		264		264	74
76 BACTERIOLOGY & MICROBIOLOGY					76
76.01 VASCULAR LAB		25,200		25,200	76.01
76.02 CARDIAC REHAB		22,985		22,985	76.02
76.03 WOUND CARE		64,543		64,543	76.03
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY		305,601		305,601	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		59,708		59,708	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	17	7,291,902		7,291,902	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,469		13,469	190
192 PHYSICIANS' PRIVATE OFFICES		76,977		76,977	192
194 PHILANTHROPY DEVELOPMENT		5,935		5,935	194
194.01 VENDING		3,742		3,742	194.01
194.02 MEALS ON WHEELS		5,098		5,098	194.02
194.03 PRAIRIE CARDIOVASCULAR		77,313		77,313	194.03

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION		SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		17	24	25	26	
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	17	7,474,436		7,474,436	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	311,563					1
2 CAP REL COSTS-MVBLE EQUIP		7,414,078				2
4 EMPLOYEE BENEFITS			31,303,062			4
5 ADMINISTRATIVE & GENERAL	783	890,201	3,884,886	-17,450,171	76,299,462	5
6 MAINTENANCE & REPAIRS	84,153	19,084	603,912		2,045,258	6
7 OPERATION OF PLANT	54,546	2,407,872	152,838		3,859,467	7
8 LAUNDRY & LINEN SERVICE	3,161	4,939	133,555		303,870	8
9 HOUSEKEEPING	3,409	8,341	729,370		1,250,995	9
10 DIETARY	4,500	19,171	434,254		854,568	10
11 CAFETERIA	1,612	9,093	264,618		278,084	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,594	6,245	727,637		1,096,119	13
14 CENTRAL SERVICES & SUPPLY	6,056				56,846	14
15 PHARMACY	1,693	322,972	1,207,691		2,146,651	15
16 MEDICAL RECORDS & LIBRARY	5,379	23,122	1,845,206		3,438,270	16
17 SOCIAL SERVICE					2,268	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	40,518	198,289	6,494,125		10,161,347	30
31 INTENSIVE CARE UNIT	4,281	98,565	1,340,518		2,096,111	31
43 NURSERY	797	4,979			30,779	43
44 SKILLED NURSING FACILITY	5,974	3,417	750,436		1,180,330	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	29,639	1,011,409	3,305,394		18,838,539	50
52 DELIVERY ROOM & LABOR ROOM	4,678	1,946	142,590		348,335	52
53 ANESTHESIOLOGY	196	112,128			210,992	53
54 RADIOLOGY-DIAGNOSTIC	11,307	1,191,490	1,529,733		3,888,420	54
54.01 ULTRASOUND	430	1,880	166,672		298,579	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	2,162	138,918	247,539		969,367	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN	200				216,927	54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,271	210,157	241,857		854,657	57
58 MAGNETIC RESONANCE IMAGING (MRI)	4,848		195,864		726,750	58
59 CARDIAC CATHETERIZATION	1,852	288,654	199,186		618,590	59
60 LABORATORY	7,461	108,104	1,205,152		4,518,382	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	766	48,283	1,149,207		1,802,429	65
66 PHYSICAL THERAPY	3,622	37,211	803,610		1,303,232	66
67 OCCUPATIONAL THERAPY	707		162,735		265,111	67
69 ELECTROCARDIOLOGY	4,670	87,211	490,378		934,255	69
70 ELECTROENCEPHALOGRAPHY	683	1,442	133,105		246,350	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					1,363,801	71
73 DRUGS CHARGED TO PATIENTS					2,481,683	73
74 RENAL DIALYSIS					34,691	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	381	17,805	157,869		249,759	76.01
76.02 CARDIAC REHAB	463	15,990	66,295		112,937	76.02
76.03 WOUND CARE	1,864	1,789	184,118		841,946	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	9,332	42,516	1,518,367		2,469,238	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,338	21,383	765,221		1,298,248	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	306,326	7,354,606	31,233,938	-17,450,171	73,694,181	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	553	550			29,351	190
192 PHYSICIANS' PRIVATE OFFICES	1,703	58,922			71,998	192
194 PHILANTHROPY DEVELOPMENT	212		61,921		131,333	194
194.01 VENDING	160				1,404	194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	2,609		7,203		2,371,195	194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,733,366	4,741,070	14,201,071		17,450,171	202
203 UNIT COST MULT-WS B PT I	8.773076	0.639469	0.453664		0.228706	203
204 COST TO BE ALLOC PER B PT II					576,125	204
205 UNIT COST MULT-WS B PT II					0.007551	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS MAINT. HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	11,765					6
7 OPERATION OF PLANT	5,410	172,081				7
8 LAUNDRY & LINEN SERVICE	429	3,161	838,152			8
9 HOUSEKEEPING	68	3,409		2,013,986		9
10 DIETARY	275	4,500	5,683	56,222	118,479	10
11 CAFETERIA	1	1,612		20,140		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	57	1,594		19,915		13
14 CENTRAL SERVICES & SUPPLY		6,056		75,662		14
15 PHARMACY	42	1,693		21,152		15
16 MEDICAL RECORDS & LIBRARY	127	5,379		67,204		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,026	40,518	405,201	506,221	91,890	30
31 INTENSIVE CARE UNIT	335	4,281	36,718	53,486	7,469	31
43 NURSERY	58	797		9,957		43
44 SKILLED NURSING FACILITY	172	5,974	37,477	74,637	14,874	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,137	29,639	196,933	370,306		50
52 DELIVERY ROOM & LABOR ROOM	236	4,678		58,446		52
53 ANESTHESIOLOGY	58	196		2,449		53
54 RADIOLOGY-DIAGNOSTIC	797	11,307	26,291	141,269		54
54.01 ULTRASOUND	2	430	1,971	5,372		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	55	2,162	4,013	27,015		54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN		200		2,499		54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN		1,271	8,296	15,880		57
58 MAGNETIC RESONANCE IMAGING (MRI)	3	4,848	10,558	60,565		58
59 CARDIAC CATHETERIZATION	7	1,852		23,138		59
60 LABORATORY	386	7,461	398	93,216		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	269	766	12,442	9,570		65
66 PHYSICAL THERAPY	146	3,622	4,793	45,256		66
67 OCCUPATIONAL THERAPY	4	707	1,036	8,833		67
69 ELECTROCARDIOLOGY	77	4,670	3,378	58,346		69
70 ELECTROENCEPHALOGRAPHY		683	191	8,533		70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	42	381	562	4,760		76.01
76.02 CARDIAC REHAB	14	463	740	5,785		76.02
76.03 WOUND CARE	173	1,864	878	23,291		76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	347	9,332	79,661	116,587		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	11	1,338		16,717		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	11,764	166,844	837,220	2,002,429	114,233	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		553		6,909		190
192 PHYSICIANS' PRIVATE OFFICES	1	1,703				192
194 PHILANTHROPY DEVELOPMENT		212		2,649		194
194.01 VENDING		160		1,999		194.01
194.02 MEALS ON WHEELS					4,246	194.02
194.03 PRAIRIE CARDIOVASCULAR		2,609	932			194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAIN- TENANCE & REPAIRS MAINT. HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,513,021	5,897,736	573,339	1,668,467	1,313,446	202
203	UNIT COST MULT-WS B PT I	213.601445	34.273023	0.684051	0.828440	11.085897	203
204	COST TO BE ALLOC PER B PT II	765,929	2,399,638	105,194	96,652	142,257	204
205	UNIT COST MULT-WS B PT II	65.102337	13.944817	0.125507	0.047990	1.200694	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
	MEALS SERVED	ADMINIS- TRATION DIRECT NRSING HRS	SUPPLY COSTED REQUIS.	COSTED REQUIS.	RECORDS & LIBRARY TIME SPENT	
	11	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	55,317					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	897	616,293				13
14 CENTRAL SERVICES & SUPPLY			16,900,034			14
15 PHARMACY	1,665		9,146	2,799,369		15
16 MEDICAL RECORDS & LIBRARY	4,388				10,000	16
17 SOCIAL SERVICE			4			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,350	290,921	146,979	11,519	8,007	30
31 INTENSIVE CARE UNIT	2,673	50,670	30,480	1,841	697	31
43 NURSERY			18,306			43
44 SKILLED NURSING FACILITY	1,916	36,314	11,770	309	1,296	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,627	144,539	13,355,249	2,105		50
52 DELIVERY ROOM & LABOR ROOM			94,304			52
53 ANESTHESIOLOGY			38,701	57,551		53
54 RADIOLOGY-DIAGNOSTIC	3,468		91,250	3,245		54
54.01 ULTRASOUND	299		13,587			54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	424		2,456	8,764		54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	493		21,190			57
58 MAGNETIC RESONANCE IMAGING (MRI)	404		7,404	97		58
59 CARDIAC CATHETERIZATION			33,116	218		59
60 LABORATORY	3,155		984,897			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,973		90,011	52		65
66 PHYSICAL THERAPY	1,463		68,241	125		66
67 OCCUPATIONAL THERAPY	250		16,624			67
69 ELECTROCARDIOLOGY	1,745		32,086			69
70 ELECTROENCEPHALOGRAPHY	279		29,445			70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			1,443,189	113		71
73 DRUGS CHARGED TO PATIENTS				2,709,069		73
74 RENAL DIALYSIS			199			74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	290		55			76.01
76.02 CARDIAC REHAB	116		1,259			76.02
76.03 WOUND CARE	467		204,893	1,072		76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	3,358	63,652	114,039	3,084		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,593	30,197	41,117	205		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	55,293	616,293	16,899,997	2,799,369	10,000	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 PHILANTHROPY DEVELOPMENT						194
194.01 VENDING						194.01
194.02 MEALS ON WHEELS						194.02
194.03 PRAIRIE CARDIOVASCULAR	24		37			194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAFETERIA	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	
		MEALS SERVED					
		11	13	14	15	16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	413,830	1,436,823	340,085	2,734,761	4,524,606	202
203	UNIT COST MULT-WS B PT I	7.481064	2.331396	0.020123	0.976921	452.460600	203
204	COST TO BE ALLOC PER B PT II	45,568	53,888	141,640	266,400	178,055	204
205	UNIT COST MULT-WS B PT II	0.823761	0.087439	0.008381	0.095164	17.805500	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	TIME SPENT	
		17	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE	10,000		17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	8,007		30
31 INTENSIVE CARE UNIT	697		31
43 NURSERY			43
44 SKILLED NURSING FACILITY	1,296		44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
52 DELIVERY ROOM & LABOR ROOM			52
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC			54
54.01 ULTRASOUND			54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC			54.02
54.04 RADIATION ONC			54.04
54.06 PET SCAN			54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN			57
58 MAGNETIC RESONANCE IMAGING (MRI)			58
59 CARDIAC CATHETERIZATION			59
60 LABORATORY			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
67 OCCUPATIONAL THERAPY			67
69 ELECTROCARDIOLOGY			69
70 ELECTROENCEPHALOGRAPHY			70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
73 DRUGS CHARGED TO PATIENTS			73
74 RENAL DIALYSIS			74
76 BACTERIOLOGY & MICROBIOLOGY			76
76.01 VASCULAR LAB			76.01
76.02 CARDIAC REHAB			76.02
76.03 WOUND CARE			76.03
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
91 EMERGENCY			91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
101 HOME HEALTH AGENCY			101
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	10,000		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
192 PHYSICIANS' PRIVATE OFFICES			192
194 PHILANTHROPY DEVELOPMENT			194
194.01 VENDING			194.01
194.02 MEALS ON WHEELS			194.02
194.03 PRAIRIE CARDIOVASCULAR			194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	TIME SPENT	
200 CROSS FOOT ADJUSTMENTS		17	200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I		2,787	202
203 UNIT COST MULT-WS B PT I		0.278700	203
204 COST TO BE ALLOC PER B PT II		17	204
205 UNIT COST MULT-WS B PT II		0.001700	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	20,240,755		20,240,755		20,240,755	30
31 INTENSIVE CARE UNIT	3,402,111		3,402,111		3,402,111	31
43 NURSERY	86,140		86,140		86,140	43
44 SKILLED NURSING FACILITY	2,630,410		2,630,410		2,630,410	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	25,512,071		25,512,071		25,512,071	50
52 DELIVERY ROOM & LABOR ROOM	689,057		689,057		689,057	52
53 ANESTHESIOLOGY	337,385		337,385		337,385	53
54 RADIOLOGY-DIAGNOSTIC	5,501,457		5,501,457		5,501,457	54
54.01 ULTRASOUND	390,338		390,338		390,338	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	1,313,821		1,313,821		1,313,821	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN	275,465		275,465		275,465	54.06
57 COMPUTED TOMOGRAPHY (CT) SC	1,116,628		1,116,628		1,116,628	57
58 MAGNETIC RESONANCE IMAGING	1,120,421		1,120,421		1,120,421	58
59 CARDIAC CATHETERIZATION	845,081		845,081		845,081	59
60 LABORATORY	6,010,842		6,010,842		6,010,842	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,338,909		2,338,909		2,338,909	65
66 PHYSICAL THERAPY	1,809,823		1,809,823		1,809,823	66
67 OCCUPATIONAL THERAPY	361,060		361,060		361,060	67
69 ELECTROCARDIOLOGY	1,388,774		1,388,774		1,388,774	69
70 ELECTROENCEPHALOGRAPHY	335,980		335,980		335,980	70
71 MEDICAL SUPPLIES CHRGED TO	1,704,861		1,704,861		1,704,861	71
73 DRUGS CHARGED TO PATIENTS	5,695,804		5,695,804		5,695,804	73
74 RENAL DIALYSIS	42,629		42,629		42,629	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	335,407		335,407		335,407	76.01
76.02 CARDIAC REHAB	163,816		163,816		163,816	76.02
76.03 WOUND CARE	1,163,902		1,163,902		1,163,902	76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	3,757,828		3,757,828		3,757,828	91
92 OBSERVATION BEDS	267,392		267,392		267,392	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,740,566		1,740,566		1,740,566	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	90,578,733		90,578,733		90,578,733	200
201 LESS OBSERVATION BEDS	267,392		267,392		267,392	201
202 TOTAL (SEE INSTRUCTIONS)	90,311,341		90,311,341		90,311,341	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	14,225,387		14,225,387			30
31 INTENSIVE CARE UNIT	2,867,872		2,867,872			31
43 NURSERY	958,160		958,160			43
44 SKILLED NURSING FACILITY	922,053		922,053			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	34,403,074	22,190,371	56,593,445	0.450796	0.450796	0.450796 50
52 DELIVERY ROOM & LABOR ROOM	1,795,449	161,360	1,956,809	0.352133	0.352133	0.352133 52
53 ANESTHESIOLOGY	2,330,770	3,004,474	5,335,244	0.063237	0.063237	0.063237 53
54 RADIOLOGY-DIAGNOSTIC	2,314,570	11,332,604	13,647,174	0.403121	0.403121	0.403121 54
54.01 ULTRASOUND	324,650	2,327,824	2,652,474	0.147160	0.147160	0.147160 54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	880,874	9,521,533	10,402,407	0.126300	0.126300	0.126300 54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN	43,211	751,210	794,421	0.346749	0.346749	0.346749 54.06
57 COMPUTED TOMOGRAPHY (CT) SC	5,042,836	17,820,460	22,863,296	0.048839	0.048839	0.048839 57
58 MAGNETIC RESONANCE IMAGING	1,306,933	11,188,758	12,495,691	0.089665	0.089665	0.089665 58
59 CARDIAC CATHETERIZATION	241,560	973,358	1,214,918	0.695587	0.695587	0.695587 59
60 LABORATORY	8,004,073	10,576,340	18,580,413	0.323504	0.323504	0.323504 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	4,155,594	790,818	4,946,412	0.472850	0.472850	0.472850 65
66 PHYSICAL THERAPY	1,497,765	1,122,651	2,620,416	0.690662	0.690662	0.690662 66
67 OCCUPATIONAL THERAPY	361,096	192,312	553,408	0.652430	0.652430	0.652430 67
69 ELECTROCARDIOLOGY	1,848,510	6,584,302	8,432,812	0.164687	0.164687	0.164687 69
70 ELECTROENCEPHALOGRAPHY	734,053	1,202,288	1,936,341	0.173513	0.173513	0.173513 70
71 MEDICAL SUPPLIES CHRGD TO	8,095,944	5,797,003	13,892,947	0.122714	0.122714	0.122714 71
73 DRUGS CHARGED TO PATIENTS	18,751,583	6,981,958	25,733,541	0.221338	0.221338	0.221338 73
74 RENAL DIALYSIS	68,652	900	69,552	0.612908	0.612908	0.612908 74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	277,363	1,288,788	1,566,151	0.214160	0.214160	0.214160 76.01
76.02 CARDIAC REHAB	387	258,644	259,031	0.632419	0.632419	0.632419 76.02
76.03 WOUND CARE	37,562	3,306,597	3,344,159	0.348040	0.348040	0.348040 76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	3,255,632	13,635,298	16,890,930	0.222476	0.222476	0.222476 91
92 OBSERVATION BEDS	53,285	2,088,609	2,141,894	0.124839	0.124839	0.124839 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		1,137,829	1,137,829			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	114,798,898	134,236,289	249,035,187			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	114,798,898	134,236,289	249,035,187			202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL. 3 + COL. 4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL. 5 x COL. 6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL. 1 MINUS COL. 2)					
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,559,282		1,559,282	21,725	71.77	13,944	1,000,761	30
31 INTENSIVE CARE UNIT	233,539		233,539	1,867	125.09	1,353	169,247	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	25,929		25,929	1,692	15.32			43
44 SKILLED NURSING FACILITY	212,116		212,116	3,470	61.13	3,208	196,105	44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	2,030,866		2,030,866	28,754		18,505	1,366,113	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL	
	(FROM WKST B, PT. II, COL. 26) 1	(FROM WKST C, PT. I, COL. 8) 2	(COL.1 ÷ COL.2) 3	4	(COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,709,895	56,593,445	0.030214	19,047,248	575,494	50
52 DELIVERY ROOM & LABOR ROOM	129,107	1,956,809	0.065978	62,103	4,097	52
53 ANESTHESIOLOGY	87,443	5,335,244	0.016390	1,169,452	19,167	53
54 RADIOLOGY-DIAGNOSTIC	1,114,050	13,647,174	0.081632	1,574,295	128,513	54
54.01 ULTRASOUND	14,220	2,652,474	0.005361	179,293	961	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	151,855	10,402,407	0.014598	642,843	9,384	54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN	6,302	794,421	0.007933	33,434	265	54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	172,105	22,863,296	0.007528	3,268,526	24,605	57
58 MAGNETIC RESONANCE IMAGING (M	120,455	12,495,691	0.009640	914,694	8,818	58
59 CARDIAC CATHETERIZATION	233,195	1,214,918	0.191943	139,567	26,789	59
60 LABORATORY	313,251	18,580,413	0.016859	6,047,945	101,962	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	84,629	4,946,412	0.017109	2,706,165	46,300	65
66 PHYSICAL THERAPY	129,988	2,620,416	0.049606	857,260	42,525	66
67 OCCUPATIONAL THERAPY	19,223	553,408	0.034736	196,440	6,824	67
69 ELECTROCARDIOLOGY	178,859	8,432,812	0.021210	1,131,142	23,992	69
70 ELECTROENCEPHALOGRAPHY	19,208	1,936,341	0.009920	349,611	3,468	70
71 MEDICAL SUPPLIES CHRGED TO PA	22,404	13,892,947	0.001613	4,114,139	6,636	71
73 DRUGS CHARGED TO PATIENTS	276,546	25,733,541	0.010747	12,235,577	131,496	73
74 RENAL DIALYSIS	264	69,552	0.003796	57,852	220	74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB	25,200	1,566,151	0.016090	177,497	2,856	76.01
76.02 CARDIAC REHAB	22,985	259,031	0.088735	350	31	76.02
76.03 WOUND CARE	64,543	3,344,159	0.019300			76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	305,601	16,890,930	0.018093	1,848,629	33,447	91
92 OBSERVATION BEDS	20,599	2,141,894	0.009617	25,038	241	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	5,221,927	228,923,886	228,923,886	56,779,100	1,198,091	200

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	21,725		13,944		30
31 INTENSIVE CARE UNIT	1,867		1,353		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	1,692				43
44 SKILLED NURSING FACILITY	3,470		3,208		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	28,754		18,505		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 ULTRASOUND						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC						54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB						76.01
76.02 CARDIAC REHAB						76.02
76.03 WOUND CARE						76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (14-0032)	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	56,593,445		19,047,248		8,591,388	50
52	DELIVERY ROOM & LABOR ROOM	1,956,809		62,103			52
53	ANESTHESIOLOGY	5,335,244		1,169,452		1,010,546	53
54	RADIOLOGY-DIAGNOSTIC	13,647,174		1,574,295		2,334,493	54
54.01	ULTRASOUND	2,652,474		179,293		571,166	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	10,402,407		642,843		4,628,605	54.02
54.04	RADIATION ONC						54.04
54.06	PET SCAN	794,421		33,434		299,217	54.06
57	COMPUTED TOMOGRAPHY (CT) SCA	22,863,296		3,268,526		5,970,174	57
58	MAGNETIC RESONANCE IMAGING (12,495,691		914,694		3,963,809	58
59	CARDIAC CATHETERIZATION	1,214,918		139,567		435,494	59
60	LABORATORY	18,580,413		6,047,945		716,364	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	4,946,412		2,706,165		247,375	65
66	PHYSICAL THERAPY	2,620,416		857,260		662	66
67	OCCUPATIONAL THERAPY	553,408		196,440		1,088	67
69	ELECTROCARDIOLOGY	8,432,812		1,131,142		2,515,778	69
70	ELECTROENCEPHALOGRAPHY	1,936,341		349,611		472,885	70
71	MEDICAL SUPPLIES CHRGED TO P	13,892,947		4,114,139		1,833,805	71
73	DRUGS CHARGED TO PATIENTS	25,733,541		12,235,577		4,432,438	73
74	RENAL DIALYSIS	69,552		57,852			74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	1,566,151		177,497		695,588	76.01
76.02	CARDIAC REHAB	259,031		350		155,471	76.02
76.03	WOUND CARE	3,344,159				904,112	76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	16,890,930		1,848,629		2,843,199	91
92	OBSERVATION BEDS	2,141,894		25,038		1,006,040	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	228,923,886		56,779,100		43,629,697	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9 1	RATIO	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.450796		8,591,388			3,872,963		50
52 DELIVERY ROOM & LABOR ROOM	0.352133							52
53 ANESTHESIOLOGY	0.063237		1,010,546			63,904		53
54 RADIOLOGY-DIAGNOSTIC	0.403121		2,334,493			941,083		54
54.01 ULTRASOUND	0.147160		571,166			84,053		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.126300		4,628,605			584,593		54.02
54.04 RADIATION ONC								54.04
54.06 PET SCAN	0.346749		299,217			103,753		54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.048839		5,970,174			291,577		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089665		3,963,809			355,415		58
59 CARDIAC CATHETERIZATION	0.695587		435,494			302,924		59
60 LABORATORY	0.323504		716,364			231,747		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.472850		247,375			116,971		65
66 PHYSICAL THERAPY	0.690662		662			457		66
67 OCCUPATIONAL THERAPY	0.652430		1,088			710		67
69 ELECTROCARDIOLOGY	0.164687		2,515,778			414,316		69
70 ELECTROENCEPHALOGRAPHY	0.173513		472,885			82,052		70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.122714		1,833,805			225,034		71
73 DRUGS CHARGED TO PATIENTS	0.221338		4,432,438			981,067		73
74 RENAL DIALYSIS	0.612908							74
76 BACTERIOLOGY & MICROBIOLOGY								76
76.01 VASCULAR LAB	0.214160		695,588			148,967		76.01
76.02 CARDIAC REHAB	0.632419		155,471			98,323		76.02
76.03 WOUND CARE	0.348040		904,112			314,667		76.03
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.222476		2,843,199			632,544		91
92 OBSERVATION BEDS	0.124839		1,006,040			125,593		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			43,629,697			9,972,713		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			43,629,697			9,972,713		202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 ULTRASOUND						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC						54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB						76.01
76.02 CARDIAC REHAB						76.02
76.03 WOUND CARE						76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[XX] SNF (14-5940)		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	56,593,445		12,655			50
52	DELIVERY ROOM & LABOR ROOM	1,956,809					52
53	ANESTHESIOLOGY	5,335,244		4,513			53
54	RADIOLOGY-DIAGNOSTIC	13,647,174		40,564			54
54.01	ULTRASOUND	2,652,474		1,142			54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	10,402,407		8,445			54.02
54.04	RADIATION ONC						54.04
54.06	PET SCAN	794,421					54.06
57	COMPUTED TOMOGRAPHY (CT) SCA	22,863,296		176			57
58	MAGNETIC RESONANCE IMAGING (12,495,691					58
59	CARDIAC CATHETERIZATION	1,214,918					59
60	LABORATORY	18,580,413		237,868			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	4,946,412		255,296			65
66	PHYSICAL THERAPY	2,620,416		301,941			66
67	OCCUPATIONAL THERAPY	553,408		79,456			67
69	ELECTROCARDIOLOGY	8,432,812		7,905			69
70	ELECTROENCEPHALOGRAPHY	1,936,341		4,599			70
71	MEDICAL SUPPLIES CHRGED TO P	13,892,947		82,145			71
73	DRUGS CHARGED TO PATIENTS	25,733,541		986,327			73
74	RENAL DIALYSIS	69,552					74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	1,566,151		7,797			76.01
76.02	CARDIAC REHAB	259,031					76.02
76.03	WOUND CARE	3,344,159					76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	16,890,930					91
92	OBSERVATION BEDS	2,141,894		87			92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	228,923,886		2,030,916			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [XX] SNF (14-5940) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.450796						50
52 DELIVERY ROOM & LABOR ROOM	0.352133						52
53 ANESTHESIOLOGY	0.063237						53
54 RADIOLOGY-DIAGNOSTIC	0.403121						54
54.01 ULTRASOUND	0.147160						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.126300						54.02
54.04 RADIATION ONC							54.04
54.06 PET SCAN	0.346749						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.048839						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089665						58
59 CARDIAC CATHETERIZATION	0.695587						59
60 LABORATORY	0.323504						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.472850						65
66 PHYSICAL THERAPY	0.690662						66
67 OCCUPATIONAL THERAPY	0.652430						67
69 ELECTROCARDIOLOGY	0.164687						69
70 ELECTROENCEPHALOGRAPHY	0.173513						70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.122714						71
73 DRUGS CHARGED TO PATIENTS	0.221338						73
74 RENAL DIALYSIS	0.612908						74
76 BACTERIOLOGY & MICROBIOLOGY							76
76.01 VASCULAR LAB	0.214160						76.01
76.02 CARDIAC REHAB	0.632419						76.02
76.03 WOUND CARE	0.348040						76.03
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.222476						91
92 OBSERVATION BEDS	0.124839						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL. 3 + COL. 4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL. 5 x COL. 6)
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL. 1 MINUS COL. 2)	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS							30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT PROGRAM CHARGES	CAPITAL
	COST (FROM WKST B, PT. II, COL. 26) 1	CHARGES (FROM WKST C, PT. I, COL. 8) 2	COST TO CHARGES (COL.1 ÷ COL.2) 3		(COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.01 ULTRASOUND					54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC					54.02
54.04 RADIATION ONC					54.04
54.06 PET SCAN					54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (M					58
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGED TO PA					71
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76 BACTERIOLOGY & MICROBIOLOGY					76
76.01 VASCULAR LAB					76.01
76.02 CARDIAC REHAB					76.02
76.03 WOUND CARE					76.03
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2011.10
01/30/2012 15:15

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/30/2012 15:15

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 ULTRASOUND						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC						54.02
54.04 RADIATION ONC						54.04
54.06 PET SCAN						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
69 ELECTROCARDIOLOGY						69
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 BACTERIOLOGY & MICROBIOLOGY						76
76.01 VASCULAR LAB						76.01
76.02 CARDIAC REHAB						76.02
76.03 WOUND CARE						76.03
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO				
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	CHARGES	(COL. 8 x	(COL. 9 x	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)		COL. 10)	COL. 12)	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	56,593,445						50
52 DELIVERY ROOM & LABOR ROOM	1,956,809						52
53 ANESTHESIOLOGY	5,335,244						53
54 RADIOLOGY-DIAGNOSTIC	13,647,174						54
54.01 ULTRASOUND	2,652,474						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	10,402,407						54.02
54.04 RADIATION ONC							54.04
54.06 PET SCAN	794,421						54.06
57 COMPUTED TOMOGRAPHY (CT) SCA	22,863,296						57
58 MAGNETIC RESONANCE IMAGING (12,495,691						58
59 CARDIAC CATHETERIZATION	1,214,918						59
60 LABORATORY	18,580,413						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	4,946,412						65
66 PHYSICAL THERAPY	2,620,416						66
67 OCCUPATIONAL THERAPY	553,408						67
69 ELECTROCARDIOLOGY	8,432,812						69
70 ELECTROENCEPHALOGRAPHY	1,936,341						70
71 MEDICAL SUPPLIES CHRGED TO P	13,892,947						71
73 DRUGS CHARGED TO PATIENTS	25,733,541						73
74 RENAL DIALYSIS	69,552						74
76 BACTERIOLOGY & MICROBIOLOGY							76
76.01 VASCULAR LAB	1,566,151						76.01
76.02 CARDIAC REHAB	259,031						76.02
76.03 WOUND CARE	3,344,159						76.03
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	16,890,930						91
92 OBSERVATION BEDS	2,141,894						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	228,923,886						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.450796						50
52 DELIVERY ROOM & LABOR ROOM	0.352133						52
53 ANESTHESIOLOGY	0.063237						53
54 RADIOLOGY-DIAGNOSTIC	0.403121						54
54.01 ULTRASOUND	0.147160						54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.126300						54.02
54.04 RADIATION ONC							54.04
54.06 PET SCAN	0.346749						54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.048839						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089665						58
59 CARDIAC CATHETERIZATION	0.695587						59
60 LABORATORY	0.323504						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.472850						65
66 PHYSICAL THERAPY	0.690662						66
67 OCCUPATIONAL THERAPY	0.652430						67
69 ELECTROCARDIOLOGY	0.164687						69
70 ELECTROENCEPHALOGRAPHY	0.173513						70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.122714						71
73 DRUGS CHARGED TO PATIENTS	0.221338						73
74 RENAL DIALYSIS	0.612908						74
76 BACTERIOLOGY & MICROBIOLOGY							76
76.01 VASCULAR LAB	0.214160						76.01
76.02 CARDIAC REHAB	0.632419						76.02
76.03 WOUND CARE	0.348040						76.03
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.222476						91
92 OBSERVATION BEDS	0.124839						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	21,725	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	21,725	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	21,725	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	13,944	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	20,240,755	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	20,240,755	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,993,235	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,993,235	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.250665	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)	413.96	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	20,240,755	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 931.68 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 12,991,346 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) 12,991,346 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	3,402,111	1,867	1,822.23	1,353	2,465,477	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					17,679,258	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					33,136,081	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 1,170,008 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 1,198,091 51
 52 TOTAL PROGRAM EXCLUDABLE COST 2,368,099 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 30,767,982 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 287 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 931.68 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 267,392 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	1,559,282	20,240,755	0.077037	267,392	20,599	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,470	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,470	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	806	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,664	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,208	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,630,410	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,630,410	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	606,060	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	240,188	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	365,872	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	4.340181	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	298.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	137.34	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	160.66	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	697.29	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	562,016	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,068,394	37

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/30/2012 15:15

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,068,394	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	596.08	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	1,912,225	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	1,912,225	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	1,912,225	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	713,805	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	2,626,030	86

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	21,725	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	21,725	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	21,725	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,318	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	1,692	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	856	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	20,240,755	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	20,240,755	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,993,235	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,993,235	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.250665	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)	413.96	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	20,240,755	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 931.68 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,159,634 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) 2,159,634 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)	86,140	1,692	50.91	856	43,579 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	3,402,111	1,867	1,822.23	86	156,712 43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,359,925 49

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

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 287 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		8,993,235			30
31 INTENSIVE CARE UNIT		2,066,409			31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.450796	19,047,248	8,586,423		50
52 DELIVERY ROOM & LABOR ROOM	0.352133	62,103	21,869		52
53 ANESTHESIOLOGY	0.063237	1,169,452	73,953		53
54 RADIOLOGY-DIAGNOSTIC	0.403121	1,574,295	634,631		54
54.01 ULTRASOUND	0.147160	179,293	26,385		54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.126300	642,843	81,191		54.02
54.04 RADIATION ONC					54.04
54.06 PET SCAN	0.346749	33,434	11,593		54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.048839	3,268,526	159,632		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089665	914,694	82,016		58
59 CARDIAC CATHETERIZATION	0.695587	139,567	97,081		59
60 LABORATORY	0.323504	6,047,945	1,956,534		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.472850	2,706,165	1,279,610		65
66 PHYSICAL THERAPY	0.690662	857,260	592,077		66
67 OCCUPATIONAL THERAPY	0.652430	196,440	128,163		67
69 ELECTROCARDIOLOGY	0.164687	1,131,142	186,284		69
70 ELECTROENCEPHALOGRAPHY	0.173513	349,611	60,662		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.122714	4,114,139	504,862		71
73 DRUGS CHARGED TO PATIENTS	0.221338	12,235,577	2,708,198		73
74 RENAL DIALYSIS	0.612908	57,852	35,458		74
76 BACTERIOLOGY & MICROBIOLOGY					76
76.01 VASCULAR LAB	0.214160	177,497	38,013		76.01
76.02 CARDIAC REHAB	0.632419	350	221		76.02
76.03 WOUND CARE	0.348040				76.03
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	0.222476	1,848,629	411,276		91
92 OBSERVATION BEDS	0.124839	25,038	3,126		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		56,779,100	17,679,258		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		56,779,100			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.450796	12,655	5,705	50
52 DELIVERY ROOM & LABOR ROOM	0.352133			52
53 ANESTHESIOLOGY	0.063237	4,513	285	53
54 RADIOLOGY-DIAGNOSTIC	0.403121	40,564	16,352	54
54.01 ULTRASOUND	0.147160	1,142	168	54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.126300	8,445	1,067	54.02
54.04 RADIATION ONC				54.04
54.06 PET SCAN	0.346749			54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.048839	176	9	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089665			58
59 CARDIAC CATHETERIZATION	0.695587			59
60 LABORATORY	0.323504	237,868	76,951	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.472850	255,296	120,717	65
66 PHYSICAL THERAPY	0.690662	301,941	208,539	66
67 OCCUPATIONAL THERAPY	0.652430	79,456	51,839	67
69 ELECTROCARDIOLOGY	0.164687	7,905	1,302	69
70 ELECTROENCEPHALOGRAPHY	0.173513	4,599	798	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.122714	82,145	10,080	71
73 DRUGS CHARGED TO PATIENTS	0.221338	986,327	218,312	73
74 RENAL DIALYSIS	0.612908			74
76 BACTERIOLOGY & MICROBIOLOGY				76
76.01 VASCULAR LAB	0.214160	7,797	1,670	76.01
76.02 CARDIAC REHAB	0.632419			76.02
76.03 WOUND CARE	0.348040			76.03
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.222476			91
92 OBSERVATION BEDS	0.124839	87	11	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,030,916	713,805	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,030,916		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.450796			50
52 DELIVERY ROOM & LABOR ROOM	0.352133			52
53 ANESTHESIOLOGY	0.063237			53
54 RADIOLOGY-DIAGNOSTIC	0.403121			54
54.01 ULTRASOUND	0.147160			54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC	0.126300			54.02
54.04 RADIATION ONC				54.04
54.06 PET SCAN	0.346749			54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.048839			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.089665			58
59 CARDIAC CATHETERIZATION	0.695587			59
60 LABORATORY	0.323504			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.472850			65
66 PHYSICAL THERAPY	0.690662			66
67 OCCUPATIONAL THERAPY	0.652430			67
69 ELECTROCARDIOLOGY	0.164687			69
70 ELECTROENCEPHALOGRAPHY	0.173513			70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.122714			71
73 DRUGS CHARGED TO PATIENTS	0.221338			73
74 RENAL DIALYSIS	0.612908			74
76 BACTERIOLOGY & MICROBIOLOGY				76
76.01 VASCULAR LAB	0.214160			76.01
76.02 CARDIAC REHAB	0.632419			76.02
76.03 WOUND CARE	0.348040			76.03
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.222476			91
92 OBSERVATION BEDS	0.124839			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	24,713,849	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	938,746	2
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	132.21	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0433	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1415	31
32	SUM OF LINES 30 AND 31	0.1848	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0476	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	1,176,379	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	26,828,974	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	26,828,974	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	2,016,473	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	28,845,447	59
60	PRIMARY PAYER PAYMENTS	40,835	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	28,804,612	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,827,260	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	24,109	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	509,449	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	356,614	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	449,784	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	26,309,857	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	26,309,857	71
72	INTERIM PAYMENTS	25,100,136	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	1,209,721	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [] IPF [] IRF
 [] SUB (OTHER) [XX] SNF (14-5940)

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		24,776,864		8,226,821	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .12 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99				3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.12 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		323,272		248,452	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		25,100,136		8,475,273	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM			121,275	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		-25,100,136		8,596,548	7

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (14-5940)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		984,945		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		984,945		4
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM			6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		984,945		7

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

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/30/2012 15:15

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0032) [] CAH
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	6,622 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	15,297 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	23,305 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	249,035,187 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/30/2012 15:15

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

1	PROSPECTIVE PAYMENT AMOUNT		
2	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1,050,354	1
3	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
4	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
5	SUBTOTAL (SUM OF LINES 1-3)	1,050,354	4
6	COMPUTATION OF NET COST OF COVERED SERVICES		
7	MEDICAL AND OTHER SERVICES		5
8	DEDUCTIBLES		6
9	COINSURANCE	65,409	7
10	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
11	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
12	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
13	UTILIZATION REVIEW		11
14	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	984,945	12
15	INPATIENT PRIMARY PAYER PAYMENTS		13
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
17	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	984,945	15
18	INTERIM PAYMENTS	984,945	16
19	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
20	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)		18
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

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

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	2,359,925 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	2,359,925 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	2,359,925 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	2,359,925 18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	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)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	3,847,828			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	35,931,207			4
5 OTHER RECEIVABLES	-38,302			5
6 ALLOWANCE FOR UNCOLLECTIBLE				
NOTES & ACCOUNTS RECEIVABLE	-18,986,363			6
7 INVENTORY	5,504,218			7
8 PREPAID EXPENSES	176,082			8
9 OTHER CURRENT ASSETS	13,016,604			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	39,451,274			11
FIXED ASSETS				
12 LAND	1,095,531			12
13 LAND IMPROVEMENTS	1,899,492			13
14 ACCUMULATED DEPRECIATION	-1,482,625			14
15 BUILDINGS	59,530,902			15
16 ACCUMULATED DEPRECIATION	-20,597,710			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT	14,589,756			19
20 ACCUMULATED DEPRECIATION	-12,956,521			20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	60,074,059			23
24 ACCUMULATED DEPRECIATION	-44,849,542			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)	57,303,342			30
OTHER ASSETS				
31 INVESTMENTS	204,107,207			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	272,113			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	204,379,320			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	301,133,936			36
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	2,531,524			37
38 SALARIES, WAGES & FEES PAYABLE				38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	12,351,217			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	12,788,509			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	27,671,250			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	18,858,851			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	10,301,891			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	29,160,742			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	56,831,992			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	244,301,944			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	244,301,944			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	301,133,936			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		198,176,423							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		39,344,516							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		237,520,939							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 REV. RECOGN. OF MIN. PENSION	6,638,927								5
6 NET ASSETS RELEASED FROM RES	1,218,725								6
7 CHG IN TEMP. RESTRICTED NET	-722,838								7
8 TRANSFER (TO)/FROM AFFILIATE	-2,342,603								8
9 PRAIRIE REVENUE	1,988,794								9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		6,781,005							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		244,301,944							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									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)		244,301,944							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	14,275,117		14,275,117	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY	922,053		922,053	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	15,197,170		15,197,170	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	2,871,427		2,871,427	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	2,871,427		2,871,427	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	18,068,597		18,068,597	17
18 ANCILLARY SERVICES	95,772,141	133,098,460	228,870,601	18
19 OUTPATIENT SERVICES				19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY		1,137,829	1,137,829	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 NURSERY	958,160		958,160	27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	114,798,898	134,236,289	249,035,187	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		99,682,978	29
30 PROVISION FOR BAD DEBT	4,209,627		30
31 PRAIRIE			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		4,209,627	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		103,892,605	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	249,035,187	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	135,504,793	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	113,530,394	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	103,892,605	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	9,637,789	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	28,786,571	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	4	8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	8,393	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	327,834	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	4,900	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	67,706	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	13,957	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (AUXILIARY)	24,600	24
24.01	OTHER (DIABETES INSTRUCTION)	22,528	24.01
24.02	OTHER (HOUSEKEEPING)	74	24.02
24.03	OTHER (PHYSICIAN APPLICATION)	2,000	24.03
24.04	OTHER (RENTAL INCOME-900 W TEMPLE (EMC))	461,791	24.04
24.05	OTHER (RECYCLING)	1,927	24.05
24.06	OTHER (UNCLAIMED PROPERTY)	2,445	24.06
24.07	OTHER (PHYSICIAN DUES)	20,300	24.07
24.08	OTHER (PERSONNEL - NAME TAGS)	135	24.08
24.09	OTHER (LIFELINE - HOME CARE)		24.09
24.10	OTHER (MEDICAL OFFICE - INHOUSE)		24.10
24.11	OTHER (RENTAL INCOME)	66,100	24.11
24.12	OTHER (HOUSEKEEPING-900 W TEMPLE (EMC))	9,870	24.12
24.13	OTHER (NEUROLOGY - EEG)	1,265	24.13
24.14	OTHER (SPIRIT COMMITTEE ACTIVITIES)	33,296	24.14
24.15	OTHER (ASSETS RELEASED FOR OPERATIONS)	5,558	24.15
24.16	OTHER (COMMUNITY SERVICES - IN SERVICE)	2,413	24.16
24.17	OTHER (PATIENT SERVICES)		24.17
24.18	OTHER (QUALITY OKLAHOMA STUDY)		24.18
24.19	OTHER (PET SCAN ALLIANCE IMAGING SALARIES)	6,545	24.19
24.20	OTHER (RADIATION ONCOLOGY CARLE RN SALARIE)		24.20
24.21	OTHER (RADIATION ONCOLOGY - RN BENEFITS)		24.21
24.22	OTHER (RADIATION ONCOLOGY - RENT)		24.22
24.23	OTHER (ASPR)	26,278	24.23
24.24	OTHER (NUC MED REIMBURSEMENT STUDENT FEES)		24.24
24.25	OTHER (IHA GRANT T1)	13,175	24.25
24.26	OTHER (PHYSICAL THERAPY)	1,045	24.26
24.27	OTHER (LAB-SURVEILLANCE PROGRAM)	525	24.27
24.28	OTHER (RADIOLOGY FILM/SCRAP)	3,995	24.28
24.99	OTHER (GAIN/LOSS ON SALE OF FIXED ASSETS)		24.99
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	29,915,230	25
26	TOTAL (LINE 5 PLUS LINE 25)	39,553,019	26
27	OTHER EXPENSES (GAIN/LOSS ON SALE OF FIXED ASSETS)	61,019	27
27.01	OTHER EXPENSES (RENTAL PROPERTIES DEPRECIATION)	53,411	27.01
27.02	OTHER EXPENSES (RENTAL PROPERTIES EXPENSE)	94,073	27.02
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	208,503	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	39,344,516	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7661

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
1 GENERAL SERVICE COST CENTER						
2 CAPITAL RELATED-BLDGS & FIXTURES						1
3 CAPITAL RELATED-MOVABLE EQUIPMENT						2
4 PLANT OPERATION & MAINTENANCE					25,185	25,185
5 TRANSPORTATION (SEE INSTRUCTIONS)						4
6 ADMINISTRATIVE AND GENERAL	89,360		417	2,483	30,404	122,664
7 HHA REIMBURSABLE SERVICES						
8 SKILLED NURSING CARE	523,106		35,503			558,609
9 PHYSICAL THERAPY	86,432		5,869			92,301
10 OCCUPATIONAL THERAPY	9,205		3,718			12,923
11 SPEECH PATHOLOGY	2,452		738			3,190
12 MEDICAL SOCIAL SERVICES	4,205		619			4,824
13 HOME HEALTH AIDE	50,461		14,199			64,660
14 SUPPLIES (SEE INSTRUCTIONS)					41,327	41,327
15 DRUGS						13
16 DME						14
17 HHA NONREIMBURSABLE SERVICES						
18 HOME DIALYSIS AIDE SERVICES						15
19 RESPIRATORY THERAPY						16
20 PRIVATE DUTY NURSING						17
21 CLINIC						18
22 HEALTH PROMOTION ACTIVITIES						19
23 DAY CARE PROGRAM						20
24 HOME DELIVERED MEALS PROGRAM						21
25 HOMEMAKER SERVICE						22
26 ALL OTHERS						23
27 TOTAL (SUM OF LINES 1-23)	765,221		61,063	2,483	96,916	925,683

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7661

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3		25,185		25,185	3
4					4
5		122,664		122,664	5
6					6
7		558,609		558,609	7
8		92,301		92,301	8
9		12,923		12,923	9
10		3,190		3,190	10
11		4,824		4,824	11
12		64,660		64,660	12
13		41,327		41,327	13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24		925,683		925,683	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7661

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6
1								1
2								2
3	25,185			25,185				3
4								4
5	122,664			25,185		147,849	147,849	5
	HHA REIMBURSABLE SERVICES							
6	558,609					558,609	106,181	6
7	92,301					92,301	17,544	7
8	12,923					12,923	2,456	8
9	3,190					3,190	606	9
10	4,824					4,824	917	10
11	64,660					64,660	12,290	11
12	41,327					41,327	7,855	12
13								13
14								14
	HHA NONREIMBURSABLE SERVICES							
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24	925,683			25,185		925,683		24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7661

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE			1,338				3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES			1,338		-147,849	777,834	5
6 SKILLED NURSING CARE						558,609	6
7 PHYSICAL THERAPY						92,301	7
8 OCCUPATIONAL THERAPY						12,923	8
9 SPEECH PATHOLOGY						3,190	9
10 MEDICAL SOCIAL SERVICES						4,824	10
11 HOME HEALTH AIDE						64,660	11
12 SUPPLIES (SEE INSTRUCTIONS)						41,327	12
13 DRUGS							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)			1,338		-147,849	777,834	24
25 COST TO BE ALLOC (PER W/S H)			25,185			147,849	25
26 UNIT COST MULTIPLIER			18.822870			0.190078	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7661

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL.4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL.4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	603,174		603,174			1
2 SKILLED NURSING CARE	816,832		816,832	433,176	1,250,008	2
3 PHYSICAL THERAPY	134,967		134,967	71,575	206,542	3
4 OCCUPATIONAL THERAPY	18,896		18,896	10,021	28,917	4
5 SPEECH PATHOLOGY	4,664		4,664	2,473	7,137	5
6 MEDICAL SOCIAL SERVICES	7,054		7,054	3,741	10,795	6
7 HOME HEALTH AIDE	94,549		94,549	50,141	144,690	7
8 SUPPLIES	60,430		60,430	32,047	92,477	8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	1,740,566		1,740,566	603,174	1,740,566	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.530313		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7661

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS MAINT. HOURS	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	1,338	21,383		765,221		372,565	11	1,338	1
2 SKILLED NURSING CARE						664,790			2
3 PHYSICAL THERAPY						109,845			3
4 OCCUPATIONAL THERAPY						15,379			4
5 SPEECH PATHOLOGY						3,796			5
6 MEDICAL SOCIAL SERVICES						5,741			6
7 HOME HEALTH AIDE						76,950			7
8 SUPPLIES						49,182			8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	1,338	21,383		765,221		1,298,248	11	1,338	20
21 TOTAL COST TO BE ALLOCATED	11,738	13,674		347,153		296,917	2,350	45,857	21
22 UNIT COST MULTIPLIER	8.772795						213.636364		22
22 UNIT COST MULTIPLIER		0.639480		0.453664		0.228706		34.272795	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7661

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	
1 ADMINISTRATIVE AND GENERAL		16,717		1,593		30,197	41,117	205	1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)		16,717		1,593		30,197	41,117	205	20
21 TOTAL COST TO BE ALLOCATED		13,849		11,917		70,401	827	200	21
22 UNIT COST MULTIPLIER							0.020113		22
22 UNIT COST MULTIPLIER		0.828438		7.480854		2.331391		0.975610	22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7661

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS (COLS. 1+2)	VISITS	COST PER VISIT (COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,250,008		1,250,008	4,144	301.64	1
2	PHYSICAL THERAPY	3	206,542		206,542	742	278.36	2
3	OCCUPATIONAL THERAPY	4	28,917		28,917	238	121.50	3
4	SPEECH PATHOLOGY	5	7,137		7,137	15	475.80	4
5	MEDICAL SOCIAL SERVICES	6	10,795		10,795	32	337.34	5
6	HOME HEALTH AIDE	7	144,690		144,690	506	285.95	6
7	TOTAL (SUM OF LINES 1-6)		1,648,089		1,648,089	5,677		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERVICES							12
13	HOME HEALTH AIDE							13
14	TOTAL (SUM OF LINES 8-13)							14

SUPPLIES AND DRUGS
 COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	RATIO	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS (COLS. 1+2)	CHARGES (FROM HHA RECORD)	(COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	92,477		92,477			15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7661

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
PATIENT SERVICES							
1 SKILLED NURSING CARE	2,506	1,621		755,910	488,958		1,244,868
2 PHYSICAL THERAPY	483	251		134,448	69,868		204,316
3 OCCUPATIONAL THERAPY	150	101		18,225	12,272		30,497
4 SPEECH PATHOLOGY	15			7,137			7,137
5 MEDICAL SOCIAL SERVICES	19	13		6,409	4,385		10,794
6 HOME HEALTH AIDE	185	298		52,901	85,213		138,114
7 TOTAL (SUM OF LINES 1-6)	3,358	2,284		975,030	660,696		1,635,726

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL PROGRAM COST (SUM OF COLS.9-10)
		PART A	SUBJECT TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	00014	2,506	1,621	8
9 PHYSICAL THERAPY	00014	483	251	9
10 OCCUPATIONAL THERAPY	00014	150	101	10
11 SPEECH PATHOLOGY	00014	15		11
12 MEDICAL SOCIAL SERVICES	00014	19	13	12
13 HOME HEALTH AIDE	00014	185	298	13
14 TOTAL (SUM OF LINES 8-13)		3,358	2,284	14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES		
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR
OTHER PATIENT SERVICES						
15 COST OF MEDICAL SUPPLIES						
16 COST OF DRUGS						

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

FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED
1 PHYSICAL THERAPY	0.690662			COL 2, LINE 2
2 OCCUPATIONAL THERAPY	0.652430			COL 2, LINE 3
3 SPEECH PATHOLOGY				COL 2, LINE 4
4 MEDICAL SUPPLIES CHRGED TO PAT	0.122714			COL 2, LINE 15
5 DRUGS CHARGED TO PATIENTS	0.221338			COL 2, LINE 16

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7661

WORKSHEET H-4
 PARTS I & II

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER		1,998,392		1
3	CAPITAL DRG OUTLIER PAYMENTS		18,081		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		63.85		3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)				4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)				5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)				6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)				7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)				8
10	SUM OF LINES 7 AND 8				9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)				10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)				11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)		2,016,473		12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL (COLS.0-4)	SUBTOTAL 24	I&R COST &	TOTAL 26
	NARY CAP- REL COSTS 0			POST STEP- DOWN ADJS 25	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.01 ULTRASOUND					54.01
54.02 NUCLEAR MEDICINE-DIAGNOSTIC					54.02
54.04 RADIATION ONC					54.04
54.06 PET SCAN					54.06
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR					58
59 CARDIAC CATHETERIZATION					59
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
69 ELECTROCARDIOLOGY					69
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGED TO PAT					71
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76 BACTERIOLOGY & MICROBIOLOGY					76
76.01 VASCULAR LAB					76.01
76.02 CARDIAC REHAB					76.02
76.03 WOUND CARE					76.03
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 PHILANTHROPY DEVELOPMENT					194
194.01 VENDING					194.01
194.02 MEALS ON WHEELS					194.02
194.03 PRAIRIE CARDIOVASCULAR					194.03

PROVIDER CCN: 14-0032 ST. ANTHONY'S MEMORIAL HOSPITA
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
01/30/2012 15:15

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

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