KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

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. [X] ELECTRONICALLY FILED COST REPORT DATE: 05/28/2014 TIME: 19:14 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [ ] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED	6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN
		10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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. BERNARD HOSPITAL (14-0103) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		1,122,016	-30,947	33,531		1
2	SUBPROVIDER - IPF		-100,251	-4			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		1,021,765	-30,951	33,531		200

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 64TH & DAN RYAN	P.O. BOX:		1
2	CITY: CHICAGO	STATE: IL	ZIP CODE: 60621	COUNTY: COOK 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	ST. BERNARD HOSPITAL	14-0103	16974	1	07/01/1967	N	P	P	3
4	SUBPROVIDER - IPF	ST. BERNARD HOSPITAL PSYCH UNIT	14-S103	16974	4	01/01/1994	N	P	P	4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013							20
21	TYPE OF CONTROL (see instructions)	1								21

	INPATIENT PPS INFORMATION	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 FACILTY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	Y	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)	N	N	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N	23

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	10,669		73		3,739		24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.	1		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS 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

	1	2	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
		1	2	3	4	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)						
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)					62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)					62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS						
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N				63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				66

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

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

	INPATIENT PSYCHIATRIC FACILITY PPS	1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, 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.	N			71

	INPATIENT REHABILITATION FACILITY PPS	1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, 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.			86

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WORKSHEET S-2
PART I

				V	XIX	
TITLE V AND XIX SERVICES				1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92
93	DOES THIS FACILITY OPERATE AN ICF/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				1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					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
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N	109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'		N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.					118
			PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		121
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.			N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					134

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

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N		140

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

141	NAME:	CONTRACTOR'S NAME:		CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:			142
143	CITY:	STATE:	ZIP CODE:		143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

		TITLE XVIII				
		PART A	PART B	TITLE V	TITLE XIX	
			1	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N		N	156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

MULTICAMPUS

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)				168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00			169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)		05/01/2013	07/31/2014	170

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3

		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		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.	N			5

		Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES		1	2	
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.	Y		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

BAD DEBTS		Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14

BED COMPLEMENT			
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		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)	Y	04/30/2014	Y	04/30/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

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

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

		Y/N	DATE	
HOME OFFICE COSTS		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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: JANE	LAST NAME: BACHMANN	TITLE: CONSULTANT	41
42	EMPLOYER: BACHMANN ASSOCIATES			42
43	PHONE NUMBER: 3122852828	E-MAIL ADDRESS: JBOPIL@ATT.NET		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	148	54,020			7,147	7,627	20,178	1
2	HMO AND OTHER (see instructions)						883	4,573		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		148	54,020			7,147	7,627	20,178	7
8	INTENSIVE CARE UNIT	31	10	3,650			1,089	1,078	3,261	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						1,113	2,845	13
14	TOTAL (see instructions)		158	57,670			8,236	9,818	26,284	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	40	14,600			2,662	6,585	11,494	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		198							27
28	OBSERVATION BED DAYS							539	1,753	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							90	172	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,633	2,512	5,933	1
2	HMO AND OTHER (see instructions)					148			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)	3.95	677.39			1,633	2,512	5,933	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		42.95			329	879	1,542	16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)	3.95	720.34						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	39,576,303	327	39,576,630	1,504,064.00	26.31	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		178,234		178,234	2,088.00	85.36	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)		484,595		484,595	8,248.00	58.75	7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		2,681,209	686,512	3,367,721	130,975.00	25.71	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		2,339,153		2,339,153	62,309.00	37.54	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		4,000		4,000	30.00	133.33	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		9,037,563		9,037,563			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		878,842		878,842			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		23,648		23,648			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		206,033		206,033	8,352.00	24.67	26
27	ADMINISTRATIVE & GENERAL		5,462,051	-91,462	5,370,589	177,097.00	30.33	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		339,872		339,872	1,246.00	272.77	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		1,495,010		1,495,010	78,175.00	19.12	30
31	LAUNDRY & LINEN SERVICE		84,371		84,371	6,243.00	13.51	31
32	HOUSEKEEPING		1,261,947		1,261,947	104,108.00	12.12	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		800,497	-372,377	428,120	35,124.00	12.19	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			354,968	354,968	28,942.00	12.26	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		905,627		905,627	23,448.00	38.62	38
39	CENTRAL SERVICES AND SUPPLY		326,170		326,170	21,047.00	15.50	39
40	PHARMACY		1,251,782		1,251,782	41,426.00	30.22	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		592,679		592,679	35,475.00	16.71	41
42	SOCIAL SERVICE		795,792	-246,267	549,525	16,967.00	32.39	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	39,253,346	327	39,253,673	1,494,974.00	26.26	1
2	EXCLUDED AREA SALARIES (see instructions)	2,681,209	686,512	3,367,721	130,975.00	25.71	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	36,572,137	-686,185	35,885,952	1,363,999.00	26.31	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	2,343,153		2,343,153	62,339.00	37.59	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	9,037,563		9,037,563		25.18%	5
6	TOTAL (sum of lines 3 through 5)	47,952,853	-686,185	47,266,668	1,426,338.00	33.14	6
7	TOTAL OVERHEAD COST (see instructions)	13,521,831	-355,138	13,166,693	577,650.00	22.79	7

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HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	751,586	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	5,540,416	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	77,973	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	110,539	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	473,467	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	2,891,705	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	86,871	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	7,496	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	9,940,053	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

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

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE	09/30/2016		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2012	12/31/2012	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	7/01/2012		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	1/01/2011		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	1/01/2014		5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE	01/01/2012		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	1/01/2011		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	1/01/2014		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	2,339,153		1
2	HOSPITAL	2,339,153		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.405269	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	19,765,711	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID	23,949,486	5
6	MEDICAID CHARGES	91,484,136	6
7	MEDICAID COST (line 1 times line 6)	37,075,684	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

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 (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	16,993,260		16,993,260	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	6,886,841		6,886,841	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	6,886,841		6,886,841	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)	809,688	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	556,458	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	253,230	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	102,626	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	6,989,467	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	6,989,467	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		3,901,650	3,901,650	-2,091,995	1,809,655		1,809,655	1
2	00200	CAP REL COSTS-MVBLE EQUIP				2,798,361	2,798,361	-41,669	2,756,692	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	206,033	7,001,838	7,207,871	-4,568	7,203,303		7,203,303	4
5	00500	ADMINISTRATIVE & GENERAL	5,462,051	10,739,324	16,201,375	-165,625	16,035,750	-7,761,888	8,273,862	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	1,495,010	3,418,106	4,913,116	-253,989	4,659,127	-87,782	4,571,345	7
8	00800	LAUNDRY & LINEN SERVICE	84,371	381,461	465,832		465,832		465,832	8
9	00900	HOUSEKEEPING	1,261,947	505,551	1,767,498		1,767,498		1,767,498	9
10	01000	DIETARY	800,497	1,835,850	2,636,347	-1,194,171	1,442,176	-435,938	1,006,238	10
11	01100	CAFETERIA				1,169,047	1,169,047		1,169,047	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	905,627	243,030	1,148,657	-1,773	1,146,884		1,146,884	13
14	01400	CENTRAL SERVICES & SUPPLY	326,170	401,903	728,073	-282,079	445,994		445,994	14
15	01500	PHARMACY	1,251,782	1,497,690	2,749,472	-1,363,476	1,385,996		1,385,996	15
16	01600	MEDICAL RECORDS & LIBRARY	592,679	465,424	1,058,103	-6,666	1,051,437	-84,783	966,654	16
17	01700	SOCIAL SERVICE	795,792	265,434	1,061,226	-246,267	814,959		814,959	17
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				484,595	484,595		484,595	22
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	10,560,864	4,097,236	14,658,100	-3,543,607	11,114,493	-1,672,784	9,441,709	30
31	03100	INTENSIVE CARE UNIT	2,177,803	485,281	2,663,084	-286,684	2,376,400		2,376,400	31
40	04000	SUBPROVIDER - IPF	2,324,745	276,788	2,601,533	619,095	3,220,628		3,220,628	40
43	04300	NURSERY	303	379,217	379,520	1,604,816	1,984,336	-264,915	1,719,421	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	1,288,842	751,987	2,040,829	-483,193	1,557,636		1,557,636	50
52	05200	DELIVERY ROOM & LABOR ROOM	777	195,583	196,360	1,178,217	1,374,577		1,374,577	52
53	05300	ANESTHESIOLOGY	21,666	1,568,578	1,590,244	-78,335	1,511,909	-1,462,260	49,649	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,157,170	771,214	2,928,384	-10,030	2,918,354		2,918,354	54
60	06000	LABORATORY	2,160,682	2,323,432	4,484,114	-130,013	4,354,101	-210,352	4,143,749	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY		1,585,715	1,585,715	146,226	1,731,941		1,731,941	65
66	06600	PHYSICAL THERAPY	326,503	39,480	365,983		365,983		365,983	66
69	06900	ELECTROCARDIOLOGY		150,792	150,792	-150,792				69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				2,021,560	2,021,560		2,021,560	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				221,416	221,416		221,416	72
73	07300	DRUGS CHARGED TO PATIENTS				1,326,433	1,326,433		1,326,433	73
74	07400	RENAL DIALYSIS	-327	294,516	294,189		294,189		294,189	74
76.97	07697	CARDIAC REHABILITATION								76.97
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	656,806	931,463	1,588,269	-3,250	1,585,019	-1,050,773	534,246	90
91	09100	EMERGENCY	4,362,046	4,954,931	9,316,977	-1,342,460	7,974,517	-3,400,107	4,574,410	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		55,400	55,400	-55,400				113
192	19200	PHYSICIANS' PRIVATE OFFICES	161,368	262,545	423,913		423,913		423,913	192
194	07950	OUTPATIENT PHARMACY	195,096	658,300	853,396		853,396		853,396	194
194.01	07951	PUBLIC RELATIONS				124,607	124,607		124,607	194.01
200		TOTAL (sum of lines 118-199)	39,576,303	50,439,719	90,016,022		90,016,022	-16,473,251	73,542,771	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASSIFY POST PARTUM	A	NURSERY	43	1,505,097	191,126	1
2			DELIVERY ROOM & LABOR ROOM	52	1,190,003	151,113	2
500	TOTAL RECLASSIFICATIONS				2,695,100	342,239	500
	CODE LETTER - A						
1	RECLASSIFY INTERNS & RESIDENTS	B	I&R SERVICES-OTHER PRGM COSTS	22		484,595	1
500	TOTAL RECLASSIFICATIONS					484,595	500
	CODE LETTER - B						
1	RECLASSIFY MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		118,948	1
500	TOTAL RECLASSIFICATIONS					118,948	500
	CODE LETTER - C						
1	RECLASSIFY DRUGS SOLD	D	DRUGS CHARGED TO PATIENTS	73		1,326,433	1
2			MEDICAL SUPPLIES CHARGED TO P	71		37,043	2
500	TOTAL RECLASSIFICATIONS					1,363,476	500
	CODE LETTER - D						
1	RECLASSIFY DIETARY COSTS	E	SUBPROVIDER - IPF	40	17,409	1,306	1
500	TOTAL RECLASSIFICATIONS				17,409	1,306	500
	CODE LETTER - E						
1	RECLASSIFY SOCIAL SERVICE	F	EMERGENCY	91	6,031		1
2			SUBPROVIDER - IPF	40	240,236		2
500	TOTAL RECLASSIFICATIONS				246,267		500
	CODE LETTER - F						
1	RECLASSIFY EMERGENCY ROOM	G	SUBPROVIDER - IPF	40	337,405	25,305	1
500	TOTAL RECLASSIFICATIONS				337,405	25,305	500
	CODE LETTER - G						
1	RECLASSIFY DEPRECIATION	H	CAP REL COSTS-MVBLE EQUIP	2		2,252,418	1
500	TOTAL RECLASSIFICATIONS					2,252,418	500
	CODE LETTER - H						
1	RECLASSIFY PROPERTY INSURANCE	I	CAP REL COSTS-BLDG & FIXT	1		160,423	1
500	TOTAL RECLASSIFICATIONS					160,423	500
	CODE LETTER - I						
1	RECLASSIFY INTEREST EXPENSE	J	CAP REL COSTS-MVBLE EQUIP	2		55,400	1
500	TOTAL RECLASSIFICATIONS					55,400	500
	CODE LETTER - J						
1	RECLASSIFY EQUIPMENT RENTAL	K	CAP REL COSTS-MVBLE EQUIP	2		490,543	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
500	TOTAL RECLASSIFICATIONS					490,543	500
	CODE LETTER - K						
1	RECLASSIFY CAFETERIA COSTS	L	CAFETERIA	11	354,968	814,079	1
500	TOTAL RECLASSIFICATIONS				354,968	814,079	500
	CODE LETTER - L						
1	RECLASS EKG COSTS	M	RESPIRATORY THERAPY	65		150,792	1
500	TOTAL RECLASSIFICATIONS					150,792	500
	CODE LETTER - M						
1	TO ZERO OUT NEGATIVE SALARIES	N	RENAL DIALYSIS	74	327		1
500	TOTAL RECLASSIFICATIONS				327		500
	CODE LETTER - N						
1	RECLASS MEDICAL SUPPLIES EXP	O	MEDICAL SUPPLIES CHARGED TO P	71		2,086,985	1

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	TOTAL RECLASSIFICATIONS					2,086,985	500
	CODE LETTER - O						
1	RECLASS PR COSTS	P	PUBLIC RELATIONS	194.01	91,462	33,145	1
500	TOTAL RECLASSIFICATIONS				91,462	33,145	500
	CODE LETTER - P						
1	RECLASS IMPLANT COSTS	Q	IMPL. DEV. CHARGED TO PATIENT	72		221,416	1
500	TOTAL RECLASSIFICATIONS					221,416	500
	CODE LETTER - Q						
	GRAND TOTAL (INCREASES)				3,742,938	8,601,070	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASSIFY POST PARTUM	A	ADULTS & PEDIATRICS	30	1,505,097	191,126		1
2			ADULTS & PEDIATRICS	30	1,190,003	151,113		2
500	TOTAL RECLASSIFICATIONS				2,695,100	342,239		500
	CODE LETTER - A							
1	RECLASSIFY INTERNS & RESIDENTS	B	EMERGENCY	91		484,595		1
500	TOTAL RECLASSIFICATIONS					484,595		500
	CODE LETTER - B							
1	RECLASSIFY MEDICAL SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		118,948		1
500	TOTAL RECLASSIFICATIONS					118,948		500
	CODE LETTER - C							
1	RECLASSIFY DRUGS SOLD	D	PHARMACY	15		1,326,433		1
2			PHARMACY	15		37,043		2
500	TOTAL RECLASSIFICATIONS					1,363,476		500
	CODE LETTER - D							
1	RECLASSIFY DIETARY COSTS	E	DIETARY	10	17,409	1,306		1
500	TOTAL RECLASSIFICATIONS				17,409	1,306		500
	CODE LETTER - E							
1	RECLASSIFY SOCIAL SERVICE	F	SOCIAL SERVICE	17	6,031			1
2			SOCIAL SERVICE	17	240,236			2
500	TOTAL RECLASSIFICATIONS				246,267			500
	CODE LETTER - F							
1	RECLASSIFY EMERGENCY ROOM	G	EMERGENCY	91	337,405	25,305		1
500	TOTAL RECLASSIFICATIONS				337,405	25,305		500
	CODE LETTER - G							
1	RECLASSIFY DEPRECIATION	H	CAP REL COSTS-BLDG & FIXT	1		2,252,418	9	1
500	TOTAL RECLASSIFICATIONS					2,252,418		500
	CODE LETTER - H							
1	RECLASSIFY PROPERTY INSURANCE	I	OPERATION OF PLANT	7		160,423	12	1
500	TOTAL RECLASSIFICATIONS					160,423		500
	CODE LETTER - I							
1	RECLASSIFY INTEREST EXPENSE	J	INTEREST EXPENSE	113		55,400	11	1
500	TOTAL RECLASSIFICATIONS					55,400		500
	CODE LETTER - J							
1	RECLASSIFY EQUIPMENT RENTAL	K	ADMINISTRATIVE & GENERAL	5		41,018	10	1
2			EMPLOYEE BENEFITS DEPARTMENT	4		4,568		2
3			OPERATION OF PLANT	7		93,566		3
4			DIETARY	10		6,409		4
5			NURSING ADMINISTRATION	13		1,773		5
6			ADULTS & PEDIATRICS	30		14,354		6
7			INTENSIVE CARE UNIT	31		139		7
8			CENTRAL SERVICES & SUPPLY	14		163,131		8
9			MEDICAL RECORDS & LIBRARY	16		6,666		9
10			NURSERY	43		92		10
11			DELIVERY ROOM & LABOR ROOM	52		1,171		11
12			SUBPROVIDER - IPF	40		2,566		12
13			OPERATING ROOM	50		4,756		13
14			CLINIC	90		3,250		14
15			RADIOLOGY-DIAGNOSTIC	54		10,030		15
16			LABORATORY	60		130,013		16
17			EMERGENCY	91		7,041		17
500	TOTAL RECLASSIFICATIONS					490,543		500
	CODE LETTER - K							
1	RECLASSIFY CAFETERIA COSTS	L	DIETARY	10	354,968	814,079		1
500	TOTAL RECLASSIFICATIONS				354,968	814,079		500
	CODE LETTER - L							
1	RECLASS EKG COSTS	M	ELECTROCARDIOLOGY	69		150,792		1
500	TOTAL RECLASSIFICATIONS					150,792		500
	CODE LETTER - M							
1	TO ZERO OUT NEGATIVE SALARIES	N	RENAL DIALYSIS	74		327		1
500	TOTAL RECLASSIFICATIONS					327		500
	CODE LETTER - N							

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASS MEDICAL SUPPLIES EXP	O	ADULTS & PEDIATRICS	30		491,914		1
2			INTENSIVE CARE UNIT	31		286,545		2
3			NURSERY	43		91,315		3
4			OPERATING ROOM	50		478,437		4
5			ANESTHESIOLOGY	53		78,335		5
6			RESPIRATORY THERAPY	65		4,566		6
7			EMERGENCY	91		494,145		7
8			DELIVERY ROOM & LABOR ROOM	52		161,728		8
500	TOTAL RECLASSIFICATIONS					2,086,985		500
	CODE LETTER - O							
1	RECLASS PR COSTS	P	ADMINISTRATIVE & GENERAL	5	91,462	33,145		1
500	TOTAL RECLASSIFICATIONS				91,462	33,145		500
	CODE LETTER - P							
1	RECLASS IMPLANT COSTS	Q	MEDICAL SUPPLIES CHARGED TO P	71		221,416		1
500	TOTAL RECLASSIFICATIONS					221,416		500
	CODE LETTER - Q							
	GRAND TOTAL (DECREASES)				3,742,611	8,601,397		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	2,192,754					2,192,754		1
2	LAND IMPROVEMENTS	3,268,156	15,000		15,000		3,283,156		2
3	BUILDINGS AND FIXTURES	43,252,827	1,340,383		1,340,383		44,593,210		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	39,684,201	1,254,634		1,254,634		40,938,835		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	88,397,938	2,610,017		2,610,017		91,007,955		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	88,397,938	2,610,017		2,610,017		91,007,955		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	3,901,650						3,901,650	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	3,901,650						3,901,650	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	50,069,120		50,069,120	0.550162					1
2	CAP REL COSTS-MVBLE EQU	40,938,835		40,938,835	0.449838					2
3	TOTAL (sum of lines 1-2)	91,007,955		91,007,955	1.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,649,232			160,423			1,809,655	1
2	CAP REL COSTS-MVBLE EQUIP	2,252,418	490,543	13,731				2,756,692	2
3	TOTAL (sum of lines 1-2)	3,901,650	490,543	13,731	160,423			4,566,347	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)	B	-41,669	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	B	-68	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-7,048,800				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-435,938	DIETARY	10		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-84,783	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-27,482	OPERATION OF PLANT	7		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	SISTERS MAINTENANCE	B	-12,000	ADMINISTRATIVE & GENERAL	5		33
34	DISCOUNTS	B	-1,272	ADMINISTRATIVE & GENERAL	5		34
35	OFFSET PEDS MOBILE VAN EXPENSES	A	-291,098	CLINIC	90		35
36	OFFSET BITS GRANT INCOME	B	-18,885	ADULTS & PEDIATRICS	30		36
37							37
38	MISCELLANEOUS REVENUE	B	-88,437	ADMINISTRATIVE & GENERAL	5		38
39	EMPLOYEE ROOM RENTALS	B	-60,300	OPERATION OF PLANT	7		39
40	ANESTHESIOLOGIST BILLING EXPENSE	A	-28,204	ANESTHESIOLOGY	53		40
41	ER PHYSICIAN BILLING EXPENSE	A	-215,011	EMERGENCY	91		41
42	OFFSET DENTAL CLINIC COSTS	A	-462,006	CLINIC	90		42
43	OFFSET OTHER LOBBYING COSTS	A	-260,000	ADMINISTRATIVE & GENERAL	5		43
44							44
45	OFFSET PROVIDER TAX	A	-7,397,298	ADMINISTRATIVE & GENERAL	5		45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-16,473,251				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12							5

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

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS AGGREGATE	1,653,899	1,653,899						1
2	43	NURSERY AGGREGATE	264,915	264,915						2
3	53	ANESTHESIOLOGY AGGREGATE	1,434,056	1,434,056						3
4	60	LABORATORY AGGREGATE	210,352	210,352						4
5	91	EMERGENCY AGGREGATE	3,185,096	3,185,096						5
6	90	CLINIC AGGREGATE	297,669	297,669						6
7	5	ADMINISTRATIVE & GEN	6,000		6,000	221,000	30	3,187	159	7
200		TOTAL	7,051,987	7,045,987	6,000		30	3,187	159	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS AGGREGATE							1,653,899	1
2	43	NURSERY AGGREGATE							264,915	2
3	53	ANESTHESIOLOGY AGGREGATE							1,434,056	3
4	60	LABORATORY AGGREGATE							210,352	4
5	91	EMERGENCY AGGREGATE							3,185,096	5
6	90	CLINIC AGGREGATE							297,669	6
7	5	ADMINISTRATIVE & GEN					3,187	2,813	2,813	7
200		TOTAL					3,187	2,813	7,048,800	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,809,655	1,809,655					1
2	CAP REL COSTS-MVBLE EQUIP	2,756,692		2,756,692				2
4	EMPLOYEE BENEFITS DEPARTMENT	7,203,303	4,385	6,679	7,214,367			4
5	ADMINISTRATIVE & GENERAL	8,273,862	595,870	907,702	984,123	10,761,557	10,761,557	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	4,571,345	253,115	385,576	273,950	5,483,986	940,032	7
8	LAUNDRY & LINEN SERVICE	465,832	9,908	15,093	15,460	506,293	86,786	8
9	HOUSEKEEPING	1,767,498	23,182	35,314	231,243	2,057,237	352,639	9
10	DIETARY	1,006,238	30,340	46,218	78,450	1,161,246	199,054	10
11	CAFETERIA	1,169,047	12,918	19,678	65,045	1,266,688	217,128	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,146,884	22,011	33,530	165,950	1,368,375	234,559	13
14	CENTRAL SERVICES & SUPPLY	445,994	14,802	22,548	59,768	543,112	93,097	14
15	PHARMACY	1,385,996	12,362	18,831	229,380	1,646,569	282,245	15
16	MEDICAL RECORDS & LIBRARY	966,654	45,901	69,923	108,604	1,191,082	204,168	16
17	SOCIAL SERVICE	814,959	7,153	10,897	100,697	933,706	160,050	17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	484,595				484,595	83,066	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	9,441,709	196,866	299,890	1,441,329	11,379,794	1,950,632	30
31	INTENSIVE CARE UNIT	2,376,400	37,151	56,593	399,067	2,869,211	491,823	31
40	SUBPROVIDER - IPF	3,220,628	76,561	116,627	535,032	3,948,848	676,888	40
43	NURSERY	1,719,421	10,038	15,291	275,854	2,020,604	346,360	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,557,636	73,056	111,288	236,171	1,978,151	339,083	50
52	DELIVERY ROOM & LABOR ROOM	1,374,577	29,910	45,562	218,202	1,668,251	285,962	52
53	ANESTHESIOLOGY	49,649	2,584	3,936	3,970	60,139	10,309	53
54	RADIOLOGY-DIAGNOSTIC	2,918,354	37,822	57,615	395,286	3,409,077	584,364	54
60	LABORATORY	4,143,749	44,452	67,715	395,930	4,651,846	797,392	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,731,941	30,849	46,994		1,809,784	310,222	65
66	PHYSICAL THERAPY	365,983	13,436	20,468	59,829	459,716	78,802	66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,021,560				2,021,560	346,524	71
72	IMPL. DEV. CHARGED TO PATIENTS	221,416				221,416	37,954	72
73	DRUGS CHARGED TO PATIENTS	1,326,433				1,326,433	227,369	73
74	RENAL DIALYSIS	294,189				294,189	50,428	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	534,246	17,723	26,999	120,355	699,323	119,874	90
91	EMERGENCY	4,574,410	64,009	97,507	738,592	5,474,518	938,409	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	72,140,855	1,666,404	2,538,474	7,132,287	71,697,306	10,445,219	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	423,913	138,565	211,080	29,570	803,128	137,667	192
194	OUTPATIENT PHARMACY	853,396	4,686	7,138	35,750	900,970	154,439	194
194.01	PUBLIC RELATIONS	124,607			16,760	141,367	24,232	194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	73,542,771	1,809,655	2,756,692	7,214,367	73,542,771	10,761,557	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	6,424,018						7
8	LAUNDRY & LINEN SERVICE	66,559	659,638					8
9	HOUSEKEEPING	155,731		2,565,607				9
10	DIETARY	203,815		84,317	1,648,432			10
11	CAFETERIA	86,776		35,899		1,606,491		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	147,862		61,169		35,504	1,847,469	13
14	CENTRAL SERVICES & SUPPLY	99,435		41,135		31,869		14
15	PHARMACY	83,044		34,355		62,726		15
16	MEDICAL RECORDS & LIBRARY	308,351		127,562		53,715		16
17	SOCIAL SERVICE	48,053		19,879		25,704		17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,322,481	352,326	547,101	919,628	432,092	706,056	30
31	INTENSIVE CARE UNIT	249,567	56,940	103,244	122,813	87,449	142,895	31
40	SUBPROVIDER - IPF	514,312	200,696	212,767	605,991	177,048	289,311	40
43	NURSERY	67,430	49,676	27,895		75,024	122,592	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	490,767		203,027		64,306	105,079	50
52	DELIVERY ROOM & LABOR ROOM	200,923		83,120		59,311	96,917	52
53	ANESTHESIOLOGY	17,355		7,180		2,687		53
54	RADIOLOGY-DIAGNOSTIC	254,077		105,110		114,639		54
60	LABORATORY	298,616		123,535		117,611		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	207,236		85,732				65
66	PHYSICAL THERAPY	90,260		37,340		14,986		66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	119,061		49,254		37,465	61,219	90
91	EMERGENCY	429,993		177,885		197,915	323,400	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	5,461,704	659,638	2,167,506	1,648,432	1,590,051	1,847,469	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	930,838		385,080				192
194	OUTPATIENT PHARMACY	31,476		13,021		10,117		194
194.01	PUBLIC RELATIONS					6,323		194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	6,424,018	659,638	2,565,607	1,648,432	1,606,491	1,847,469	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	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	808,648						14
15	PHARMACY		2,108,939					15
16	MEDICAL RECORDS & LIBRARY			1,884,878				16
17	SOCIAL SERVICE				1,187,392			17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					567,661		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	159,656	34,391	346,983	634,210		18,785,350	30
31	INTENSIVE CARE UNIT	94,066	6,985	73,190	102,496		4,400,679	31
40	SUBPROVIDER - IPF	11,128	5,160	132,098	361,265		7,135,512	40
43	NURSERY	30,353	12,365	51,799	89,421		2,893,519	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	157,059	26,568	58,948			3,422,988	50
52	DELIVERY ROOM & LABOR ROOM	53,091	8,702	10,187			2,466,464	52
53	ANESTHESIOLOGY	25,715	19,425	10,125			152,935	53
54	RADIOLOGY-DIAGNOSTIC	30,141	76	212,406			4,709,890	54
60	LABORATORY	21,157	91	450,791			6,461,039	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,499		116,204			2,530,677	65
66	PHYSICAL THERAPY	863		6,740			688,707	66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,048	877	79,947			2,487,956	71
72	IMPL. DEV. CHARGED TO PATIENTS			4,046			263,416	72
73	DRUGS CHARGED TO PATIENTS	12,160	1,324,117	159,296			3,049,375	73
74	RENAL DIALYSIS		1,244	23,217			369,078	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	10,110	281	4,536			1,101,123	90
91	EMERGENCY	162,216	27,665	144,365		567,661	8,444,027	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	808,262	1,467,947	1,884,878	1,187,392	567,661	69,362,735	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	370	8				2,257,091	192
194	OUTPATIENT PHARMACY	16	640,984				1,751,023	194
194.01	PUBLIC RELATIONS						171,922	194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	808,648	2,108,939	1,884,878	1,187,392	567,661	73,542,771	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	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
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		18,785,350					30
31	INTENSIVE CARE UNIT		4,400,679					31
40	SUBPROVIDER - IPF		7,135,512					40
43	NURSERY		2,893,519					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		3,422,988					50
52	DELIVERY ROOM & LABOR ROOM		2,466,464					52
53	ANESTHESIOLOGY		152,935					53
54	RADIOLOGY-DIAGNOSTIC		4,709,890					54
60	LABORATORY		6,461,039					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		2,530,677					65
66	PHYSICAL THERAPY		688,707					66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,487,956					71
72	IMPL. DEV. CHARGED TO PATIENTS		263,416					72
73	DRUGS CHARGED TO PATIENTS		3,049,375					73
74	RENAL DIALYSIS		369,078					74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		1,101,123					90
91	EMERGENCY	-567,661	7,876,366					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	-567,661	68,795,074					118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		2,257,091					192
194	OUTPATIENT PHARMACY		1,751,023					194
194.01	PUBLIC RELATIONS		171,922					194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	-567,661	72,975,110					202

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ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		4,385	6,679	11,064	11,064		4
5	ADMINISTRATIVE & GENERAL		595,870	907,702	1,503,572	1,509	1,505,081	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		253,115	385,576	638,691	420	131,468	7
8	LAUNDRY & LINEN SERVICE		9,908	15,093	25,001	24	12,137	8
9	HOUSEKEEPING		23,182	35,314	58,496	355	49,318	9
10	DIETARY		30,340	46,218	76,558	120	27,839	10
11	CAFETERIA		12,918	19,678	32,596	100	30,366	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		22,011	33,530	55,541	254	32,804	13
14	CENTRAL SERVICES & SUPPLY		14,802	22,548	37,350	92	13,020	14
15	PHARMACY		12,362	18,831	31,193	352	39,473	15
16	MEDICAL RECORDS & LIBRARY		45,901	69,923	115,824	167	28,554	16
17	SOCIAL SERVICE		7,153	10,897	18,050	154	22,384	17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						11,617	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		196,866	299,890	496,756	2,210	272,832	30
31	INTENSIVE CARE UNIT		37,151	56,593	93,744	612	68,784	31
40	SUBPROVIDER - IPF		76,561	116,627	193,188	820	94,666	40
43	NURSERY		10,038	15,291	25,329	423	48,440	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		73,056	111,288	184,344	362	47,422	50
52	DELIVERY ROOM & LABOR ROOM		29,910	45,562	75,472	335	39,993	52
53	ANESTHESIOLOGY		2,584	3,936	6,520	6	1,442	53
54	RADIOLOGY-DIAGNOSTIC		37,822	57,615	95,437	606	81,726	54
60	LABORATORY		44,452	67,715	112,167	607	111,519	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		30,849	46,994	77,843		43,386	65
66	PHYSICAL THERAPY		13,436	20,468	33,904	92	11,021	66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						48,463	71
72	IMPL. DEV. CHARGED TO PATIENTS						5,308	72
73	DRUGS CHARGED TO PATIENTS						31,799	73
74	RENAL DIALYSIS						7,053	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		17,723	26,999	44,722	185	16,765	90
91	EMERGENCY		64,009	97,507	161,516	1,133	131,241	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		1,666,404	2,538,474	4,204,878	10,938	1,460,840	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		138,565	211,080	349,645	45	19,253	192
194	OUTPATIENT PHARMACY		4,686	7,138	11,824	55	21,599	194
194.01	PUBLIC RELATIONS					26	3,389	194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,809,655	2,756,692	4,566,347	11,064	1,505,081	202

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	770,579						7
8	LAUNDRY & LINEN SERVICE	7,984	45,146					8
9	HOUSEKEEPING	18,680		126,849				9
10	DIETARY	24,448		4,169	133,134			10
11	CAFETERIA	10,409		1,775		75,246		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	17,736		3,024		1,663	111,022	13
14	CENTRAL SERVICES & SUPPLY	11,927		2,034		1,493		14
15	PHARMACY	9,961		1,699		2,938		15
16	MEDICAL RECORDS & LIBRARY	36,988		6,307		2,516		16
17	SOCIAL SERVICE	5,764		983		1,204		17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	158,636	24,113	27,048	74,273	20,237	42,430	30
31	INTENSIVE CARE UNIT	29,936	3,897	5,105	9,919	4,096	8,587	31
40	SUBPROVIDER - IPF	61,693	13,736	10,520	48,942	8,293	17,386	40
43	NURSERY	8,088	3,400	1,379		3,514	7,367	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	58,869		10,038		3,012	6,315	50
52	DELIVERY ROOM & LABOR ROOM	24,101		4,110		2,778	5,824	52
53	ANESTHESIOLOGY	2,082		355		126		53
54	RADIOLOGY-DIAGNOSTIC	30,477		5,197		5,370		54
60	LABORATORY	35,820		6,108		5,509		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	24,859		4,239				65
66	PHYSICAL THERAPY	10,827		1,846		702		66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	14,282		2,435		1,755	3,679	90
91	EMERGENCY	51,579		8,795		9,270	19,434	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	655,146	45,146	107,166	133,134	74,476	111,022	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	111,657		19,039				192
194	OUTPATIENT PHARMACY	3,776		644		474		194
194.01	PUBLIC RELATIONS					296		194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	770,579	45,146	126,849	133,134	75,246	111,022	202

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	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	65,916						14
15	PHARMACY		85,616					15
16	MEDICAL RECORDS & LIBRARY			190,356				16
17	SOCIAL SERVICE				48,539			17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					11,617		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	13,014	1,396	35,030	25,926		1,193,901	30
31	INTENSIVE CARE UNIT	7,668	284	7,389	4,190		244,211	31
40	SUBPROVIDER - IPF	907	209	13,336	14,768		478,464	40
43	NURSERY	2,474	502	5,229	3,655		109,800	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	12,802	1,079	5,951			330,194	50
52	DELIVERY ROOM & LABOR ROOM	4,328	353	1,028			158,322	52
53	ANESTHESIOLOGY	2,096	789	1,022			14,438	53
54	RADIOLOGY-DIAGNOSTIC	2,457	3	21,443			242,716	54
60	LABORATORY	1,725	4	45,580			319,039	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	122		11,731			162,180	65
66	PHYSICAL THERAPY	70		680			59,142	66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,183	36	8,071			59,753	71
72	IMPL. DEV. CHARGED TO PATIENTS			408			5,716	72
73	DRUGS CHARGED TO PATIENTS	991	53,755	16,082			102,627	73
74	RENAL DIALYSIS		50	2,344			9,447	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	824	11	458			85,116	90
91	EMERGENCY	13,224	1,123	14,574			411,889	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	65,885	59,594	190,356	48,539		3,986,955	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	30					499,669	192
194	OUTPATIENT PHARMACY	1	26,022				64,395	194
194.01	PUBLIC RELATIONS						3,711	194.01
200	CROSS FOOT ADJUSTMENTS					11,617	11,617	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	65,916	85,616	190,356	48,539	11,617	4,566,347	202

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	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
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		1,193,901					30
31	INTENSIVE CARE UNIT		244,211					31
40	SUBPROVIDER - IPF		478,464					40
43	NURSERY		109,800					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		330,194					50
52	DELIVERY ROOM & LABOR ROOM		158,322					52
53	ANESTHESIOLOGY		14,438					53
54	RADIOLOGY-DIAGNOSTIC		242,716					54
60	LABORATORY		319,039					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		162,180					65
66	PHYSICAL THERAPY		59,142					66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		59,753					71
72	IMPL. DEV. CHARGED TO PATIENTS		5,716					72
73	DRUGS CHARGED TO PATIENTS		102,627					73
74	RENAL DIALYSIS		9,447					74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		85,116					90
91	EMERGENCY		411,889					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		3,986,955					118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		499,669					192
194	OUTPATIENT PHARMACY		64,395					194
194.01	PUBLIC RELATIONS		3,711					194.01
200	CROSS FOOT ADJUSTMENTS		11,617					200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		4,566,347					202

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	390,858						1
2	CAP REL COSTS-MVBLE EQUIP		390,858					2
4	EMPLOYEE BENEFITS DEPARTMENT	947	947	39,370,597				4
5	ADMINISTRATIVE & GENERAL	128,699	128,699	5,370,589	-10,761,557	62,781,214		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	54,669	54,669	1,495,010		5,483,986	206,543	7
8	LAUNDRY & LINEN SERVICE	2,140	2,140	84,371		506,293	2,140	8
9	HOUSEKEEPING	5,007	5,007	1,261,947		2,057,237	5,007	9
10	DIETARY	6,553	6,553	428,120		1,161,246	6,553	10
11	CAFETERIA	2,790	2,790	354,968		1,266,688	2,790	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	4,754	4,754	905,627		1,368,375	4,754	13
14	CENTRAL SERVICES & SUPPLY	3,197	3,197	326,170		543,112	3,197	14
15	PHARMACY	2,670	2,670	1,251,782		1,646,569	2,670	15
16	MEDICAL RECORDS & LIBRARY	9,914	9,914	592,679		1,191,082	9,914	16
17	SOCIAL SERVICE	1,545	1,545	549,525		933,706	1,545	17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					484,595		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	42,520	42,520	7,865,764		11,379,794	42,520	30
31	INTENSIVE CARE UNIT	8,024	8,024	2,177,803		2,869,211	8,024	31
40	SUBPROVIDER - IPF	16,536	16,536	2,919,795		3,948,848	16,536	40
43	NURSERY	2,168	2,168	1,505,400		2,020,604	2,168	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	15,779	15,779	1,288,842		1,978,151	15,779	50
52	DELIVERY ROOM & LABOR ROOM	6,460	6,460	1,190,780		1,668,251	6,460	52
53	ANESTHESIOLOGY	558	558	21,666		60,139	558	53
54	RADIOLOGY-DIAGNOSTIC	8,169	8,169	2,157,170		3,409,077	8,169	54
60	LABORATORY	9,601	9,601	2,160,682		4,651,846	9,601	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	6,663	6,663			1,809,784	6,663	65
66	PHYSICAL THERAPY	2,902	2,902	326,503		459,716	2,902	66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					2,021,560		71
72	IMPL. DEV. CHARGED TO PATIENTS					221,416		72
73	DRUGS CHARGED TO PATIENTS					1,326,433		73
74	RENAL DIALYSIS					294,189		74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	3,828	3,828	656,806		699,323	3,828	90
91	EMERGENCY	13,825	13,825	4,030,672		5,474,518	13,825	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	359,918	359,918	38,922,671	-10,761,557	60,935,749	175,603	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	29,928	29,928	161,368		803,128	29,928	192
194	OUTPATIENT PHARMACY	1,012	1,012	195,096		900,970	1,012	194
194.01	PUBLIC RELATIONS			91,462		141,367		194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,809,655	2,756,692	7,214,367		10,761,557	6,424,018	202
203	UNIT COST MULT-WS B PT I	4.629955	7.052925	0.183243		0.171414	31.102569	203
204	COST TO BE ALLOC PER B PT II			11,064		1,505,081	770,579	204
205	UNIT COST MULT-WS B PT II			0.000281		0.023973	3.730841	205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	37,778						8
9	HOUSEKEEPING		199,396					9
10	DIETARY		6,553	109,432				10
11	CAFETERIA		2,790		50,813			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		4,754		1,123	746,693		13
14	CENTRAL SERVICES & SUPPLY		3,197		1,008		2,463,323	14
15	PHARMACY		2,670		1,984			15
16	MEDICAL RECORDS & LIBRARY		9,914		1,699			16
17	SOCIAL SERVICE		1,545		813			17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	20,178	42,520	61,050	13,667	285,367	486,347	30
31	INTENSIVE CARE UNIT	3,261	8,024	8,153	2,766	57,754	286,545	31
40	SUBPROVIDER - IPF	11,494	16,536	40,229	5,600	116,931	33,899	40
43	NURSERY	2,845	2,168		2,373	49,548	92,461	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		15,779		2,034	42,470	478,437	50
52	DELIVERY ROOM & LABOR ROOM		6,460		1,876	39,171	161,728	52
53	ANESTHESIOLOGY		558		85		78,335	53
54	RADIOLOGY-DIAGNOSTIC		8,169		3,626		91,817	54
60	LABORATORY		9,601		3,720		64,450	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		6,663				4,566	65
66	PHYSICAL THERAPY		2,902		474		2,628	66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						118,948	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS						37,043	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		3,828		1,185	24,743	30,798	90
91	EMERGENCY		13,825		6,260	130,709	494,145	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	37,778	168,456	109,432	50,293	746,693	2,462,147	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		29,928				1,128	192
194	OUTPATIENT PHARMACY		1,012		320		48	194
194.01	PUBLIC RELATIONS				200			194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	659,638	2,565,607	1,648,432	1,606,491	1,847,469	808,648	202
203	UNIT COST MULT-WS B PT I	17.460903	12.866893	15.063528	31.615748	2.474202	0.328275	203
204	COST TO BE ALLOC PER B PT II	45,146	126,849	133,134	75,246	111,022	65,916	204
205	UNIT COST MULT-WS B PT II	1.195034	0.636166	1.216591	1.480842	0.148685	0.026759	205

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	I&R PROGRAM COSTS ASSIGNED TIME			
		15	16	17	22			
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	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	2,112,625						15
16	MEDICAL RECORDS & LIBRARY		169,751,670					16
17	SOCIAL SERVICE			37,778				17
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				100			22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	34,451	31,248,445	20,178				30
31	INTENSIVE CARE UNIT	6,997	6,591,287	3,261				31
40	SUBPROVIDER - IPF	5,169	11,896,410	11,494				40
43	NURSERY	12,387	4,664,884	2,845				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	26,614	5,308,697					50
52	DELIVERY ROOM & LABOR ROOM	8,717	917,408					52
53	ANESTHESIOLOGY	19,459	911,855					53
54	RADIOLOGY-DIAGNOSTIC	76	19,128,791					54
60	LABORATORY	91	40,601,250					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		10,465,081					65
66	PHYSICAL THERAPY		607,010					66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	879	7,199,859					71
72	IMPL. DEV. CHARGED TO PATIENTS		364,363					72
73	DRUGS CHARGED TO PATIENTS	1,326,433	14,345,850					73
74	RENAL DIALYSIS	1,246	2,090,842					74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	281	408,464					90
91	EMERGENCY	27,713	13,001,174		100			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,470,513	169,751,670	37,778	100			118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	8						192
194	OUTPATIENT PHARMACY	642,104						194
194.01	PUBLIC RELATIONS							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,108,939	1,884,878	1,187,392	567,661			202
203	UNIT COST MULT-WS B PT I	0.998255	0.011104	31.430780	5,676.610000			203
204	COST TO BE ALLOC PER B PT II	85,616	190,356	48,539	11,617			204
205	UNIT COST MULT-WS B PT II	0.040526	0.001121	1.284848	116.170000			205

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	18,785,350		18,785,350		18,785,350	30
31	INTENSIVE CARE UNIT	4,400,679		4,400,679		4,400,679	31
40	SUBPROVIDER - IPF	7,135,512		7,135,512		7,135,512	40
43	NURSERY	2,893,519		2,893,519		2,893,519	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,422,988		3,422,988		3,422,988	50
52	DELIVERY ROOM & LABOR ROOM	2,466,464		2,466,464		2,466,464	52
53	ANESTHESIOLOGY	152,935		152,935		152,935	53
54	RADIOLOGY-DIAGNOSTIC	4,709,890		4,709,890		4,709,890	54
60	LABORATORY	6,461,039		6,461,039		6,461,039	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,530,677		2,530,677		2,530,677	65
66	PHYSICAL THERAPY	688,707		688,707		688,707	66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,487,956		2,487,956		2,487,956	71
72	IMPL. DEV. CHARGED TO PATIENTS	263,416		263,416		263,416	72
73	DRUGS CHARGED TO PATIENTS	3,049,375		3,049,375		3,049,375	73
74	RENAL DIALYSIS	369,078		369,078		369,078	74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,101,123		1,101,123		1,101,123	90
91	EMERGENCY	7,876,366		7,876,366		7,876,366	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,501,567		1,501,567		1,501,567	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	70,296,641		70,296,641		70,296,641	200
201	LESS OBSERVATION BEDS	1,501,567		1,501,567		1,501,567	201
202	TOTAL (SEE INSTRUCTIONS)	68,795,074		68,795,074		68,795,074	202

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	28,976,901		28,976,901				30
31	INTENSIVE CARE UNIT	6,591,287		6,591,287				31
40	SUBPROVIDER - IPF	11,896,410		11,896,410				40
43	NURSERY	4,664,884		4,664,884				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,745,640	2,563,057	5,308,697	0.644789	0.644789	0.644789	50
52	DELIVERY ROOM & LABOR ROOM	909,764	7,644	917,408	2.688514	2.688514	2.688514	52
53	ANESTHESIOLOGY	460,574	451,281	911,855	0.167719	0.167719	0.167719	53
54	RADIOLOGY-DIAGNOSTIC	6,715,036	12,413,755	19,128,791	0.246220	0.246220	0.246220	54
60	LABORATORY	20,224,984	20,376,266	40,601,250	0.159134	0.159134	0.159134	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	8,577,513	1,887,568	10,465,081	0.241821	0.241821	0.241821	65
66	PHYSICAL THERAPY	277,502	329,508	607,010	1.134589	1.134589	1.134589	66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,057,100	2,142,759	7,199,859	0.345556	0.345556	0.345556	71
72	IMPL. DEV. CHARGED TO PATIENTS	282,303	82,060	364,363	0.722949	0.722949	0.722949	72
73	DRUGS CHARGED TO PATIENTS	12,191,876	2,153,974	14,345,850	0.212561	0.212561	0.212561	73
74	RENAL DIALYSIS	1,974,494	116,348	2,090,842	0.176521	0.176521	0.176521	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	150,547	257,917	408,464	2.695765	2.695765	2.695765	90
91	EMERGENCY	2,384,290	10,616,884	13,001,174	0.605820	0.605820	0.605820	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	160,576	2,110,968	2,271,544	0.661034	0.661034	0.661034	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	114,241,681	55,509,989	169,751,670				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	114,241,681	55,509,989	169,751,670				202

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,193,901		1,193,901	21,931	54.44	7,147	389,083	30
31	INTENSIVE CARE UNIT	244,211		244,211	3,261	74.89	1,089	81,555	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	478,464		478,464	11,494	41.63	2,662	110,819	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	109,800		109,800	2,845	38.59			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,026,376		2,026,376	39,531		10,898	581,457	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	330,194	5,308,697	0.062199	738,575	45,939	50
52	DELIVERY ROOM & LABOR ROOM	158,322	917,408	0.172575	14,722	2,541	52
53	ANESTHESIOLOGY	14,438	911,855	0.015834	79,006	1,251	53
54	RADIOLOGY-DIAGNOSTIC	242,716	19,128,791	0.012689	2,634,995	33,435	54
60	LABORATORY	319,039	40,601,250	0.007858	6,730,953	52,892	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	162,180	10,465,081	0.015497	1,838,111	28,485	65
66	PHYSICAL THERAPY	59,142	607,010	0.097432	139,377	13,580	66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,753	7,199,859	0.008299	2,817,499	23,382	71
72	IMPL. DEV. CHARGED TO PATIENTS	5,716	364,363	0.015688	115,756	1,816	72
73	DRUGS CHARGED TO PATIENTS	102,627	14,345,850	0.007154	3,751,243	26,836	73
74	RENAL DIALYSIS	9,447	2,090,842	0.004518	1,099,674	4,968	74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	85,116	408,464	0.208381	1,651	344	90
91	EMERGENCY	411,889	13,001,174	0.031681	722,295	22,883	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	95,432	2,271,544	0.042012			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,056,011	117,622,188		20,683,857	258,352	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS; [XX] TITLE XVIII, PART A [ ] TEFRA; [ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	21,931		7,147		30
31	INTENSIVE CARE UNIT	3,261		1,089		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	11,494		2,662		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	2,845				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	39,531		10,898		200

(A) Worksheet A line numbers

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	5,308,697			738,575		292,642		50
52	DELIVERY ROOM & LABOR ROOM	917,408			14,722				52
53	ANESTHESIOLOGY	911,855			79,006		43,150		53
54	RADIOLOGY-DIAGNOSTIC	19,128,791			2,634,995		1,392,067		54
60	LABORATORY	40,601,250			6,730,953		75,782		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	10,465,081			1,838,111		247,697		65
66	PHYSICAL THERAPY	607,010			139,377				66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,199,859			2,817,499		426,378		71
72	IMPL. DEV. CHARGED TO PATIENTS	364,363			115,756		26,493		72
73	DRUGS CHARGED TO PATIENTS	14,345,850			3,751,243		230,254		73
74	RENAL DIALYSIS	2,090,842			1,099,674		30,798		74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	408,464			1,651		63,693		90
91	EMERGENCY	13,001,174			722,295		1,041,256		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,271,544					291,438		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	117,622,188			20,683,857		4,161,648		200

(A) Worksheet A line numbers

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[XX] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF
[ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.644789	292,642			188,692			50
52	DELIVERY ROOM & LABOR ROOM	2.688514							52
53	ANESTHESIOLOGY	0.167719	43,150			7,237			53
54	RADIOLOGY-DIAGNOSTIC	0.246220	1,392,067			342,755			54
60	LABORATORY	0.159134	75,782			12,059			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241821	247,697			59,898			65
66	PHYSICAL THERAPY	1.134589							66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556	426,378			147,337			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949	26,493			19,153			72
73	DRUGS CHARGED TO PATIENTS	0.212561	230,254		1,300	48,943		276	73
74	RENAL DIALYSIS	0.176521	30,798			5,436			74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2.695765	63,693			171,701			90
91	EMERGENCY	0.605820	1,041,256			630,814			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034	291,438			192,650			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		4,161,648		1,300	1,826,675		276	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		4,161,648		1,300	1,826,675		276	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	330,194	5,308,697	0.062199	693	43	50
52	DELIVERY ROOM & LABOR ROOM	158,322	917,408	0.172575			52
53	ANESTHESIOLOGY	14,438	911,855	0.015834			53
54	RADIOLOGY-DIAGNOSTIC	242,716	19,128,791	0.012689	56,828	721	54
60	LABORATORY	319,039	40,601,250	0.007858	591,358	4,647	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	162,180	10,465,081	0.015497	32,734	507	65
66	PHYSICAL THERAPY	59,142	607,010	0.097432	5,070	494	66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,753	7,199,859	0.008299	4,156	34	71
72	IMPL. DEV. CHARGED TO PATIENTS	5,716	364,363	0.015688			72
73	DRUGS CHARGED TO PATIENTS	102,627	14,345,850	0.007154	517,100	3,699	73
74	RENAL DIALYSIS	9,447	2,090,842	0.004518			74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	85,116	408,464	0.208381			90
91	EMERGENCY	411,889	13,001,174	0.031681	134,449	4,259	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		2,271,544				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	1,960,579	117,622,188		1,342,388	14,404	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S103** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	5,308,697			693				50
52	DELIVERY ROOM & LABOR ROOM	917,408							52
53	ANESTHESIOLOGY	911,855							53
54	RADIOLOGY-DIAGNOSTIC	19,128,791			56,828		5,685		54
60	LABORATORY	40,601,250			591,358				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	10,465,081			32,734		1,908		65
66	PHYSICAL THERAPY	607,010			5,070				66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,199,859			4,156				71
72	IMPL. DEV. CHARGED TO PATIENTS	364,363							72
73	DRUGS CHARGED TO PATIENTS	14,345,850			517,100				73
74	RENAL DIALYSIS	2,090,842							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	408,464							90
91	EMERGENCY	13,001,174			134,449		458		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,271,544							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	117,622,188			1,342,388		8,051		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[XX] TITLE XVIII, PART B [XX] IPF [ ] SNF [ ] SWING BED NF
[ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.644789							50
52	DELIVERY ROOM & LABOR ROOM	2.688514							52
53	ANESTHESIOLOGY	0.167719							53
54	RADIOLOGY-DIAGNOSTIC	0.246220	5,685			1,400			54
60	LABORATORY	0.159134							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241821	1,908			461			65
66	PHYSICAL THERAPY	1.134589							66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949							72
73	DRUGS CHARGED TO PATIENTS	0.212561							73
74	RENAL DIALYSIS	0.176521							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2.695765							90
91	EMERGENCY	0.605820	458			277			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		8,051			2,138			200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		8,051			2,138			202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,193,901		1,193,901	21,931	54.44	7,627	415,214	30
31	INTENSIVE CARE UNIT	244,211		244,211	3,261	74.89	1,078	80,731	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	478,464		478,464	11,494	41.63	6,585	274,134	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	109,800		109,800	2,845	38.59	1,113	42,951	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,026,376		2,026,376	39,531		16,403	813,030	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX [ ] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	330,194	5,308,697	0.062199	1,169,508	72,742	50
52	DELIVERY ROOM & LABOR ROOM	158,322	917,408	0.172575	290,204	50,082	52
53	ANESTHESIOLOGY	14,438	911,855	0.015834	142,885	2,262	53
54	RADIOLOGY-DIAGNOSTIC	242,716	19,128,791	0.012689	1,997,871	25,351	54
60	LABORATORY	319,039	40,601,250	0.007858	6,361,781	49,991	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	162,180	10,465,081	0.015497	2,967,664	45,990	65
66	PHYSICAL THERAPY	59,142	607,010	0.097432	64,077	6,243	66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,753	7,199,859	0.008299	1,130,021	9,378	71
72	IMPL. DEV. CHARGED TO PATIENTS	5,716	364,363	0.015688	100,666	1,579	72
73	DRUGS CHARGED TO PATIENTS	102,627	14,345,850	0.007154	3,642,637	26,059	73
74	RENAL DIALYSIS	9,447	2,090,842	0.004518			74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	85,116	408,464	0.208381	49,485	10,312	90
91	EMERGENCY	411,889	13,001,174	0.031681	611,278	19,366	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	95,432	2,271,544	0.042012			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,056,011	117,622,188		18,528,077	319,355	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS; [ ] TITLE XVIII, PART A [ ] TEFRA; [XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	21,931		7,627		30
31	INTENSIVE CARE UNIT	3,261		1,078		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	11,494		6,585		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	2,845		1,113		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	39,531		16,403		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	5,308,697			1,169,508				50
52	DELIVERY ROOM & LABOR ROOM	917,408			290,204				52
53	ANESTHESIOLOGY	911,855			142,885				53
54	RADIOLOGY-DIAGNOSTIC	19,128,791			1,997,871				54
60	LABORATORY	40,601,250			6,361,781				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	10,465,081			2,967,664				65
66	PHYSICAL THERAPY	607,010			64,077				66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,199,859			1,130,021				71
72	IMPL. DEV. CHARGED TO PATIENTS	364,363			100,666				72
73	DRUGS CHARGED TO PATIENTS	14,345,850			3,642,637				73
74	RENAL DIALYSIS	2,090,842							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	408,464			49,485				90
91	EMERGENCY	13,001,174			611,278				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,271,544							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	117,622,188			18,528,077				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.644789							50
52	DELIVERY ROOM & LABOR ROOM	2.688514							52
53	ANESTHESIOLOGY	0.167719							53
54	RADIOLOGY-DIAGNOSTIC	0.246220							54
60	LABORATORY	0.159134							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241821							65
66	PHYSICAL THERAPY	1.134589							66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949							72
73	DRUGS CHARGED TO PATIENTS	0.212561							73
74	RENAL DIALYSIS	0.176521							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2.695765							90
91	EMERGENCY	0.605820							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[ ] TITLE XVIII, PART A [XX] IPF [ ] TEFRA
[XX] TITLE XIX [ ] IRF

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	330,194	5,308,697	0.062199	163	10	50
52	DELIVERY ROOM & LABOR ROOM	158,322	917,408	0.172575			52
53	ANESTHESIOLOGY	14,438	911,855	0.015834			53
54	RADIOLOGY-DIAGNOSTIC	242,716	19,128,791	0.012689	133,965	1,700	54
60	LABORATORY	319,039	40,601,250	0.007858	1,111,605	8,735	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	162,180	10,465,081	0.015497	67,975	1,053	65
66	PHYSICAL THERAPY	59,142	607,010	0.097432	11,694	1,139	66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,753	7,199,859	0.008299	5,435	45	71
72	IMPL. DEV. CHARGED TO PATIENTS	5,716	364,363	0.015688			72
73	DRUGS CHARGED TO PATIENTS	102,627	14,345,850	0.007154	1,165,429	8,337	73
74	RENAL DIALYSIS	9,447	2,090,842	0.004518			74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	85,116	408,464	0.208381			90
91	EMERGENCY	411,889	13,001,174	0.031681	371,736	11,777	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		2,271,544				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	1,960,579	117,622,188		2,868,002	32,796	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS
[ ] TITLE XVIII, PART A [XX] IPF [ ] SNF [ ] TEFRA
[XX] TITLE XIX [ ] IRF [ ] NF

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	5,308,697			163				50
52	DELIVERY ROOM & LABOR ROOM	917,408							52
53	ANESTHESIOLOGY	911,855							53
54	RADIOLOGY-DIAGNOSTIC	19,128,791			133,965				54
60	LABORATORY	40,601,250			1,111,605				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	10,465,081			67,975				65
66	PHYSICAL THERAPY	607,010			11,694				66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,199,859			5,435				71
72	IMPL. DEV. CHARGED TO PATIENTS	364,363							72
73	DRUGS CHARGED TO PATIENTS	14,345,850			1,165,429				73
74	RENAL DIALYSIS	2,090,842							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	408,464							90
91	EMERGENCY	13,001,174			371,736				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,271,544							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	117,622,188			2,868,002				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[ ] TITLE XVIII, PART B [XX] IPF [ ] SNF [ ] SWING BED NF
[XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.644789							50
52	DELIVERY ROOM & LABOR ROOM	2.688514							52
53	ANESTHESIOLOGY	0.167719							53
54	RADIOLOGY-DIAGNOSTIC	0.246220							54
60	LABORATORY	0.159134							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241821							65
66	PHYSICAL THERAPY	1.134589							66
69	ELECTROCARDIOLOGY								69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949							72
73	DRUGS CHARGED TO PATIENTS	0.212561							73
74	RENAL DIALYSIS	0.176521							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2.695765							90
91	EMERGENCY	0.605820							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0103** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	21,931	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	21,931	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	20,178	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	7,147	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)	18,785,350	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	18,785,350	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	18,785,350	37

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0103** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	856.57	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	6,121,906	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)	6,121,906	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,400,679	3,261	1,349.49	1,089	1,469,595	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	5,342,403	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	12,933,904	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	470,638	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	258,352	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	728,990	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	12,204,914	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0103** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					1,753	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					856.57	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					1,501,567	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,193,901	18,785,350	0.063555	1,501,567	95,432	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S103** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	11,494	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	11,494	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	11,494	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,662	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	7,135,512	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,135,512	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	7,135,512	37

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S103** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[XX] TITLE XVIII, PART A [XX] IPF [ ] TEFRA
[ ] TITLE XIX - I/P [ ] IRF [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	620.80	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	1,652,570	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	1,652,570	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	315,015	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	1,967,585	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	110,819	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	14,404	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	125,223	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	1,842,362	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0103** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	[ ] TITLE V - I/P	[XX] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS	
	[ ] TITLE XVIII, PART A	[ ] IPF	[ ] SNF		[ ] TEFRA	
	[XX] TITLE XIX - I/P	[ ] IRF	[ ] NF		[ ] OTHER	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	21,931	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	21,931	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	20,178	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	7,627	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)	2,845	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	1,113	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)	18,785,350	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	18,785,350	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	18,785,350	37

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0103** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	856.57	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	6,533,059	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)	6,533,059	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)	2,893,519	2,845	1,017.05	1,113	1,131,977	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,400,679	3,261	1,349.49	1,078	1,454,750	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	5,594,174	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	14,713,960	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	538,896	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	319,355	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	858,251	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	13,855,709	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0103** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					1,753	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		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

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S103** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS
[ ] TITLE XVIII, PART A [XX] IPF [ ] SNF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [ ] NF [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	11,494	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	11,494	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	11,494	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	6,585	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	7,135,512	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,135,512	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	7,135,512	37

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S103** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[ ] TITLE XVIII, PART A [XX] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	620.80	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	4,087,968	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	4,087,968	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	714,498	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	4,802,466	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	274,134	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	32,796	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	306,930	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	4,495,536	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0103** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	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		9,501,120		30
31	INTENSIVE CARE UNIT		2,410,687		31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.644789	738,575	476,225	50
52	DELIVERY ROOM & LABOR ROOM	2.688514	14,722	39,580	52
53	ANESTHESIOLOGY	0.167719	79,006	13,251	53
54	RADIOLOGY-DIAGNOSTIC	0.246220	2,634,995	648,788	54
60	LABORATORY	0.159134	6,730,953	1,071,123	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241821	1,838,111	444,494	65
66	PHYSICAL THERAPY	1.134589	139,377	158,136	66
69	ELECTROCARDIOLOGY				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556	2,817,499	973,604	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949	115,756	83,686	72
73	DRUGS CHARGED TO PATIENTS	0.212561	3,751,243	797,368	73
74	RENAL DIALYSIS	0.176521	1,099,674	194,116	74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	2.695765	1,651	4,451	90
91	EMERGENCY	0.605820	722,295	437,581	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		20,683,857	5,342,403	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		20,683,857		202

(A) Worksheet A line numbers

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S103** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	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
40	SUBPROVIDER - IPF		2,847,420		40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.644789	693	447	50
52	DELIVERY ROOM & LABOR ROOM	2.688514			52
53	ANESTHESIOLOGY	0.167719			53
54	RADIOLOGY-DIAGNOSTIC	0.246220	56,828	13,992	54
60	LABORATORY	0.159134	591,358	94,105	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241821	32,734	7,916	65
66	PHYSICAL THERAPY	1.134589	5,070	5,752	66
69	ELECTROCARDIOLOGY				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556	4,156	1,436	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949			72
73	DRUGS CHARGED TO PATIENTS	0.212561	517,100	109,915	73
74	RENAL DIALYSIS	0.176521			74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	2.695765			90
91	EMERGENCY	0.605820	134,449	81,452	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,342,388	315,015	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,342,388		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0103** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

(A)	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		10,783,401		30
31	INTENSIVE CARE UNIT		1,976,975		31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.644789	1,169,508	754,086	50
52	DELIVERY ROOM & LABOR ROOM	2.688514	290,204	780,218	52
53	ANESTHESIOLOGY	0.167719	142,885	23,965	53
54	RADIOLOGY-DIAGNOSTIC	0.246220	1,997,871	491,916	54
60	LABORATORY	0.159134	6,361,781	1,012,376	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241821	2,967,664	717,643	65
66	PHYSICAL THERAPY	1.134589	64,077	72,701	66
69	ELECTROCARDIOLOGY				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556	1,130,021	390,486	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949	100,666	72,776	72
73	DRUGS CHARGED TO PATIENTS	0.212561	3,642,637	774,283	73
74	RENAL DIALYSIS	0.176521			74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	2.695765	49,485	133,400	90
91	EMERGENCY	0.605820	611,278	370,324	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		18,528,077	5,594,174	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		18,528,077		202

(A) Worksheet A line numbers

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S103** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

(A)	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
40	SUBPROVIDER - IPF		7,137,779		40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.644789	163	105	50
52	DELIVERY ROOM & LABOR ROOM	2.688514			52
53	ANESTHESIOLOGY	0.167719			53
54	RADIOLOGY-DIAGNOSTIC	0.246220	133,965	32,985	54
60	LABORATORY	0.159134	1,111,605	176,894	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241821	67,975	16,438	65
66	PHYSICAL THERAPY	1.134589	11,694	13,268	66
69	ELECTROCARDIOLOGY				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.345556	5,435	1,878	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.722949			72
73	DRUGS CHARGED TO PATIENTS	0.212561	1,165,429	247,725	73
74	RENAL DIALYSIS	0.176521			74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	2.695765			90
91	EMERGENCY	0.605820	371,736	225,205	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.661034			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		2,868,002	714,498	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		2,868,002		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	7,799,223			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	2,599,741			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	17,986			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	720,581			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	153.20			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)	3.92			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)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002	1.06			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)	4.98			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	3.95			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	3.95			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	4.02			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	3.92			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	3.96			15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	3.96			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.025849			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.025518			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.025518			21
22	IME PAYMENT ADJUSTMENT (see instructions)	153,972			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)	-1.03			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)	153,972			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.2433			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.5474			31
32	SUM OF LINES 30 AND 31	0.7907			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.5445			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	4,600,567			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000588832		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		5,326,798		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,342,646		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,342,646			36
	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)	1,584			40

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CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)	159			41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)	10.04			42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)	819			43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)	0.735849			44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)	405.45			45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)	47,438			46
47	SUBTOTAL (see instructions)	16,561,573			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)	16,561,573			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	996,971			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)	107,135			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)	17,665,679			59
60	PRIMARY PAYER PAYMENTS	2,690			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	17,662,989			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	933,812			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	192,344			63
64	ALLOWABLE BAD DEBTS (see instructions)	620,106			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	403,069			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	615,809			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	16,939,902			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
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-61,455			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-108,794			70.94
71	AMOUNT DUE PROVIDER (see instructions)	16,769,653			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	253,222			71.01
72	INTERIM PAYMENTS	15,394,415			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	1,122,016			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	400,085			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

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0103** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	276			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	1,826,675			2
3	PPS PAYMENTS	1,441,025			3
4	OUTLIER PAYMENT (see instructions)	6,495			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)	276			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	1,300			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)	1,300			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)	1,300			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	1,024			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)	276			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	1,447,520			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	340,932			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,106,864			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	13,153			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	1,120,017			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	1,120,017			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)	139,684			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	90,795			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	138,236			36
37	SUBTOTAL (see instructions)	1,210,812			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,210,812			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	18,283			40.01
41	INTERIM PAYMENTS	1,223,476			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-30,947			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 (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S103** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	2,138			2
3	PPS PAYMENTS	2,112			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 instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	2,112			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	525			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,587			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)	1,587			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	1,587			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	1,587			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,587			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	24			40.01
41	INTERIM PAYMENTS	1,567			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-4			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 (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0103** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				17,848,205		1,091,082	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				568,410		132,394	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	07/08/2013	433,600			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	01/03/2014	3,455,800			3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-3,022,200			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				15,394,415		1,223,476	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S103** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [XX] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,927,484		1,567	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				71,510			2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	07/08/2013	89,200			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		89,200			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,088,194		1,567	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1 PART II**

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	5,933	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	8,236	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	883	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	23,439	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	169,751,670	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	16,993,260	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)	1,278,225	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	25,565	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,252,660	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,219,129	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	33,531	32

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S103** **WORKSHEET E-3 PART II**

CHECK APPLICABLE BOX: **[ ] HOSPITAL** **[XX] SUBPROVIDER IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	2,158,249	1
2	NET IPF PPS OUTLIER PAYMENT	36,476	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	31.490411	9
10	TEACHING ADJUSTMENT FACTOR {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	2,194,725	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	2,194,725	16
17	PRIMARY PAYER PAYMENTS	730	17
18	SUBTOTAL (line 16 less line 17)	2,193,995	18
19	DEDUCTIBLES	199,984	19
20	SUBTOTAL (line 18 minus line 19)	1,994,011	20
21	COINSURANCE	38,184	21
22	SUBTOTAL (line 20 minus line 21)	1,955,827	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	96,298	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	62,594	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	92,830	25
26	SUBTOTAL (sum of lines 22 and 24)	2,018,421	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	2,018,421	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	30,478	31.01
32	INTERIM PAYMENTS	2,088,194	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	-100,251	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0103** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[XX] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[ ] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	10,776,800		8
9	ANCILLARY SERVICE CHARGES	18,528,077		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)	29,304,877		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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	29,304,877		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	29,304,877		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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 (LESS INPATIENT COSTS)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet 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

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S103** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XIX** **[XX] PPS** **[ ] TEFRA** **[ ] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	7,137,780		8
9	ANCILLARY SERVICE CHARGES	2,868,002		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	10,005,782		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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	10,005,782		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	10,005,782		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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 Worksheet 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

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			3.03	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))			1.06	4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			4.09	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			3.95	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			3.95	7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	3.90	3.90	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	3.90	3.90	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	3.90		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	4.02		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	4.02		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	3.98		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	3.98		17
18	PER RESIDENT AMOUNT	90,577.00	90,577.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS		360,496	360,496	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			360,496	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	10,898	883		26
27	TOTAL INPATIENT DAYS (see instructions)	34,933	34,933		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.311969	0.025277		28
29	PROGRAM DIRECT GME AMOUNT	112,464	9,112		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		1,288		30
31	NET PROGRAM DIRECT GME AMOUNT			120,288	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			2,090,842	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			14,901,489	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)			3,420	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			14,898,069	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			1,829,089	42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			1,829,089	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			16,727,158	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.890652	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.109348	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)			120,288	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			107,135	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			13,153	50

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00		17
18	PER RESIDENT AMOUNT	0.00	0.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	15,290	4,573		26
27	TOTAL INPATIENT DAYS (see instructions)	34,933	34,933		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.437695	0.130908		28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)				37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)				42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)				44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)				48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)				49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)				50

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	5,055,432				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	16,576,799				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	1,247,380				7
8	PREPAID EXPENSES	4,732,502				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	27,612,113				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	26,582,644				15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	26,582,644				30
	OTHER ASSETS					
31	INVESTMENTS	30,841				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	17,123,245				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	17,154,086				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	71,348,843				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	11,296,201				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	89,301				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,935,309				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	13,320,811				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	17,184,533				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	17,184,533				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	30,505,344				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	40,843,499				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	40,843,499				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	71,348,843				60

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STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		33,592,085			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		3,886,512			2
3	TOTAL (sun of line 1 and line 2)		37,478,597			3
4	ADDITIONS (credit adjustments)	20				4
5	GAINS ON INVESTMENTS	240,538				5
6	TEMPORARILY RESTRICTED					6
7	CONTRIBUTIONS	4,150,007				7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		4,390,565			10
11	SUBTOTAL (line 3 plus line 10)		41,869,162			11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED	1,025,663				13
14	EQUITY TRANSFER					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		1,025,663			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		40,843,499			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	GAINS ON INVESTMENTS					5
6	TEMPORARILY RESTRICTED					6
7	CONTRIBUTIONS					7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED					13
14	EQUITY TRANSFER					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	30,335,405		30,335,405	1
2	SUBPROVIDER IPF	11,943,900		11,943,900	2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	42,279,305		42,279,305	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	6,603,746		6,603,746	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	6,603,746		6,603,746	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	48,883,051		48,883,051	17
18	ANCILLARY SERVICES	64,597,517		64,597,517	18
19	OUTPATIENT SERVICES		56,296,810	56,296,810	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OP PHARMACY	1,014,404	1,001,538	2,015,942	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	114,494,972	57,298,348	171,793,320	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		90,016,022	29
30	ADD (SPECIFY)			30
31	BAD DEBTS			31
32	BP	34,974		32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		34,974	36
37	DEDUCT (SPECIFY)	-5,123		37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)		-5,123	42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		90,045,873	43

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STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	171,793,320	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	89,764,367	2
3	NET PATIENT REVENUES (line 1 minus line 2)	82,028,953	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	90,045,873	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-8,016,920	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	39,798	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES	68	8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,272	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	435,938	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	84,783	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	27,482	21
22	RENTAL OF HOSPITAL SPACE	147,851	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS INCOME)	3,609,576	24
24.01	OTHER (ER PRO FEE INCOME)	1,930,854	24.01
24.02	OTHER (ANEST PRO FEE INCOME)	587,829	24.02
24.03	OTHER (SISTERS MAINTENANCE)	12,000	24.03
24.04	OTHER (OTHER RENTAL INCOME)	51,823	24.04
24.05	OTHER (EMPLOYEES ROOM RENT)	60,300	24.05
24.06	OTHER (PARTNERS IN HEALTH)	3,278,027	24.06
24.07	OTHER (CAPITATION REVENUE)		24.07
24.08	OTHER (CLINIC REVENUE)	608,668	24.08
24.09	OTHER (CLINIC REVENUES)		24.09
24.10	OTHER (NET ASSETS RELEASED)	1,024,956	24.10
24.11	OTHER (GAIN ON SALE OF EQUIPMENT)	104	24.11
24.12	OTHER (NET ASSETS RELEASED)		24.12
24.13	OTHER (CAPITAL GAIN)	788	24.13
24.14	OTHER (BP INCOME)	2,208	24.14
25	TOTAL OTHER INCOME (sum of lines 6-24)	11,904,325	25
26	TOTAL (line 5 plus line 25)	3,887,405	26
27	OTHER EXPENSES (CHANGE IN NET UNREALIZED GAINS/LOSS)	893	27
27.01	OTHER EXPENSES (CAPITAL LOSS)		27.01
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	893	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	3,886,512	29

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0103** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	836,350	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	711	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	64.22	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	3.96	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	1.76	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	14,720	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.2433	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.5474	8
9	SUM OF LINES 7 AND 8	0.7907	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1736	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	145,190	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	996,971	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 19:14 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0103** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	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
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
40	SUBPROVIDER - IPF							40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
194	OUTPATIENT PHARMACY							194
194.01	PUBLIC RELATIONS							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202