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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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: 11/26/2014 TIME: 09:52 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] 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. ANTHONY'S MEMORIAL HOSPITAL (14-0032) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, 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		348,945	-81,052	63,878		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		348,945	-81,052	63,878		200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 503 N MAPLE	P.O. Box:		1
2	City: EFFINGHAM	State: IL	ZIP Code: 62401-	County: EFFINGHAM 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. ANTHONY'S MEMORIAL HOSPITAL	14-0032	41180	1	07/01/1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	ST. ANTHONY'S MEMORIAL HOSPITAL SNF	14-5940	41180		06/27/1997	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	ST. ANTHONY'S MEMORIAL HOSPITAL HHA	14-7661	41180		02/17/1997	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014	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 payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	2	N	23

		In-State 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.	1,908	478					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.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39

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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	N	N	45
46	Is this facility eligible for additional paymetn 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.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad 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 baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived 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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WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 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 Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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 Facilty 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.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.				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 5th or 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 appilcable 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? (see instructions)					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 elinination would not be on Worksheet B, Part I, column 25 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	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.			Y		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.					118
			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.			N		121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified 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 cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name:	Contractor's Number:	141
142	Street: 4936 LAVERNA ROAD	P.O. Box:		142
143	City: SPRINGFIELD, IL 62707	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	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)		06/02/2012	08/30/2012	170

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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)	Y			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.	Y			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.		N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
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)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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: RICK	LAST NAME: SCHUMACHER	TITLE: BUSINESS OFFICE MANAGER	41
42	EMPLOYER: ST ANTHONY'S MEMORIAL HOSPITAL			42
43	PHONE NUMBER: 217-347-1299	E-MAIL ADDRESS: RICK.SCHUMACHER@HSHS.ORG		43

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	123	44,895			9,293	2,556	15,616	1
2	HMO AND OTHER (see instructions)						489			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)		123	44,895			9,293	2,556	15,616	7
8	INTENSIVE CARE UNIT	31	10	3,650			1,028	193	1,556	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						510	1,500	13
14	TOTAL (see instructions)		133	48,545			10,321	3,259	18,672	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	13	4,745			1,448		1,617	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					14,856	1,145	18,351	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)		146							27
28	OBSERVATION BED DAYS								2,022	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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)					2,565	1,039	5,094	1
2	HMO AND OTHER (see instructions)					72			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)		600.73			2,565	1,039	5,094	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								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)		600.73						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	30,357,102	1,868,271	32,225,373	1,256,679.00	25.64	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							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44	296,901		296,901	12,921.00	22.98	9
10	EXCLUDED AREA SALARIES (see instructions)		1,674,764		1,674,764	52,105.00	32.14	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		383,799		383,799	5,173.00	74.19	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,608,051		3,608,051	59,128.00	61.02	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)		13,581,659		13,581,659			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		838,128		838,128			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
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		35,981	372,587	408,568	10,477.00	39.00	26
27	ADMINISTRATIVE & GENERAL		3,394,208	1,447,883	4,842,091	200,272.00	24.18	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		129,686		129,686	1,014.00	127.90	28
29	MAINTENANCE & REPAIRS		602,944		602,944	26,678.00	22.60	29
30	OPERATION OF PLANT		159,502		159,502	10,641.00	14.99	30
31	LAUNDRY & LINEN SERVICE		69,810		69,810	5,302.00	13.17	31
32	HOUSEKEEPING		625,199		625,199	53,872.00	11.61	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		613,319	-471,924	141,395	16,652.00	8.49	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA		78,551	471,924	550,475	34,934.00	15.76	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		826,381		826,381	18,308.00	45.14	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		1,134,190		1,134,190	28,869.00	39.29	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,946,789	47,801	1,994,590	73,282.00	27.22	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	30,486,788	1,868,271	32,355,059	1,257,693.00	25.73	1
2	EXCLUDED AREA SALARIES (see instructions)	1,971,665		1,971,665	65,026.00	30.32	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	28,515,123	1,868,271	30,383,394	1,192,667.00	25.48	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	3,991,850		3,991,850	64,301.00	62.08	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	13,581,659		13,581,659		44.70%	5
6	TOTAL (sum of lines 3 through 5)	46,088,632	1,868,271	47,956,903	1,256,968.00	38.15	6
7	TOTAL OVERHEAD COST (see instructions)	9,616,560	1,868,271	11,484,831	480,301.00	23.91	7

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	2,924,933	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)		8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY		17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	2,924,933	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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

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

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

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7661** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA COUNTY: EFFINGHAM

		TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
	DESCRIPTION	1	2	3	4	5	
1	HOME HEALTH AIDE HOURS		5,651	106	303	6,060	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		516.00	57.00	129.00	689.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF	CONTRACT	TOTAL	
		1	2	3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	2.49		2.49	5
6	DIRECT NURSING SERVICE	15.20		15.20	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	4.27		4.27	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	0.31		0.31	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE	0.08		0.08	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	1.01		1.01	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	2.91		2.91	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	99914	20

PPS ACTIVITY

		FULL EPISODES					
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES	TOTAL (columns 1 through 4)	
		1	2	3	4	5	
21	SKILLED NURSING VISITS	7,763	1,454	290	151	9,658	21
22	SKILLED NURSING VISIT CHARGES	1,374,424	272,062	41,387	25,027	1,712,900	22
23	PHYSICAL THERAPY VISITS	2,415	126	29	65	2,635	23
24	PHYSICAL THERAPY VISIT CHARGES	494,214	26,460	5,670	13,596	539,940	24
25	OCCUPATIONAL THERAPY VISITS	1,003	86	11	41	1,141	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	205,968	17,586	2,100	8,556	234,210	26
27	SPEECH PATHOLOGY VISITS	33		1	5	39	27
28	SPEECH PATHOLOGY VISIT CHARGES	6,930		210	1,050	8,190	28
29	MEDICAL SOCIAL SERVICE VISITS	117	4	3	2	126	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	30,030	1,040	780	520	32,370	30
31	HOME HEALTH AIDE VISITS	814	103	6	23	946	31
32	HOME HEALTH AIDE VISIT CHARGES	75,174	9,785	380	2,185	87,524	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	12,145	1,773	340	287	14,545	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,186,740	326,933	50,527	50,934	2,615,134	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	759		83	23	865	36
37	TOTAL NUMBER OF OUTLIER EPISODES		33			33	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	58,951	14,208	1,404	859	75,422	38

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	N	/ /	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL	13		13	8
9	RMX				9
10	RML	58		58	10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA	14		14	17
18	RHC	20		20	18
19	RHB	52		52	19
20	RHA	230		230	20
21	RMC	124		124	21
22	RMB	69		69	22
23	RMA	406		406	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2	10		10	27
28	ES1	5		5	28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1	7		7	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	91		91	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1	6		6	40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	46		46	48
49	CC2				49
50	CC1	8		8	50
51	CB2				51
52	CB1	125		125	52
53	CA2				53
54	CA1	35		35	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1	5		5	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1	5		5	70

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1	17		17	72
73	PC2				73
74	PC1	19		19	74
75	PB2				75
76	PB1	43		43	76
77	PA2				77
78	PA1	31		31	78
199	AAA	9		9	199
200	TOTAL	1,448		1,448	200

SNF SERVICES

		CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable).	99914		201

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

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)	492,922			207

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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)	0.316624	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	8,539,294	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	60,667,919	6
7	MEDICAID COST (line 1 times line 6)	19,208,919	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.	10,669,625	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)	10,669,625	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	4,475,166	925,254	5,400,420	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	1,416,945	292,958	1,709,903	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	1,416,945	292,958	1,709,903	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	5,172,199	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	585,290	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	4,586,909	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,452,325	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	3,162,228	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	13,831,853	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		2,043,588	2,043,588	403,170	2,446,758	530,863	2,977,621	1
2	00200	CAP REL COSTS-MVBLE EQUIP		5,458,677	5,458,677	77,041	5,535,718	-71,429	5,464,289	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	35,981	12,936,434	12,972,415	1,111,524	14,083,939	-150,289	13,933,650	4
5	00500	ADMINISTRATIVE & GENERAL	3,394,208	18,207,893	21,602,101	-1,238,318	20,363,783	-2,491,595	17,872,188	5
6	00600	MAINTENANCE & REPAIRS	602,944	464,997	1,067,941		1,067,941	-16,616	1,051,325	6
7	00700	OPERATION OF PLANT	159,502	1,335,679	1,495,181		1,495,181	-2,895	1,492,286	7
8	00800	LAUNDRY & LINEN SERVICE	69,810	492,983	562,793		562,793		562,793	8
9	00900	HOUSEKEEPING	625,199	285,988	911,187		911,187	-96	911,091	9
10	01000	DIETARY	613,319	345,627	958,946	-749,971	208,975	-32,543	176,432	10
11	01100	CAFETERIA	78,551	444	78,995	749,971	828,966		828,966	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	826,381	36,033	862,414		862,414	-2,010	860,404	13
14	01400	CENTRAL SERVICES & SUPPLY		1,241,722	1,241,722	-1,238,840	2,882		2,882	14
15	01500	PHARMACY	1,134,190	2,857,777	3,991,967	-2,808,712	1,183,255	-2,418	1,180,837	15
16	01600	MEDICAL RECORDS & LIBRARY	1,946,789	862,527	2,809,316	47,801	2,857,117	-66,012	2,791,105	16
17	01700	SOCIAL SERVICE		1,910	1,910		1,910		1,910	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	5,438,509	432,105	5,870,614		5,870,614	-28,339	5,842,275	30
31	03100	INTENSIVE CARE UNIT	1,078,710	39,058	1,117,768		1,117,768		1,117,768	31
43	04300	NURSERY		22,729	22,729		22,729		22,729	43
44	04400	SKILLED NURSING FACILITY	296,901	26,930	323,831		323,831		323,831	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	3,070,934	9,722,585	12,793,519		12,793,519	-2,590,780	10,202,739	50
52	05200	DELIVERY ROOM & LABOR ROOM	139,034	-48,106	90,928		90,928		90,928	52
53	05300	ANESTHESIOLOGY	1,385,129	1,587,534	2,972,663		2,972,663	-1,346,353	1,626,310	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,414,851	514,261	1,929,112		1,929,112	-31,214	1,897,898	54
54.01	03630	ULTRASOUND	160,101	23,445	183,546		183,546		183,546	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	159,821	326,163	485,984		485,984		485,984	54.02
54.04	03480	RADIATION ONC		52,225	52,225		52,225		52,225	54.04
54.06	05401	PET SCAN		130,435	130,435		130,435		130,435	54.06
57	05700	CT SCAN	230,601	357,398	587,999		587,999		587,999	57
58	05800	MRI	162,872	259,231	422,103		422,103		422,103	58
59	05900	CARDIAC CATHETERIZATION	184,656	175,752	360,408		360,408		360,408	59
60	06000	LABORATORY	1,259,088	1,860,315	3,119,403		3,119,403	-29,923	3,089,480	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	667,634	109,136	776,770		776,770	-25,228	751,542	65
66	06600	PHYSICAL THERAPY	993,105	105,678	1,098,783		1,098,783		1,098,783	66
67	06700	OCCUPATIONAL THERAPY	167,508	18,712	186,220		186,220	-1,577	184,643	67
69	06900	ELECTROCARDIOLOGY	441,160	261,652	702,812		702,812	-173,641	529,171	69
70	07000	ELECTROENCEPHALOGRAPHY	113,289	100,282	213,571		213,571	-76,450	137,121	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				1,238,840	1,238,840	-3,092	1,235,748	71
73	07300	DRUGS CHARGED TO PATIENTS				2,808,712	2,808,712	-37,552	2,771,160	73
74	07400	RENAL DIALYSIS		33,271	33,271		33,271		33,271	74
76	03050	BACTERIOLOGY & MICROBIOLOGY								76
76.01	03650	VASCULAR LAB	171,286	40,168	211,454		211,454		211,454	76.01
76.02	03651	CARDIAC REHAB	74,354	3,602	77,956		77,956		77,956	76.02
76.03	03950	WOUND CARE	220,116	788,882	1,008,998		1,008,998	-270,035	738,963	76.03
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	3,252	4,396	7,648		7,648		7,648	90
91	09100	EMERGENCY	1,362,553	1,084,051	2,446,604		2,446,604	-870,094	1,576,510	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	HOME HEALTH AGENCY	1,442,556	266,628	1,709,184		1,709,184		1,709,184	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		401,218	401,218	-401,218				113
116	11600	HOSPICE	148,057	96,200	244,257		244,257		244,257	116
118		SUBTOTALS (sum of lines 1-117)	30,272,951	65,368,215	95,641,166		95,641,166	-7,789,318	87,851,848	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		28,296	28,296		28,296		28,296	190

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	
194	07950	PHILANTHROPY DEVELOPMENT	84,151	-121,554	-37,403		-37,403	37,403		194
194.01	07951	VENDING								194.01
194.02	07952	MEALS ON WHEELS								194.02
194.03	07953	PRAIRIE CARDIOVASCULAR		3,260,352	3,260,352		3,260,352		3,260,352	194.03
200		TOTAL (sum of lines 118-199)	30,357,102	68,535,309	98,892,411		98,892,411	-7,751,915	91,140,496	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	PERSONNELCOSTS	A	EMPLOYEE BENEFITS DEPARTMENT	4	234,372	63,150	1
500	TOTAL RECLASSIFICATIONS				234,372	63,150	500
	CODE LETTER - A						
1	CAFETERIA COSTS	B	CAFETERIA	11	471,924	278,047	1
500	TOTAL RECLASSIFICATIONS				471,924	278,047	500
	CODE LETTER - B						
1	PHARMACY DRUGS	C	DRUGS CHARGED TO PATIENTS	73		2,808,712	1
500	TOTAL RECLASSIFICATIONS					2,808,712	500
	CODE LETTER - C						
1	CENTRAL SUPPLY	D	MEDICAL SUPPLIES CHARGED TO P	71		1,238,840	1
500	TOTAL RECLASSIFICATIONS					1,238,840	500
	CODE LETTER - D						
1	BUSINESS PROPERTY INSURANCE	E	CAP REL COSTS-BLDG & FIXT	1		78,993	1
500	TOTAL RECLASSIFICATIONS					78,993	500
	CODE LETTER - E						
1	INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		324,177	1
2	INTEREST EXPENSE	F	CAP REL COSTS-MVBLE EQUIP	2		77,041	2
500	TOTAL RECLASSIFICATIONS					401,218	500
	CODE LETTER - F						
1	DIVISIONAL EXPENSES SALARIES	G	ADMINISTRATIVE & GENERAL	5	1,682,255		1
2	DIVISIONAL EXPENSES BENEFITS	G	EMPLOYEE BENEFITS DEPARTMENT	4		675,787	2
3	DIVISONAL EXPENSES SALARIES	G	EMPLOYEE BENEFITS DEPARTMENT	4	138,215		3
4	DIVISIONAL EXPENSES SALARIES	G	MEDICAL RECORDS & LIBRARY	16	47,801		4
500	TOTAL RECLASSIFICATIONS				1,868,271	675,787	500
	CODE LETTER - G						
	GRAND TOTAL (INCREASES)				2,574,567	5,544,747	

(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	PERSONNELCOSTS	A	ADMINISTRATIVE & GENERAL	5	234,372	63,150		1
500	TOTAL RECLASSIFICATIONS				234,372	63,150		500
	CODE LETTER - A							
1	CAFETERIA COSTS	B	DIETARY	10	471,924	278,047		1
500	TOTAL RECLASSIFICATIONS				471,924	278,047		500
	CODE LETTER - B							
1	PHARMACY DRUGS	C	PHARMACY	15		2,808,712		1
500	TOTAL RECLASSIFICATIONS					2,808,712		500
	CODE LETTER - C							
1	CENTRAL SUPPLY	D	CENTRAL SERVICES & SUPPLY	14		1,238,840		1
500	TOTAL RECLASSIFICATIONS					1,238,840		500
	CODE LETTER - D							
1	BUSINESS PROPERTY INSURANCE	E	ADMINISTRATIVE & GENERAL	5		78,993	9	1
500	TOTAL RECLASSIFICATIONS					78,993		500
	CODE LETTER - E							
1	INTEREST EXPENSE	F					9	1
2	INTEREST EXPENSE	F	INTEREST EXPENSE	113		401,218	9	2
500	TOTAL RECLASSIFICATIONS					401,218		500
	CODE LETTER - F							
1	DIVISIONAL EXPENSES SALARIES	G	ADMINISTRATIVE & GENERAL	5		1,682,255		1
2	DIVISIONAL EXPENSES BENEFITS	G	ADMINISTRATIVE & GENERAL	5		675,787		2
3	DIVISONAL EXPENSES SALARIES	G	ADMINISTRATIVE & GENERAL	5		138,215		3
4	DIVISIONAL EXPENSES SALARIES	G	ADMINISTRATIVE & GENERAL	5		47,801		4
500	TOTAL RECLASSIFICATIONS					2,544,058		500
	CODE LETTER - G							
	GRAND TOTAL (DECREASES)				706,296	7,413,018		

(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	3,026,628					3,026,628		1
2	LAND IMPROVEMENTS	2,074,344	1,356,748		1,356,748		3,431,092	1,793,688	2
3	BUILDINGS AND FIXTURES	63,746,569	2,032,665		2,032,665	317,972	65,461,262	25,446,035	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	15,070,591	619		619		15,071,210	13,660,183	5
6	MOVABLE EQUIPMENT	68,203,758	3,237,398		3,237,398	3,129,918	68,311,238	54,385,559	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	152,121,890	6,627,430		6,627,430	3,447,890	155,301,430	95,285,465	8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	152,121,890	6,627,430		6,627,430	3,447,890	155,301,430	95,285,465	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	2,043,588						2,043,588	1
2	CAP REL COSTS-MVBLE EQUIP	4,373,438	1,085,239					5,458,677	2
3	TOTAL (sum of lines 1-2)	6,417,026	1,085,239					7,502,265	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				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					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	3,274,430		-296,809				2,977,621	1
2	CAP REL COSTS-MVBLE EQUIP	4,446,476	1,085,239	-67,426				5,464,289	2
3	TOTAL (sum of lines 1-2)	7,720,906	1,085,239	-364,235				8,441,910	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)	B	-296,809	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)	B	-67,426	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-4,476	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-4,004	CAP REL COSTS-MVBLE EQUIP	2	9	7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,404,680				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-13,526	RADIOLOGY-DIAGNOSTIC	54		11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-12,092				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-66,012	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE 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	A	827,672	CAP REL COSTS-BLDG & FIXT	1	9	26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	1	CAP REL COSTS-MVBLE EQUIP	2	9	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	TELEPHONE EMPLOYEE BENEFITS	A	-5,010	EMPLOYEE BENEFITS DEPARTMENT	4		33
34	TELEPHONE A&G SALARIES	A	-11,778	ADMINISTRATIVE & GENERAL	5		34
35	TELEPHONE A&G EXPENSES	A	836	ADMINISTRATIVE & GENERAL	5		35
36	TELEVISION EMPLOYEE BENEFITS	A	-926	EMPLOYEE BENEFITS DEPARTMENT	4		36
37	TELEVISION MAINTENANCE SALARIES	A	-2,178	MAINTENANCE & REPAIRS	6		37
38	TELEVISION MAINTENANCE CABLE	A	-14,438	MAINTENANCE & REPAIRS	6		38
39	TELEVISION PLANT ELECTRIC	A	-506	OPERATION OF PLANT	7		39
40	RECYCLING	B	-1,987	OPERATION OF PLANT	7		40
41							41
42	NON-OPERATING BUILDINGS	A	-53,293	ADMINISTRATIVE & GENERAL	5		42
43	PHYSICIAN EXPENSE	A	-7,459	ADMINISTRATIVE & GENERAL	5		43
44	COMMUNITY RELATION ADVERTISING	A	-551,131	ADMINISTRATIVE & GENERAL	5		44
45	HOUSKEEPING	B	-96	HOUSEKEEPING	9		45
45.04	LOBBYING EXPENSE	A	-32,109	ADMINISTRATIVE & GENERAL	5		45.04
45.06	NAME BADGES	B	-565	EMPLOYEE BENEFITS DEPARTMENT	4		45.06
45.07	PHYSICIAN APPLICATIONS	B	-6,500	ADMINISTRATIVE & GENERAL	5		45.07
45.08	GUEST MEALS	B	-9	DIETARY	10		45.08
45.10	PHYSICIAN RECRUITMENT	A	-123,943	ADMINISTRATIVE & GENERAL	5		45.10
45.11	REBATES	B	-13,204	ADMINISTRATIVE & GENERAL	5		45.11
45.12	REBATES	B	-13,228	DIETARY	10		45.12
45.13	REBATES	B	-37,552	DRUGS CHARGED TO PATIENTS	73		45.13
45.14	REBATES	B	-28,339	ADULTS & PEDIATRICS	30		45.14
45.15	REBATES	B	-4,373	LABORATORY	60		45.15
45.16	REBATES	B	-21	ELECTROCARDIOLOGY	69		45.16
45.17	REBATES	B	-3,092	MEDICAL SUPPLIES CHARGED TO PATIENTS	71		45.17
45.18	REBATES	B	-160,569	OPERATING ROOM	50		45.18
45.19	REBATES	B	-402	OPERATION OF PLANT	7		45.19
45.20	REBATES	B	-6,178	RADIOLOGY-DIAGNOSTIC	54		45.20
45.22	ALCOHOLIC BEVERAGES	A	-3,118	ADMINISTRATIVE & GENERAL	5		45.22
45.26	IN-SERVICE	B	-1,398	ADMINISTRATIVE & GENERAL	5		45.26
45.28	MISC INCOME - SPIRIT COMMITTEE	B	-18,618	EMPLOYEE BENEFITS DEPARTMENT	4		45.28

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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	
45.30	IN-SERVICE	B	-2,010	NURSING ADMINISTRATION	13		45.30
45.40	MISC INC	B	-550	LABORATORY	60		45.40
45.43	DRUGS NON PATIENT	B	-2,418	PHARMACY	15		45.43
45.47	PHYSICIAN DUES	B	-13,816	ADMINISTRATIVE & GENERAL	5		45.47
45.48	DIABETES INSTRUCTION	B	-19,306	DIETARY	10		45.48
45.50	HOUSEKEEPING 900 W TEMPLE	B	-6,562	ADMINISTRATIVE & GENERAL	5		45.50
45.52	ASPR GRANT	B	-7,295	EMERGENCY	91		45.52
45.53	CRNA SALARIES	B	-1,805,016	OPERATING ROOM	50		45.53
45.54	MISC INCOME	B	-104	ADMINISTRATIVE & GENERAL	5		45.54
45.55	MOBILE IPAD DONATION	B	-49,400	ADMINISTRATIVE & GENERAL	5		45.55
45.57	BOUTIQUE SALES	B	-10,802	RADIOLOGY-DIAGNOSTIC	54		45.57
46	OCCUPATIONAL THERAPY-IN SERVICE	B	-1,577	OCCUPATIONAL THERAPY	67		46
47	FOUNDATION EXPENSE	B	37,403	PHILANTHROPY DEVELOPMENT	194		47
48	ALTAMONT DIAG CTR	B	-708	RADIOLOGY-DIAGNOSTIC	54		48
49	MEANINGFUL USE FUNDS	B	-1,727,218	ADMINISTRATIVE & GENERAL	5		49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-7,751,915				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	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,798,484	6,027,769	-4,229,285		1
2	5	ADMINISTRATIVE & GENERAL	CCC (FAMIS) FEE	5,730,571	1,388,208	4,342,363		2
3	4	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	10,045,138	10,170,308	-125,170		3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			17,574,193	17,586,285	-12,092		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	G	HSHS		HSHS		CORPORATE OFFICE	6
7							7
8							8
9							9
10							10

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

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

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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	91	EMERGENCY EMERGENCY	862,799	862,799						1
2	53	ANESTHESIOLOGY ANESTHESIA	1,346,353	1,346,353						2
3	69	ELECTROCARDIOLOGY CARDIOLOGY	173,620	173,620						3
4	65	RESPIRATORY THERAPY RESPIRATORY CAR	25,228	25,228						4
5	76.01	VASCULAR LAB VASCULAR LAB								5
6	60	LABORATORY LABORATORY	25,000	25,000						6
7	76.03	WOUND CARE WOUND CARE	270,035	270,035						7
8	54	RADIOLOGY-DIAGNOSTIC WOMENS WELLNESS								8
9	70	ELECTROENCEPHALOGRAP NEUROLOGY	76,450	76,450						9
10	69	ELECTROCARDIOLOGY PRAIRIE CARDIOV								10
11	50	OPERATING ROOM HSHS MEDICAL GR	625,195	625,195						11
12	66	PHYSICAL THERAPY SPEECH THERAPIS								12
13	54.04	RADIATION ONC RADIATION ONCOL								13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	3,404,680	3,404,680						200

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	91	EMERGENCY EMERGENCY							862,799	1
2	53	ANESTHESIOLOGY ANESTHESIA							1,346,353	2
3	69	ELECTROCARDIOLOGY CARDIOLOGY							173,620	3
4	65	RESPIRATORY THERAPY RESPIRATORY CAR							25,228	4
5	76.01	VASCULAR LAB VASCULAR LAB								5
6	60	LABORATORY LABORATORY							25,000	6
7	76.03	WOUND CARE WOUND CARE							270,035	7
8	54	RADIOLOGY-DIAGNOSTIC WOMENS WELLNESS								8
9	70	ELECTROENCEPHALOGRAP NEUROLOGY							76,450	9
10	69	ELECTROCARDIOLOGY PRAIRIE CARDIOV								10
11	50	OPERATING ROOM HSHS MEDICAL GR							625,195	11
12	66	PHYSICAL THERAPY SPEECH THERAPIS								12
13	54.04	RADIATION ONC RADIATION ONCOL								13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							3,404,680	200

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COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	2,977,621	2,977,621					1
2	CAP REL COSTS-MVBLE EQUIP	5,464,289		5,464,289				2
4	EMPLOYEE BENEFITS DEPARTMENT	13,933,650	8,061		13,941,711			4
5	ADMINISTRATIVE & GENERAL	17,872,188	779,098	1,047,577	1,464,217	21,163,080	21,163,080	5
6	MAINTENANCE & REPAIRS	1,051,325	41,108	22,597	279,395	1,394,425	421,712	6
7	OPERATION OF PLANT	1,492,286	468,232	1,469,809	73,911	3,504,238	1,059,776	7
8	LAUNDRY & LINEN SERVICE	562,793	29,425	2,003	32,349	626,570	189,492	8
9	HOUSEKEEPING	911,091	31,734	900	289,707	1,233,432	373,023	9
10	DIETARY	176,432	42,355	10,646	108,727	338,160	102,269	10
11	CAFETERIA	828,966	15,006	2,457	211,874	1,058,303	320,059	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	860,404	23,402	3,766	382,916	1,270,488	384,230	13
14	CENTRAL SERVICES & SUPPLY	2,882	56,374			59,256	17,921	14
15	PHARMACY	1,180,837	26,539	222,113	525,565	1,955,054	591,261	15
16	MEDICAL RECORDS & LIBRARY	2,791,105	35,839	43,212	902,111	3,772,267	1,140,835	16
17	SOCIAL SERVICE	1,910				1,910	578	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,842,275	390,206	193,916	2,584,556	9,010,953	2,725,155	30
31	INTENSIVE CARE UNIT	1,117,768	39,851	107,239	499,857	1,764,715	533,697	31
43	NURSERY	22,729	7,419	2,209		32,357	9,786	43
44	SKILLED NURSING FACILITY	323,831	32,441	1,074	137,579	494,925	149,679	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,202,739	277,756	647,131	1,423,022	12,550,648	3,795,674	50
52	DELIVERY ROOM & LABOR ROOM	90,928	43,547	39,985		174,460	52,761	52
53	ANESTHESIOLOGY	1,626,310	1,825	92,780	641,847	2,362,762	714,563	53
54	RADIOLOGY-DIAGNOSTIC	1,897,898	140,851	585,527	657,126	3,281,402	992,385	54
54.01	ULTRASOUND	183,546	4,282	30,578	74,188	292,594	88,488	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	485,984	22,630	41,581	74,058	624,253	188,791	54.02
54.04	RADIATION ONC	52,225		530		52,755	15,955	54.04
54.06	PET SCAN	130,435	1,862			132,297	40,010	54.06
57	CT SCAN	587,999	13,042	140,919	106,857	848,817	256,705	57
58	MRI	422,103	45,082	205,749	75,472	748,406	226,338	58
59	CARDIAC CATHETERIZATION	360,408	17,240	29,026	85,567	492,241	148,867	59
60	LABORATORY	3,089,480	67,954	139,621	583,441	3,880,496	1,173,567	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	751,542	18,115	46,170	309,371	1,125,198	340,290	65
66	PHYSICAL THERAPY	1,098,783	41,117	19,662	460,189	1,619,751	489,856	66
67	OCCUPATIONAL THERAPY	184,643	6,581		77,621	268,845	81,306	67
69	ELECTROCARDIOLOGY	529,171	37,282	153,049	204,426	923,928	279,421	69
70	ELECTROENCEPHALOGRAPHY	137,121	6,358	5,223	52,496	201,198	60,848	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,235,748				1,235,748	373,724	71
73	DRUGS CHARGED TO PATIENTS	2,771,160				2,771,160	838,074	73
74	RENAL DIALYSIS	33,271	4,161			37,432	11,320	74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB	211,454	3,547	76,662	79,371	371,034	112,211	76.01
76.02	CARDIAC REHAB	77,956	6,144	1,312	34,454	119,866	36,251	76.02
76.03	WOUND CARE	738,963	41,489	16,910	101,998	899,360	271,991	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	7,648	3,146			10,794	3,264	90
91	EMERGENCY	1,576,510	85,045	23,719	631,385	2,316,659	700,620	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	1,709,184	19,614	36,614	668,457	2,433,869	736,068	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	244,257	3,109		68,607	315,973	95,559	116
118	SUBTOTALS (sum of lines 1-117)	87,851,848	2,938,869	5,462,266	13,902,717	87,772,079	20,144,380	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,296	5,148	2,023		35,467	10,726	190
194	PHILANTHROPY DEVELOPMENT		4,235		38,994	43,229	13,074	194

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	
194.01	VENDING		1,489			1,489	450	194.01
194.02	MEALS ON WHEELS							194.02
194.03	PRAIRIE CARDIOVASCULAR	3,260,352	27,880			3,288,232	994,450	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	91,140,496	2,977,621	5,464,289	13,941,711	91,140,496	21,163,080	202

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	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	1,816,137						6
7	OPERATION OF PLANT	591,449	5,155,463					7
8	LAUNDRY & LINEN SERVICE	11,679	90,237	917,978				8
9	HOUSEKEEPING	155,846	97,317	36,547	1,896,165			9
10	DIETARY	52,922	129,889	5,452	50,488	679,180		10
11	CAFETERIA	2,372	46,018		17,887		1,444,639	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	61,317	71,767		26,316		29,407	13
14	CENTRAL SERVICES & SUPPLY		172,881		67,199			14
15	PHARMACY	17,154	81,388		31,635		46,376	15
16	MEDICAL RECORDS & LIBRARY	11,862	109,906		42,715		116,505	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	172,635	1,196,637	364,683	465,132	565,368	350,522	30
31	INTENSIVE CARE UNIT	46,535	122,210	34,935	47,503	52,577	59,243	31
43	NURSERY	16,424	22,752		8,844			43
44	SKILLED NURSING FACILITY	10,949	99,487	24,082	38,669	58,537	20,747	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	195,629	851,788	218,591	331,081		200,097	50
52	DELIVERY ROOM & LABOR ROOM	55,477	133,543		51,908			52
53	ANESTHESIOLOGY	7,300	5,595		2,175		25,462	53
54	RADIOLOGY-DIAGNOSTIC	102,924	431,946	34,151	167,891		94,619	54
54.01	ULTRASOUND	1,095	13,132	4,015	5,098		7,818	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	15,147	69,398	3,206	26,975		9,352	54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN		5,709		2,219			54.06
57	CT SCAN	365	39,994	9,747	15,546		13,034	57
58	MRI	730	138,254	17,994	53,738		10,693	58
59	CARDIAC CATHETERIZATION	8,760	52,869	66	20,550			59
60	LABORATORY	44,710	208,394	449	80,997		93,050	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	65,879	55,553	13,162	21,594		42,432	65
66	PHYSICAL THERAPY	47,447	126,093	5,204	49,011		51,188	66
67	OCCUPATIONAL THERAPY	1,277	20,183	1,024	7,845		8,450	67
69	ELECTROCARDIOLOGY	10,949	114,331	4,281	44,441		44,141	69
70	ELECTROENCEPHALOGRAPHY		19,498	129	7,579		6,986	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		12,761		4,960			74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB	2,737	10,876	783	4,227		9,326	76.01
76.02	CARDIAC REHAB	4,015	18,841	779	7,324		3,839	76.02
76.03	WOUND CARE	7,482	127,234	10,517	49,456		16,338	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,015	9,649		3,744		167	90
91	EMERGENCY	81,208	260,806		101,373		92,331	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	6,022	60,149	126,925	23,377		83,698	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE		9,535		3,706		8,818	116
118	SUBTOTALS (sum of lines 1-117)	1,814,312	5,036,620	916,722	1,883,203	676,482	1,444,639	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		15,787		6,137			190
194	PHILANTHROPY DEVELOPMENT		12,989		5,049			194
194.01	VENDING		4,568		1,776	2,698		194.01
194.02	MEALS ON WHEELS							194.02

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COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
194.03	PRAIRIE CARDIOVASCULAR	1,825	85,499	1,256				194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,816,137	5,155,463	917,978	1,896,165	679,180	1,444,639	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		13	14	15	16	17	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	1,843,525						13
14	CENTRAL SERVICES & SUPPLY		317,257					14
15	PHARMACY		187	2,723,055				15
16	MEDICAL RECORDS & LIBRARY				5,194,090			16
17	SOCIAL SERVICE					2,488		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	792,499	3,888	6,595	4,316,896	2,068	19,973,031	30
31	INTENSIVE CARE UNIT	133,921	680	1,264	430,028	206	3,227,514	31
43	NURSERY		370				90,533	43
44	SKILLED NURSING FACILITY	46,925	205	335	447,166	214	1,391,920	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	452,480	230,972	1,959			18,828,919	50
52	DELIVERY ROOM & LABOR ROOM		2,048				470,197	52
53	ANESTHESIOLOGY		1,167	51,170			3,170,194	53
54	RADIOLOGY-DIAGNOSTIC		3,839	2,646			5,111,803	54
54.01	ULTRASOUND		568				412,808	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC		6,445	2,690			946,257	54.02
54.04	RADIATION ONC						68,710	54.04
54.06	PET SCAN		1				180,236	54.06
57	CT SCAN		2,553	30			1,186,791	57
58	MRI		1,275				1,197,428	58
59	CARDIAC CATHETERIZATION		1,825	73			725,251	59
60	LABORATORY		18,862	1,770			5,502,295	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		1,990	36			1,666,134	65
66	PHYSICAL THERAPY		209	70			2,388,829	66
67	OCCUPATIONAL THERAPY		425				389,355	67
69	ELECTROCARDIOLOGY		453	447			1,422,392	69
70	ELECTROENCEPHALOGRAPHY		361	209			296,808	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		31,958	25			1,641,455	71
73	DRUGS CHARGED TO PATIENTS			2,635,986			6,245,220	73
74	RENAL DIALYSIS		5				66,478	74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB		399	502			512,095	76.01
76.02	CARDIAC REHAB		50				190,965	76.02
76.03	WOUND CARE		2,255	3,213			1,387,846	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		98	32			31,763	90
91	EMERGENCY	208,498	2,091	2,387			3,765,973	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	189,228	1,958	160			3,661,454	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	19,974	118	11,456			465,139	116
118	SUBTOTALS (sum of lines 1-117)	1,843,525	317,255	2,723,055	5,194,090	2,488	86,615,793	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						68,117	190
194	PHILANTHROPY DEVELOPMENT						74,341	194
194.01	VENDING						10,981	194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		13	14	15	16	17	24	
194.03	PRAIRIE CARDIOVASCULAR		2				4,371,264	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,843,525	317,257	2,723,055	5,194,090	2,488	91,140,496	202

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		19,973,031					30
31	INTENSIVE CARE UNIT		3,227,514					31
43	NURSERY		90,533					43
44	SKILLED NURSING FACILITY		1,391,920					44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		18,828,919					50
52	DELIVERY ROOM & LABOR ROOM		470,197					52
53	ANESTHESIOLOGY		3,170,194					53
54	RADIOLOGY-DIAGNOSTIC		5,111,803					54
54.01	ULTRASOUND		412,808					54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC		946,257					54.02
54.04	RADIATION ONC		68,710					54.04
54.06	PET SCAN		180,236					54.06
57	CT SCAN		1,186,791					57
58	MRI		1,197,428					58
59	CARDIAC CATHETERIZATION		725,251					59
60	LABORATORY		5,502,295					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		1,666,134					65
66	PHYSICAL THERAPY		2,388,829					66
67	OCCUPATIONAL THERAPY		389,355					67
69	ELECTROCARDIOLOGY		1,422,392					69
70	ELECTROENCEPHALOGRAPHY		296,808					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,641,455					71
73	DRUGS CHARGED TO PATIENTS		6,245,220					73
74	RENAL DIALYSIS		66,478					74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB		512,095					76.01
76.02	CARDIAC REHAB		190,965					76.02
76.03	WOUND CARE		1,387,846					76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		31,763					90
91	EMERGENCY		3,765,973					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		3,661,454					101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE		465,139					116
118	SUBTOTALS (sum of lines 1-117)		86,615,793					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		68,117					190
194	PHILANTHROPY DEVELOPMENT		74,341					194
194.01	VENDING		10,981					194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
194.03	PRAIRIE CARDIOVASCULAR		4,371,264					194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		91,140,496					202

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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		8,061		8,061	8,061		4
5	ADMINISTRATIVE & GENERAL		779,098	1,047,577	1,826,675	847	1,827,522	5
6	MAINTENANCE & REPAIRS		41,108	22,597	63,705	162	36,417	6
7	OPERATION OF PLANT		468,232	1,469,809	1,938,041	43	91,517	7
8	LAUNDRY & LINEN SERVICE		29,425	2,003	31,428	19	16,364	8
9	HOUSEKEEPING		31,734	900	32,634	168	32,212	9
10	DIETARY		42,355	10,646	53,001	63	8,831	10
11	CAFETERIA		15,006	2,457	17,463	123	27,639	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		23,402	3,766	27,168	221	33,180	13
14	CENTRAL SERVICES & SUPPLY		56,374		56,374		1,548	14
15	PHARMACY		26,539	222,113	248,652	304	51,058	15
16	MEDICAL RECORDS & LIBRARY		35,839	43,212	79,051	522	98,517	16
17	SOCIAL SERVICE						50	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		390,206	193,916	584,122	1,490	235,330	30
31	INTENSIVE CARE UNIT		39,851	107,239	147,090	289	46,087	31
43	NURSERY		7,419	2,209	9,628		845	43
44	SKILLED NURSING FACILITY		32,441	1,074	33,515	80	12,925	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		277,756	647,131	924,887	823	327,765	50
52	DELIVERY ROOM & LABOR ROOM		43,547	39,985	83,532		4,556	52
53	ANESTHESIOLOGY		1,825	92,780	94,605	371	61,706	53
54	RADIOLOGY-DIAGNOSTIC		140,851	585,527	726,378	380	85,697	54
54.01	ULTRASOUND		4,282	30,578	34,860	43	7,641	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC		22,630	41,581	64,211	43	16,303	54.02
54.04	RADIATION ONC			530	530		1,378	54.04
54.06	PET SCAN		1,862		1,862		3,455	54.06
57	CT SCAN		13,042	140,919	153,961	62	22,168	57
58	MRI		45,082	205,749	250,831	44	19,545	58
59	CARDIAC CATHETERIZATION		17,240	29,026	46,266	49	12,855	59
60	LABORATORY		67,954	139,621	207,575	337	101,343	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		18,115	46,170	64,285	179	29,386	65
66	PHYSICAL THERAPY		41,117	19,662	60,779	266	42,301	66
67	OCCUPATIONAL THERAPY		6,581		6,581	45	7,021	67
69	ELECTROCARDIOLOGY		37,282	153,049	190,331	118	24,129	69
70	ELECTROENCEPHALOGRAPHY		6,358	5,223	11,581	30	5,254	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						32,273	71
73	DRUGS CHARGED TO PATIENTS						72,372	73
74	RENAL DIALYSIS		4,161		4,161		978	74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB		3,547	76,662	80,209	46	9,690	76.01
76.02	CARDIAC REHAB		6,144	1,312	7,456	20	3,130	76.02
76.03	WOUND CARE		41,489	16,910	58,399	59	23,488	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		3,146		3,146		282	90
91	EMERGENCY		85,045	23,719	108,764	365	60,502	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		19,614	36,614	56,228	387	63,563	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE		3,109		3,109	40	8,252	116
118	SUBTOTALS (sum of lines 1-117)		2,938,869	5,462,266	8,401,135	8,038	1,739,553	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,148	2,023	7,171		926	190
194	PHILANTHROPY DEVELOPMENT		4,235		4,235	23	1,129	194
194.01	VENDING		1,489		1,489		39	194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	
194.03	PRAIRIE CARDIOVASCULAR		27,880		27,880		85,875	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		2,977,621	5,464,289	8,441,910	8,061	1,827,522	202

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	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	100,284						6
7	OPERATION OF PLANT	32,657	2,062,258					7
8	LAUNDRY & LINEN SERVICE	645	36,096	84,552				8
9	HOUSEKEEPING	8,606	38,928	3,366	115,914			9
10	DIETARY	2,922	51,958	502	3,086	120,363		10
11	CAFETERIA	131	18,408		1,093		64,857	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,386	28,708		1,609		1,320	13
14	CENTRAL SERVICES & SUPPLY		69,155		4,108			14
15	PHARMACY	947	32,556		1,934		2,082	15
16	MEDICAL RECORDS & LIBRARY	655	43,964		2,611		5,230	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	9,533	478,673	33,590	28,434	100,193	15,739	30
31	INTENSIVE CARE UNIT	2,570	48,886	3,218	2,904	9,318	2,660	31
43	NURSERY	907	9,101		541			43
44	SKILLED NURSING FACILITY	605	39,796	2,218	2,364	10,374	931	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,802	340,727	20,134	20,239		8,983	50
52	DELIVERY ROOM & LABOR ROOM	3,063	53,419		3,173			52
53	ANESTHESIOLOGY	403	2,238		133		1,143	53
54	RADIOLOGY-DIAGNOSTIC	5,683	172,785	3,146	10,263		4,248	54
54.01	ULTRASOUND	60	5,253	370	312		351	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	836	27,760	295	1,649		420	54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN		2,284		136			54.06
57	CT SCAN	20	15,998	898	950		585	57
58	MRI	40	55,303	1,657	3,285		480	58
59	CARDIAC CATHETERIZATION	484	21,148	6	1,256			59
60	LABORATORY	2,469	83,360	41	4,951		4,177	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,638	22,222	1,212	1,320		1,905	65
66	PHYSICAL THERAPY	2,620	50,439	479	2,996		2,298	66
67	OCCUPATIONAL THERAPY	71	8,073	94	480		379	67
69	ELECTROCARDIOLOGY	605	45,734	394	2,717		1,982	69
70	ELECTROENCEPHALOGRAPHY		7,799	12	463		314	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		5,104		303			74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB	151	4,351	72	258		419	76.01
76.02	CARDIAC REHAB	222	7,537	72	448		172	76.02
76.03	WOUND CARE	413	50,896	969	3,023		733	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	222	3,860		229		7	90
91	EMERGENCY	4,484	104,326		6,197		4,145	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	333	24,060	11,691	1,429		3,758	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE		3,814		227		396	116
118	SUBTOTALS (sum of lines 1-117)	100,183	2,014,719	84,436	115,121	119,885	64,857	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,315		375			190
194	PHILANTHROPY DEVELOPMENT		5,196		309			194
194.01	VENDING		1,827		109	478		194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
194.03	PRAIRIE CARDIOVASCULAR	101	34,201	116				194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	100,284	2,062,258	84,552	115,914	120,363	64,857	202

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		13	14	15	16	17	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	95,592						13
14	CENTRAL SERVICES & SUPPLY		131,185					14
15	PHARMACY		77	337,610				15
16	MEDICAL RECORDS & LIBRARY				230,550			16
17	SOCIAL SERVICE					50		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	41,094	1,608	818	191,614	42	1,722,280	30
31	INTENSIVE CARE UNIT	6,944	281	157	19,088	4	289,496	31
43	NURSERY		153				21,175	43
44	SKILLED NURSING FACILITY	2,433	85	42	19,848	4	125,220	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	23,462	95,508	243			1,773,573	50
52	DELIVERY ROOM & LABOR ROOM		847				148,590	52
53	ANESTHESIOLOGY		483	6,344			167,426	53
54	RADIOLOGY-DIAGNOSTIC		1,588	328			1,010,496	54
54.01	ULTRASOUND		235				49,125	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC		2,665	333			114,515	54.02
54.04	RADIATION ONC						1,908	54.04
54.06	PET SCAN						7,737	54.06
57	CT SCAN		1,056	4			195,702	57
58	MRI		527				331,712	58
59	CARDIAC CATHETERIZATION		754	9			82,827	59
60	LABORATORY		7,799	219			412,271	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		823	5			124,975	65
66	PHYSICAL THERAPY		86	9			162,273	66
67	OCCUPATIONAL THERAPY		176				22,920	67
69	ELECTROCARDIOLOGY		187	55			266,252	69
70	ELECTROENCEPHALOGRAPHY		149	26			25,628	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		13,214	3			45,490	71
73	DRUGS CHARGED TO PATIENTS			326,815			399,187	73
74	RENAL DIALYSIS		2				10,548	74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB		165	62			95,423	76.01
76.02	CARDIAC REHAB		21				19,078	76.02
76.03	WOUND CARE		932	398			139,310	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		40	4			7,790	90
91	EMERGENCY	10,811	865	296			300,755	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	9,812	809	20			172,090	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	1,036	49	1,420			18,343	116
118	SUBTOTALS (sum of lines 1-117)	95,592	131,184	337,610	230,550	50	8,264,115	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						14,787	190
194	PHILANTHROPY DEVELOPMENT						10,892	194
194.01	VENDING						3,942	194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		13	14	15	16	17	24	
194.03	PRAIRIE CARDIOVASCULAR		1				148,174	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	95,592	131,185	337,610	230,550	50	8,441,910	202

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		1,722,280					30
31	INTENSIVE CARE UNIT		289,496					31
43	NURSERY		21,175					43
44	SKILLED NURSING FACILITY		125,220					44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		1,773,573					50
52	DELIVERY ROOM & LABOR ROOM		148,590					52
53	ANESTHESIOLOGY		167,426					53
54	RADIOLOGY-DIAGNOSTIC		1,010,496					54
54.01	ULTRASOUND		49,125					54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC		114,515					54.02
54.04	RADIATION ONC		1,908					54.04
54.06	PET SCAN		7,737					54.06
57	CT SCAN		195,702					57
58	MRI		331,712					58
59	CARDIAC CATHETERIZATION		82,827					59
60	LABORATORY		412,271					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		124,975					65
66	PHYSICAL THERAPY		162,273					66
67	OCCUPATIONAL THERAPY		22,920					67
69	ELECTROCARDIOLOGY		266,252					69
70	ELECTROENCEPHALOGRAPHY		25,628					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		45,490					71
73	DRUGS CHARGED TO PATIENTS		399,187					73
74	RENAL DIALYSIS		10,548					74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB		95,423					76.01
76.02	CARDIAC REHAB		19,078					76.02
76.03	WOUND CARE		139,310					76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		7,790					90
91	EMERGENCY		300,755					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		172,090					101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE		18,343					116
118	SUBTOTALS (sum of lines 1-117)		8,264,115					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,787					190
194	PHILANTHROPY DEVELOPMENT		10,892					194
194.01	VENDING		3,942					194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
194.03	PRAIRIE CARDIOVASCULAR		148,174					194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		8,441,910					202

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM. COST	MAIN-TENANCE & REPAIRS MAINT. HOURS	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	319,872						1
2	CAP REL COSTS-MVBLE EQUIP		7,502,265					2
4	EMPLOYEE BENEFITS DEPARTMENT	866		30,086,713				4
5	ADMINISTRATIVE & GENERAL	83,695	1,438,284	3,159,836	-21,163,080	69,977,416		5
6	MAINTENANCE & REPAIRS	4,416	31,025	602,944		1,394,425	9,952	6
7	OPERATION OF PLANT	50,300	2,017,996	159,502		3,504,238	3,241	7
8	LAUNDRY & LINEN SERVICE	3,161	2,750	69,810		626,570	64	8
9	HOUSEKEEPING	3,409	1,235	625,199		1,233,432	854	9
10	DIETARY	4,550	14,617	234,638		338,160	290	10
11	CAFETERIA	1,612	3,373	457,232		1,058,303	13	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,514	5,171	826,346		1,270,488	336	13
14	CENTRAL SERVICES & SUPPLY	6,056				59,256		14
15	PHARMACY	2,851	304,953	1,134,190		1,955,054	94	15
16	MEDICAL RECORDS & LIBRARY	3,850	59,328	1,946,789		3,772,267	65	16
17	SOCIAL SERVICE					1,910		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	41,918	266,239	5,577,542		9,010,953	946	30
31	INTENSIVE CARE UNIT	4,281	147,235	1,078,710		1,764,715	255	31
43	NURSERY	797	3,033			32,357	90	43
44	SKILLED NURSING FACILITY	3,485	1,474	296,901		494,925	60	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	29,838	888,486	3,070,934		12,550,648	1,072	50
52	DELIVERY ROOM & LABOR ROOM	4,678	54,898			174,460	304	52
53	ANESTHESIOLOGY	196	127,383	1,385,129		2,362,762	40	53
54	RADIOLOGY-DIAGNOSTIC	15,131	803,906	1,418,103		3,281,402	564	54
54.01	ULTRASOUND	460	41,983	160,101		292,594	6	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	2,431	57,089	159,821		624,253	83	54.02
54.04	RADIATION ONC		727			52,755		54.04
54.06	PET SCAN	200				132,297		54.06
57	CT SCAN	1,401	193,477	230,601		848,817	2	57
58	MRI	4,843	282,485	162,872		748,406	4	58
59	CARDIAC CATHETERIZATION	1,852	39,851	184,656		492,241	48	59
60	LABORATORY	7,300	191,695	1,259,088		3,880,496	245	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,946	63,390	667,634		1,125,198	361	65
66	PHYSICAL THERAPY	4,417	26,995	993,105		1,619,751	260	66
67	OCCUPATIONAL THERAPY	707		167,508		268,845	7	67
69	ELECTROCARDIOLOGY	4,005	210,131	441,160		923,928	60	69
70	ELECTROENCEPHALOGRAPHY	683	7,171	113,289		201,198		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					1,235,748		71
73	DRUGS CHARGED TO PATIENTS					2,771,160		73
74	RENAL DIALYSIS	447				37,432		74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB	381	105,254	171,286		371,034	15	76.01
76.02	CARDIAC REHAB	660	1,801	74,354		119,866	22	76.02
76.03	WOUND CARE	4,457	23,217	220,116		899,360	41	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	338				10,794	22	90
91	EMERGENCY	9,136	32,565	1,362,553		2,316,659	445	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	2,107	50,270	1,442,556		2,433,869	33	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	334		148,057		315,973		116
118	SUBTOTALS (sum of lines 1-117)	315,709	7,499,487	30,002,562	-21,163,080	66,608,999	9,942	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	553	2,778			35,467		190
194	PHILANTHROPY DEVELOPMENT	455		84,151		43,229		194
194.01	VENDING	160				1,489		194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM. COST	MAIN-TENANCE & REPAIRS MAINT. HOURS	
		1	2	4	5A	5	6	
194.03	PRAIRIE CARDIOVASCULAR	2,995				3,288,232	10	194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,977,621	5,464,289	13,941,711		21,163,080	1,816,137	202
203	UNIT COST MULT-WS B PT I	9.308789	0.728352	0.463384		0.302427	182.489650	203
204	COST TO BE ALLOC PER B PT II			8,061		1,827,522	100,284	204
205	UNIT COST MULT-WS B PT II			0.000268		0.026116	10.076768	205

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		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	180,595						7
8	LAUNDRY & LINEN SERVICE	3,161	787,952					8
9	HOUSEKEEPING	3,409	31,370	1,491,824				9
10	DIETARY	4,550	4,680	39,722	50,599			10
11	CAFETERIA	1,612		14,073		164,818		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,514		20,704		3,355	507,625	13
14	CENTRAL SERVICES & SUPPLY	6,056		52,869				14
15	PHARMACY	2,851		24,889		5,291		15
16	MEDICAL RECORDS & LIBRARY	3,850		33,606		13,292		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	41,918	313,027	365,948	42,120	39,991	218,219	30
31	INTENSIVE CARE UNIT	4,281	29,987	37,373	3,917	6,759	36,876	31
43	NURSERY	797		6,958				43
44	SKILLED NURSING FACILITY	3,485	20,671	30,423	4,361	2,367	12,921	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	29,838	187,629	260,481		22,829	124,593	50
52	DELIVERY ROOM & LABOR ROOM	4,678		40,839				52
53	ANESTHESIOLOGY	196		1,711		2,905		53
54	RADIOLOGY-DIAGNOSTIC	15,131	29,314	132,090		10,795		54
54.01	ULTRASOUND	460	3,446	4,011		892		54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	2,431	2,752	21,223		1,067		54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN	200		1,746				54.06
57	CT SCAN	1,401	8,366	12,231		1,487		57
58	MRI	4,843	15,445	42,279		1,220		58
59	CARDIAC CATHETERIZATION	1,852	57	16,168				59
60	LABORATORY	7,300	385	63,725		10,616		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,946	11,298	16,989		4,841		65
66	PHYSICAL THERAPY	4,417	4,467	38,560		5,840		66
67	OCCUPATIONAL THERAPY	707	879	6,172		964		67
69	ELECTROCARDIOLOGY	4,005	3,675	34,964		5,036		69
70	ELECTROENCEPHALOGRAPHY	683	111	5,963		797		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	447		3,902				74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB	381	672	3,326		1,064		76.01
76.02	CARDIAC REHAB	660	669	5,762		438		76.02
76.03	WOUND CARE	4,457	9,027	38,910		1,864		76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	338		2,946		19		90
91	EMERGENCY	9,136		79,756		10,534	57,411	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	2,107	108,947	18,392		9,549	52,105	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	334		2,916		1,006	5,500	116
118	SUBTOTALS (sum of lines 1-117)	176,432	786,874	1,481,627	50,398	164,818	507,625	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	553		4,828				190
194	PHILANTHROPY DEVELOPMENT	455		3,972				194
194.01	VENDING	160		1,397	201			194.01
194.02	MEALS ON WHEELS							194.02

KPMG LLP

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		7	8	9	10	11	13	
194.03	PRAIRIE CARDIOVASCULAR	2,995	1,078					194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	5,155,463	917,978	1,896,165	679,180	1,444,639	1,843,525	202
203	UNIT COST MULT-WS B PT I	28.547097	1.165018	1.271038	13.422795	8.765056	3.631667	203
204	COST TO BE ALLOC PER B PT II	2,062,258	84,552	115,914	120,363	64,857	95,592	204
205	UNIT COST MULT-WS B PT II	11.419242	0.107306	0.077700	2.378762	0.393507	0.188312	205

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT			
		14	15	16	17			
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	12,260,153						14
15	PHARMACY	7,225	2,918,703					15
16	MEDICAL RECORDS & LIBRARY			10,001				16
17	SOCIAL SERVICE				10,001			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	150,238	7,069	8,312	8,312			30
31	INTENSIVE CARE UNIT	26,270	1,355	828	828			31
43	NURSERY	14,280						43
44	SKILLED NURSING FACILITY	7,925	359	861	861			44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,925,791	2,100					50
52	DELIVERY ROOM & LABOR ROOM	79,154						52
53	ANESTHESIOLOGY	45,100	54,846					53
54	RADIOLOGY-DIAGNOSTIC	148,369	2,836					54
54.01	ULTRASOUND	21,958						54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	249,050	2,883					54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN	25						54.06
57	CT SCAN	98,649	32					57
58	MRI	49,286						58
59	CARDIAC CATHETERIZATION	70,512	78					59
60	LABORATORY	728,924	1,897					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	76,907	39					65
66	PHYSICAL THERAPY	8,076	75					66
67	OCCUPATIONAL THERAPY	16,409						67
69	ELECTROCARDIOLOGY	17,522	479					69
70	ELECTROENCEPHALOGRAPHY	13,952	224					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,234,996	27					71
73	DRUGS CHARGED TO PATIENTS		2,825,380					73
74	RENAL DIALYSIS	201						74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB	15,422	538					76.01
76.02	CARDIAC REHAB	1,927						76.02
76.03	WOUND CARE	87,146	3,444					76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	3,771	34					90
91	EMERGENCY	80,814	2,558					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	75,648	171					101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	4,541	12,279					116
118	SUBTOTALS (sum of lines 1-117)	12,260,088	2,918,703	10,001	10,001			118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	PHILANTHROPY DEVELOPMENT							194

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT			
		14	15	16	17			
194.01	VENDING							194.01
194.02	MEALS ON WHEELS							194.02
194.03	PRAIRIE CARDIOVASCULAR	65						194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	317,257	2,723,055	5,194,090	2,488			202
203	UNIT COST MULT-WS B PT I	0.025877	0.932967	519.357064	0.248775			203
204	COST TO BE ALLOC PER B PT II	131,185	337,610	230,550	50			204
205	UNIT COST MULT-WS B PT II	0.010700	0.115671	23.052695	0.005000			205

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COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	19,973,031		19,973,031		19,973,031	30
31	INTENSIVE CARE UNIT	3,227,514		3,227,514		3,227,514	31
43	NURSERY	90,533		90,533		90,533	43
44	SKILLED NURSING FACILITY	1,391,920		1,391,920		1,391,920	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	18,828,919		18,828,919		18,828,919	50
52	DELIVERY ROOM & LABOR ROOM	470,197		470,197		470,197	52
53	ANESTHESIOLOGY	3,170,194		3,170,194		3,170,194	53
54	RADIOLOGY-DIAGNOSTIC	5,111,803		5,111,803		5,111,803	54
54.01	ULTRASOUND	412,808		412,808		412,808	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	946,257		946,257		946,257	54.02
54.04	RADIATION ONC	68,710		68,710		68,710	54.04
54.06	PET SCAN	180,236		180,236		180,236	54.06
57	CT SCAN	1,186,791		1,186,791		1,186,791	57
58	MRI	1,197,428		1,197,428		1,197,428	58
59	CARDIAC CATHETERIZATION	725,251		725,251		725,251	59
60	LABORATORY	5,502,295		5,502,295		5,502,295	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,666,134		1,666,134		1,666,134	65
66	PHYSICAL THERAPY	2,388,829		2,388,829		2,388,829	66
67	OCCUPATIONAL THERAPY	389,355		389,355		389,355	67
69	ELECTROCARDIOLOGY	1,422,392		1,422,392		1,422,392	69
70	ELECTROENCEPHALOGRAPHY	296,808		296,808		296,808	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,641,455		1,641,455		1,641,455	71
73	DRUGS CHARGED TO PATIENTS	6,245,220		6,245,220		6,245,220	73
74	RENAL DIALYSIS	66,478		66,478		66,478	74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	512,095		512,095		512,095	76.01
76.02	CARDIAC REHAB	190,965		190,965		190,965	76.02
76.03	WOUND CARE	1,387,846		1,387,846		1,387,846	76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	31,763		31,763		31,763	90
91	EMERGENCY	3,765,973		3,765,973		3,765,973	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,289,693		2,289,693		2,289,693	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	3,661,454		3,661,454		3,661,454	101
113	INTEREST EXPENSE						113
116	HOSPICE	465,139		465,139		465,139	116
200	SUBTOTAL (SEE INSTRUCTIONS)	88,905,486		88,905,486		88,905,486	200
201	LESS OBSERVATION BEDS	2,289,693		2,289,693		2,289,693	201
202	TOTAL (SEE INSTRUCTIONS)	86,615,793		86,615,793		86,615,793	202

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	11,934,158		11,934,158				30
31	INTENSIVE CARE UNIT	2,919,629		2,919,629				31
43	NURSERY	1,038,745		1,038,745				43
44	SKILLED NURSING FACILITY	492,922		492,922				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	28,219,911	38,862,952	67,082,863	0.280682	0.280682	0.280682	50
52	DELIVERY ROOM & LABOR ROOM	1,897,647	309,150	2,206,797	0.213068	0.213068	0.213068	52
53	ANESTHESIOLOGY	1,907,111	3,694,780	5,601,891	0.565915	0.565915	0.565915	53
54	RADIOLOGY-DIAGNOSTIC	1,986,952	13,042,581	15,029,533	0.340117	0.340117	0.340117	54
54.01	ULTRASOUND	295,988	2,475,851	2,771,839	0.148929	0.148929	0.148929	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	816,256	9,873,540	10,689,796	0.088520	0.088520	0.088520	54.02
54.04	RADIATION ONC	33,929		33,929	2.025111	2.025111	2.025111	54.04
54.06	PET SCAN	19,033	746,449	765,482	0.235454	0.235454	0.235454	54.06
57	CT SCAN	4,335,408	22,248,330	26,583,738	0.044643	0.044643	0.044643	57
58	MRI	784,806	14,472,109	15,256,915	0.078484	0.078484	0.078484	58
59	CARDIAC CATHETERIZATION	400,065	2,403,095	2,803,160	0.258726	0.258726	0.258726	59
60	LABORATORY	7,025,363	11,670,929	18,696,292	0.294299	0.294299	0.294299	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,336,607	993,958	4,330,565	0.384738	0.384738	0.384738	65
66	PHYSICAL THERAPY	1,123,693	1,569,837	2,693,530	0.886877	0.886877	0.886877	66
67	OCCUPATIONAL THERAPY	299,763	264,390	564,153	0.690159	0.690159	0.690159	67
69	ELECTROCARDIOLOGY	1,909,252	10,422,065	12,331,317	0.115348	0.115348	0.115348	69
70	ELECTROENCEPHALOGRAPHY	10,695	1,857,837	1,868,532	0.158846	0.158846	0.158846	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,317,049	7,940,879	15,257,928	0.107580	0.107580	0.107580	71
73	DRUGS CHARGED TO PATIENTS	14,514,458	8,912,413	23,426,871	0.266584	0.266584	0.266584	73
74	RENAL DIALYSIS	72,620	1,854	74,474	0.892634	0.892634	0.892634	74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB	241,884	1,602,921	1,844,805	0.277588	0.277588	0.277588	76.01
76.02	CARDIAC REHAB	1,398	355,764	357,162	0.534673	0.534673	0.534673	76.02
76.03	WOUND CARE	14,274	4,383,881	4,398,155	0.315552	0.315552	0.315552	76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		9,237	9,237	3.438671	3.438671	3.438671	90
91	EMERGENCY	2,537,715	14,284,867	16,822,582	0.223864	0.223864	0.223864	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	77,087	2,734,219	2,811,306	0.814459	0.814459	0.814459	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		2,862,395	2,862,395				101
113	INTEREST EXPENSE							113
116	HOSPICE							116
200	SUBTOTAL (SEE INSTRUCTIONS)	95,564,418	177,996,283	273,560,701				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	95,564,418	177,996,283	273,560,701				202

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COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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)	1,722,280		1,722,280	17,638	97.65	9,293	907,461	30
31	INTENSIVE CARE UNIT	289,496		289,496	1,556	186.05	1,028	191,259	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	21,175		21,175	1,500	14.12			43
44	SKILLED NURSING FACILITY	125,220		125,220	1,617	77.44	1,448	112,133	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,158,171		2,158,171	22,311		11,769	1,210,853	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0032** **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

(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	1,773,573	67,082,863	0.026439	14,913,711	394,304	50
52	DELIVERY ROOM & LABOR ROOM	148,590	2,206,797	0.067333	58,613	3,947	52
53	ANESTHESIOLOGY	167,426	5,601,891	0.029887	899,727	26,890	53
54	RADIOLOGY-DIAGNOSTIC	1,010,496	15,029,533	0.067234	1,344,726	90,411	54
54.01	ULTRASOUND	49,125	2,771,839	0.017723	172,338	3,054	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	114,515	10,689,796	0.010713	529,432	5,672	54.02
54.04	RADIATION ONC	1,908	33,929	0.056235	18,987	1,068	54.04
54.06	PET SCAN	7,737	765,482	0.010107	19,022	192	54.06
57	CT SCAN	195,702	26,583,738	0.007362	2,818,531	20,750	57
58	MRI	331,712	15,256,915	0.021742	504,835	10,976	58
59	CARDIAC CATHETERIZATION	82,827	2,803,160	0.029548	285,464	8,435	59
60	LABORATORY	412,271	18,696,292	0.022051	4,935,587	108,835	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	124,975	4,330,565	0.028859	2,025,730	58,461	65
66	PHYSICAL THERAPY	162,273	2,693,530	0.060245	660,663	39,802	66
67	OCCUPATIONAL THERAPY	22,920	564,153	0.040627	161,761	6,572	67
69	ELECTROCARDIOLOGY	266,252	12,331,317	0.021592	1,145,097	24,725	69
70	ELECTROENCEPHALOGRAPHY	25,628	1,868,532	0.013716	9,859	135	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,490	15,257,928	0.002981	3,895,889	11,614	71
73	DRUGS CHARGED TO PATIENTS	399,187	23,426,871	0.017040	9,020,585	153,711	73
74	RENAL DIALYSIS	10,548	74,474	0.141633	65,905	9,334	74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	95,423	1,844,805	0.051725	145,612	7,532	76.01
76.02	CARDIAC REHAB	19,078	357,162	0.053416	806	43	76.02
76.03	WOUND CARE	139,310	4,398,155	0.031675	1,065	34	76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	7,790	9,237	0.843347			90
91	EMERGENCY	300,755	16,822,582	0.017878	1,657,865	29,639	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	197,440	2,811,306	0.070231	37,717	2,649	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,112,951	254,312,852		45,329,527	1,018,785	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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)	17,638		9,293		30
31	INTENSIVE CARE UNIT	1,556		1,028		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	1,500				43
44	SKILLED NURSING FACILITY	1,617		1,448		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	22,311		11,769		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0032** | **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
54.01	ULTRASOUND							54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC							54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN							54.06
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB							76.01
76.02	CARDIAC REHAB							76.02
76.03	WOUND CARE							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0032** | **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	67,082,863			14,913,711		16,433,406		50
52	DELIVERY ROOM & LABOR ROOM	2,206,797			58,613		148		52
53	ANESTHESIOLOGY	5,601,891			899,727		1,596,797		53
54	RADIOLOGY-DIAGNOSTIC	15,029,533			1,344,726		2,803,304		54
54.01	ULTRASOUND	2,771,839			172,338		821,260		54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	10,689,796			529,432		5,151,933		54.02
54.04	RADIATION ONC	33,929			18,987				54.04
54.06	PET SCAN	765,482			19,022		217,990		54.06
57	CT SCAN	26,583,738			2,818,531		7,828,654		57
58	MRI	15,256,915			504,835		5,147,626		58
59	CARDIAC CATHETERIZATION	2,803,160			285,464		1,362,665		59
60	LABORATORY	18,696,292			4,935,587		1,798,878		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	4,330,565			2,025,730		314,914		65
66	PHYSICAL THERAPY	2,693,530			660,663		821		66
67	OCCUPATIONAL THERAPY	564,153			161,761		4,445		67
69	ELECTROCARDIOLOGY	12,331,317			1,145,097		3,228,542		69
70	ELECTROENCEPHALOGRAPHY	1,868,532			9,859		538,625		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,257,928			3,895,889		2,978,610		71
73	DRUGS CHARGED TO PATIENTS	23,426,871			9,020,585		5,399,738		73
74	RENAL DIALYSIS	74,474			65,905				74
76	BACTERIOLOGY & MICROBIOLOGY								76
76.01	VASCULAR LAB	1,844,805			145,612		895,145		76.01
76.02	CARDIAC REHAB	357,162			806		190,318		76.02
76.03	WOUND CARE	4,398,155			1,065		1,132,774		76.03
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	9,237					828		90
91	EMERGENCY	16,822,582			1,657,865		3,654,930		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,811,306			37,717		793,559		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	254,312,852			45,329,527		62,295,910		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0032** **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	0.280682	16,433,406			4,612,561			50
52	DELIVERY ROOM & LABOR ROOM	0.213068	148			32			52
53	ANESTHESIOLOGY	0.565915	1,596,797			903,651			53
54	RADIOLOGY-DIAGNOSTIC	0.340117	2,803,304			953,451			54
54.01	ULTRASOUND	0.148929	821,260			122,309			54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	0.088520	5,151,933			456,049			54.02
54.04	RADIATION ONC	2.025111							54.04
54.06	PET SCAN	0.235454	217,990			51,327			54.06
57	CT SCAN	0.044643	7,828,654			349,495			57
58	MRI	0.078484	5,147,626			404,006			58
59	CARDIAC CATHETERIZATION	0.258726	1,362,665			352,557			59
60	LABORATORY	0.294299	1,798,878			529,408			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.384738	314,914			121,159			65
66	PHYSICAL THERAPY	0.886877	821			728			66
67	OCCUPATIONAL THERAPY	0.690159	4,445			3,068			67
69	ELECTROCARDIOLOGY	0.115348	3,228,542			372,406			69
70	ELECTROENCEPHALOGRAPHY	0.158846	538,625			85,558			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107580	2,978,610			320,439			71
73	DRUGS CHARGED TO PATIENTS	0.266584	5,399,738			1,439,484			73
74	RENAL DIALYSIS	0.892634							74
76	BACTERIOLOGY & MICROBIOLOGY								76
76.01	VASCULAR LAB	0.277588	895,145			248,482			76.01
76.02	CARDIAC REHAB	0.534673	190,318			101,758			76.02
76.03	WOUND CARE	0.315552	1,132,774			357,449			76.03
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3.438671	828			2,847			90
91	EMERGENCY	0.223864	3,654,930			818,207			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.814459	793,559			646,321			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		62,295,910			13,252,752			200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		62,295,910			13,252,752			202

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-5940** | **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST (1)	NURSING SCHOOL (2)	ALLIED HEALTH (3)	ALL OTHER MEDICAL EDUCATION COST (4)	TOTAL COST (sum of col. 1 through col. 4) (5)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) (6)	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC							54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN							54.06
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB							76.01
76.02	CARDIAC REHAB							76.02
76.03	WOUND CARE							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-5940** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [XX] 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)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	67,082,863			24,800				50
52	DELIVERY ROOM & LABOR ROOM	2,206,797							52
53	ANESTHESIOLOGY	5,601,891			5,006				53
54	RADIOLOGY-DIAGNOSTIC	15,029,533			18,952				54
54.01	ULTRASOUND	2,771,839			2,800				54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	10,689,796			1,324				54.02
54.04	RADIATION ONC	33,929							54.04
54.06	PET SCAN	765,482							54.06
57	CT SCAN	26,583,738			2,369				57
58	MRI	15,256,915							58
59	CARDIAC CATHETERIZATION	2,803,160							59
60	LABORATORY	18,696,292			126,883				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	4,330,565			110,520				65
66	PHYSICAL THERAPY	2,693,530			143,125				66
67	OCCUPATIONAL THERAPY	564,153			40,504				67
69	ELECTROCARDIOLOGY	12,331,317			3,074				69
70	ELECTROENCEPHALOGRAPHY	1,868,532			639				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,257,928			44,155				71
73	DRUGS CHARGED TO PATIENTS	23,426,871			613,045				73
74	RENAL DIALYSIS	74,474							74
76	BACTERIOLOGY & MICROBIOLOGY								76
76.01	VASCULAR LAB	1,844,805			6,603				76.01
76.02	CARDIAC REHAB	357,162							76.02
76.03	WOUND CARE	4,398,155							76.03
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	9,237							90
91	EMERGENCY	16,822,582							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,811,306							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	254,312,852			1,143,799				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5940** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [XX] 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	0.280682							50
52	DELIVERY ROOM & LABOR ROOM	0.213068							52
53	ANESTHESIOLOGY	0.565915							53
54	RADIOLOGY-DIAGNOSTIC	0.340117							54
54.01	ULTRASOUND	0.148929							54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	0.088520							54.02
54.04	RADIATION ONC	2.025111							54.04
54.06	PET SCAN	0.235454							54.06
57	CT SCAN	0.044643							57
58	MRI	0.078484							58
59	CARDIAC CATHETERIZATION	0.258726							59
60	LABORATORY	0.294299							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.384738							65
66	PHYSICAL THERAPY	0.886877							66
67	OCCUPATIONAL THERAPY	0.690159							67
69	ELECTROCARDIOLOGY	0.115348							69
70	ELECTROENCEPHALOGRAPHY	0.158846							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107580							71
73	DRUGS CHARGED TO PATIENTS	0.266584							73
74	RENAL DIALYSIS	0.892634							74
76	BACTERIOLOGY & MICROBIOLOGY								76
76.01	VASCULAR LAB	0.277588							76.01
76.02	CARDIAC REHAB	0.534673							76.02
76.03	WOUND CARE	0.315552							76.03
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3.438671							90
91	EMERGENCY	0.223864							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.814459							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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[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)	1,722,280		1,722,280	17,638	97.65	2,556	249,593	30
31	INTENSIVE CARE UNIT	289,496		289,496	1,556	186.05	193	35,908	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	21,175		21,175	1,500	14.12	510	7,201	43
44	SKILLED NURSING FACILITY	125,220		125,220	1,617	77.44			44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,158,171		2,158,171	22,311		3,259	292,702	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0032** **WORKSHEET D PART II**

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

(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	1,773,573	67,082,863	0.026439	3,369,613	89,089	50
52	DELIVERY ROOM & LABOR ROOM	148,590	2,206,797	0.067333	1,248,338	84,054	52
53	ANESTHESIOLOGY	167,426	5,601,891	0.029887	331,988	9,922	53
54	RADIOLOGY-DIAGNOSTIC	1,010,496	15,029,533	0.067234	239,117	16,077	54
54.01	ULTRASOUND	49,125	2,771,839	0.017723	66,828	1,184	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	114,515	10,689,796	0.010713	47,398	508	54.02
54.04	RADIATION ONC	1,908	33,929	0.056235			54.04
54.06	PET SCAN	7,737	765,482	0.010107			54.06
57	CT SCAN	195,702	26,583,738	0.007362	643,688	4,739	57
58	MRI	331,712	15,256,915	0.021742	95,744	2,082	58
59	CARDIAC CATHETERIZATION	82,827	2,803,160	0.029548	51,981	1,536	59
60	LABORATORY	412,271	18,696,292	0.022051	1,077,266	23,755	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	124,975	4,330,565	0.028859	441,097	12,730	65
66	PHYSICAL THERAPY	162,273	2,693,530	0.060245	60,572	3,649	66
67	OCCUPATIONAL THERAPY	22,920	564,153	0.040627	18,844	766	67
69	ELECTROCARDIOLOGY	266,252	12,331,317	0.021592	157,959	3,411	69
70	ELECTROENCEPHALOGRAPHY	25,628	1,868,532	0.013716			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,490	15,257,928	0.002981	1,205,663	3,594	71
73	DRUGS CHARGED TO PATIENTS	399,187	23,426,871	0.017040	2,246,676	38,283	73
74	RENAL DIALYSIS	10,548	74,474	0.141633			74
76	BACTERIOLOGY & MICROBIOLOGY						76
76.01	VASCULAR LAB	95,423	1,844,805	0.051725	25,323	1,310	76.01
76.02	CARDIAC REHAB	19,078	357,162	0.053416			76.02
76.03	WOUND CARE	139,310	4,398,155	0.031675	2,001	63	76.03
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	7,790	9,237	0.843347			90
91	EMERGENCY	300,755	16,822,582	0.017878	321,303	5,744	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	197,440	2,811,306	0.070231			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,112,951	254,312,852		11,651,399	302,496	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[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)	17,638		2,556		30
31	INTENSIVE CARE UNIT	1,556		193		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	1,500		510		43
44	SKILLED NURSING FACILITY	1,617				44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	22,311		3,259		200

(A) Worksheet A line numbers

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COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0032** | **WORKSHEET D PART IV**

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

		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
54.01	ULTRASOUND							54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC							54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN							54.06
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB							76.01
76.02	CARDIAC REHAB							76.02
76.03	WOUND CARE							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0032** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF
[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	67,082,863			3,369,613				50
52	DELIVERY ROOM & LABOR ROOM	2,206,797			1,248,338				52
53	ANESTHESIOLOGY	5,601,891			331,988				53
54	RADIOLOGY-DIAGNOSTIC	15,029,533			239,117				54
54.01	ULTRASOUND	2,771,839			66,828				54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	10,689,796			47,398				54.02
54.04	RADIATION ONC	33,929							54.04
54.06	PET SCAN	765,482							54.06
57	CT SCAN	26,583,738			643,688				57
58	MRI	15,256,915			95,744				58
59	CARDIAC CATHETERIZATION	2,803,160			51,981				59
60	LABORATORY	18,696,292			1,077,266				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	4,330,565			441,097				65
66	PHYSICAL THERAPY	2,693,530			60,572				66
67	OCCUPATIONAL THERAPY	564,153			18,844				67
69	ELECTROCARDIOLOGY	12,331,317			157,959				69
70	ELECTROENCEPHALOGRAPHY	1,868,532							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,257,928			1,205,663				71
73	DRUGS CHARGED TO PATIENTS	23,426,871			2,246,676				73
74	RENAL DIALYSIS	74,474							74
76	BACTERIOLOGY & MICROBIOLOGY								76
76.01	VASCULAR LAB	1,844,805			25,323				76.01
76.02	CARDIAC REHAB	357,162							76.02
76.03	WOUND CARE	4,398,155			2,001				76.03
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	9,237							90
91	EMERGENCY	16,822,582			321,303				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,811,306							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	254,312,852			11,651,399				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0032** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[ ] TITLE XVIII, PART B [ ] 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	0.280682		9,321,592			2,616,403		50
52	DELIVERY ROOM & LABOR ROOM	0.213068		185,626			39,551		52
53	ANESTHESIOLOGY	0.565915		896,128			507,132		53
54	RADIOLOGY-DIAGNOSTIC	0.340117		2,726,650			927,380		54
54.01	ULTRASOUND	0.148929		1,200,872			178,845		54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	0.088520		1,114,694			98,673		54.02
54.04	RADIATION ONC	2.025111							54.04
54.06	PET SCAN	0.235454		437,437			102,996		54.06
57	CT SCAN	0.044643		5,792,675			258,602		57
58	MRI	0.078484		3,776,384			296,386		58
59	CARDIAC CATHETERIZATION	0.258726		387,779			100,329		59
60	LABORATORY	0.294299		3,209,344			944,507		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.384738		232,824			89,576		65
66	PHYSICAL THERAPY	0.886877		456,245			404,633		66
67	OCCUPATIONAL THERAPY	0.690159		81,174			56,023		67
69	ELECTROCARDIOLOGY	0.115348		1,321,068			152,383		69
70	ELECTROENCEPHALOGRAPHY	0.158846		1,038,494			164,961		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107580		2,212,422			238,012		71
73	DRUGS CHARGED TO PATIENTS	0.266584		1,925,903			513,415		73
74	RENAL DIALYSIS	0.892634							74
76	BACTERIOLOGY & MICROBIOLOGY								76
76.01	VASCULAR LAB	0.277588		136,174			37,800		76.01
76.02	CARDIAC REHAB	0.534673		3,432			1,835		76.02
76.03	WOUND CARE	0.315552		746,159			235,452		76.03
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3.438671		4,406			15,151		90
91	EMERGENCY	0.223864		8,133,254			1,820,743		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.814459		738,193			601,228		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			46,078,929			10,402,016		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			46,078,929			10,402,016		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0032** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	17,638	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	17,638	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	15,616	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)	9,293	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)	19,973,031	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	19,973,031	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)	19,973,031	37

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0032** **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)	1,132.39	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	10,523,300	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)	10,523,300	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	3,227,514	1,556	2,074.24	1,028	2,132,319	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)	11,908,666	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	24,564,285	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	1,098,720	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	1,018,785	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	2,117,505	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	22,446,780	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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0032** **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)					2,022	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,132.39	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					2,289,693	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	1,722,280	19,973,031	0.086230	2,289,693	197,440	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5940** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [XX] 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)	1,617	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,617	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	336	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,281	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)	1,448	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)	336	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)	1,391,920	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	1,391,920	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	324,483	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	115,700	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	208,783	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	4.289655	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	344.35	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	162.98	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	181.37	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	778.01	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	261,411	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	1,130,509	37

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5940** **WORKSHEET D-1 PARTS III & IV**

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	1,130,509	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	699.14	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	1,012,355	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (line 14 x line 35)	261,411	73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (line 72 + line 73)	1,273,766	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 26, line 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (line 75 ÷ line 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (line 9 x line 76)		77
78	INPATIENT ROUTINE SERVICE COST (line 74 minus line 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (from provider records)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (line 78 minus line 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (line 9 x line 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (see instructions)	1,273,766	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	422,099	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	1,695,865	86

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0032** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	17,638	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	17,638	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	15,616	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)	2,556	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	1,500	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	510	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)	19,973,031	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	19,973,031	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)	19,973,031	37

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0032** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,132.39	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					2,894,389	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					2,894,389	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)	90,533	1,500	60.36	510	30,784	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	3,227,514	1,556	2,074.24	193	400,328	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)					2,924,735	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					6,250,236	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					292,702	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					302,496	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					595,198	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0032** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					2,022	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0032** **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		6,868,691		30
31	INTENSIVE CARE UNIT		1,991,819		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.280682	14,913,711	4,186,010	50
52	DELIVERY ROOM & LABOR ROOM	0.213068	58,613	12,489	52
53	ANESTHESIOLOGY	0.565915	899,727	509,169	53
54	RADIOLOGY-DIAGNOSTIC	0.340117	1,344,726	457,364	54
54.01	ULTRASOUND	0.148929	172,338	25,666	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	0.088520	529,432	46,865	54.02
54.04	RADIATION ONC	2.025111	18,987	38,451	54.04
54.06	PET SCAN	0.235454	19,022	4,479	54.06
57	CT SCAN	0.044643	2,818,531	125,828	57
58	MRI	0.078484	504,835	39,621	58
59	CARDIAC CATHETERIZATION	0.258726	285,464	73,857	59
60	LABORATORY	0.294299	4,935,587	1,452,538	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.384738	2,025,730	779,375	65
66	PHYSICAL THERAPY	0.886877	660,663	585,927	66
67	OCCUPATIONAL THERAPY	0.690159	161,761	111,641	67
69	ELECTROCARDIOLOGY	0.115348	1,145,097	132,085	69
70	ELECTROENCEPHALOGRAPHY	0.158846	9,859	1,566	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107580	3,895,889	419,120	71
73	DRUGS CHARGED TO PATIENTS	0.266584	9,020,585	2,404,744	73
74	RENAL DIALYSIS	0.892634	65,905	58,829	74
76	BACTERIOLOGY & MICROBIOLOGY				76
76.01	VASCULAR LAB	0.277588	145,612	40,420	76.01
76.02	CARDIAC REHAB	0.534673	806	431	76.02
76.03	WOUND CARE	0.315552	1,065	336	76.03
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	3.438671			90
91	EMERGENCY	0.223864	1,657,865	371,136	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.814459	37,717	30,719	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		45,329,527	11,908,666	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		45,329,527		202

(A) Worksheet A line numbers

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5940** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:
[ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX
[ ] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [XX] 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
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.280682	24,800	6,961	50
52	DELIVERY ROOM & LABOR ROOM	0.213068			52
53	ANESTHESIOLOGY	0.565915	5,006	2,833	53
54	RADIOLOGY-DIAGNOSTIC	0.340117	18,952	6,446	54
54.01	ULTRASOUND	0.148929	2,800	417	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	0.088520	1,324	117	54.02
54.04	RADIATION ONC	2.025111			54.04
54.06	PET SCAN	0.235454			54.06
57	CT SCAN	0.044643	2,369	106	57
58	MRI	0.078484			58
59	CARDIAC CATHETERIZATION	0.258726			59
60	LABORATORY	0.294299	126,883	37,342	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.384738	110,520	42,521	65
66	PHYSICAL THERAPY	0.886877	143,125	126,934	66
67	OCCUPATIONAL THERAPY	0.690159	40,504	27,954	67
69	ELECTROCARDIOLOGY	0.115348	3,074	355	69
70	ELECTROENCEPHALOGRAPHY	0.158846	639	102	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107580	44,155	4,750	71
73	DRUGS CHARGED TO PATIENTS	0.266584	613,045	163,428	73
74	RENAL DIALYSIS	0.892634			74
76	BACTERIOLOGY & MICROBIOLOGY				76
76.01	VASCULAR LAB	0.277588	6,603	1,833	76.01
76.02	CARDIAC REHAB	0.534673			76.02
76.03	WOUND CARE	0.315552			76.03
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	3.438671			90
91	EMERGENCY	0.223864			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.814459			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,143,799	422,099	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,143,799		202

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0032** **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 [ ] PPS [ ] TEFRA [XX] 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		1,981,750		30
31	INTENSIVE CARE UNIT		294,570		31
43	NURSERY		643,362		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.280682	3,369,613	945,790	50
52	DELIVERY ROOM & LABOR ROOM	0.213068	1,248,338	265,981	52
53	ANESTHESIOLOGY	0.565915	331,988	187,877	53
54	RADIOLOGY-DIAGNOSTIC	0.340117	239,117	81,328	54
54.01	ULTRASOUND	0.148929	66,828	9,953	54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC	0.088520	47,398	4,196	54.02
54.04	RADIATION ONC	2.025111			54.04
54.06	PET SCAN	0.235454			54.06
57	CT SCAN	0.044643	643,688	28,736	57
58	MRI	0.078484	95,744	7,514	58
59	CARDIAC CATHETERIZATION	0.258726	51,981	13,449	59
60	LABORATORY	0.294299	1,077,266	317,038	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.384738	441,097	169,707	65
66	PHYSICAL THERAPY	0.886877	60,572	53,720	66
67	OCCUPATIONAL THERAPY	0.690159	18,844	13,005	67
69	ELECTROCARDIOLOGY	0.115348	157,959	18,220	69
70	ELECTROENCEPHALOGRAPHY	0.158846			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107580	1,205,663	129,705	71
73	DRUGS CHARGED TO PATIENTS	0.266584	2,246,676	598,928	73
74	RENAL DIALYSIS	0.892634			74
76	BACTERIOLOGY & MICROBIOLOGY				76
76.01	VASCULAR LAB	0.277588	25,323	7,029	76.01
76.02	CARDIAC REHAB	0.534673			76.02
76.03	WOUND CARE	0.315552	2,001	631	76.03
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	3.438671			90
91	EMERGENCY	0.223864	321,303	71,928	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.814459			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		11,651,399	2,924,735	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		11,651,399		202

(A) Worksheet A line numbers

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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)	4,745,634			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	13,379,590			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)	187,929			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	127.46			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0409			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1278			31
32	SUM OF LINES 30 AND 31	0.1687			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0498			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	402,909			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)		0.000105573		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		955,053		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		714,327		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	714,327			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)				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)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	19,430,389			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)	19,430,389			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,455,237			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)				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)	20,885,626			59
60	PRIMARY PAYER PAYMENTS	14,967			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	20,870,659			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,272,000			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	14,864			63
64	ALLOWABLE BAD DEBTS (see instructions)	451,999			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	293,799			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	285,497			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	18,877,594			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
71	AMOUNT DUE PROVIDER (see instructions)	18,877,594			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	377,552			71.01
72	INTERIM PAYMENTS	18,151,097			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	348,945			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	54,207			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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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0032** **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)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	13,252,752			2
3	PPS PAYMENTS	13,107,388			3
4	OUTLIER PAYMENT (see instructions)	29,804			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)	13,137,192			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	3,040,789			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	10,096,403			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)	10,096,403			30
31	PRIMARY PAYER PAYMENTS	1,775			31
32	SUBTOTAL (line 30 minus line 31)	10,094,628			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)	448,448			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	291,491			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	348,939			36
37	SUBTOTAL (see instructions)	10,386,119			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	10,386,119			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	207,722			40.01
41	INTERIM PAYMENTS	10,259,449			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-81,052			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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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5940** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] 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
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0032** **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							1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					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
			.11		17,862,626		9,892,373	3.11
			.14		288,471		367,076	3.14
			.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		18,151,097		10,259,449	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)				18,151,097		10,259,449	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		726,497		126,670	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				18,877,594		10,386,119	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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5940** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [ ] IPF [XX] 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
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					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
			.13		385,495			3.13
			.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		385,495			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)				385,495			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		7,867			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				393,362			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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	5,094	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	10,321	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	489	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	17,172	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	273,560,701	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	5,400,420	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)	1,791,096	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,727,218	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	63,878	32

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	423,802	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	423,802	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES		6
7	COINSURANCE	30,440	7
8	ALLOWABLE BAD DEBTS (see instructions)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	393,362	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 ± line 14)	393,362	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	7,867	15.01
16	INTERIM PAYMENTS	385,495	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)		18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0032** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] 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	6,250,236		1
2	MEDICAL AND OTHER SERVICES		10,402,016	2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	6,250,236	10,402,016	4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	6,250,236	10,402,016	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	11,651,399	46,078,929	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)	11,651,399	46,078,929	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)	11,651,399	46,078,929	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	5,401,163	35,676,913	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)	6,250,236	10,402,016	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	6,250,236	10,402,016	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	6,250,236	10,402,016	31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	6,250,236	10,402,016	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	6,250,236	10,402,016	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)	6,250,236	10,402,016	40
41	INTERIM PAYMENTS	6,250,236	10,402,016	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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	3,079,567				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	65,108,102				4
5	OTHER RECEIVABLES	379,924				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-39,584,471				6
7	INVENTORY	4,515,658				7
8	PREPAID EXPENSES	220,340				8
9	OTHER CURRENT ASSETS	8,588,724				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	42,307,844				11
	FIXED ASSETS					
12	LAND	3,026,627				12
13	LAND IMPROVEMENTS	3,431,092				13
14	ACCUMULATED DEPRECIATION	-1,793,688				14
15	BUILDINGS	80,532,472				15
16	ACCUMULATED DEPRECIATION	-39,107,048				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	68,311,238				19
20	ACCUMULATED DEPRECIATION	-54,384,729				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	60,015,964				30
	OTHER ASSETS					
31	INVESTMENTS	289,019,399				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	143,864				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	289,163,263				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	391,487,071				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	4,577,947				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	7,965,226				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	13,339,219				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	25,882,392				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	20,432,230				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	10,040,774				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	30,473,004				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	56,355,396				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	335,131,675				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)	335,131,675				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	391,487,071				60

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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		288,808,251			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		34,364,352			2
3	TOTAL (sun of line 1 and line 2)		323,172,603			3
4	ADDITIONS (credit adjustments)					4
5	REV. RECOGN. OF MIN. PENSION LIABIL					5
6	NET ASSETS RELEASED FROM RESTRICT.	11,931,961				6
7	CHG IN TEMP. RESTRICTED NET ASSETS	27,111				7
8	PROCEEDS FROM GRANT FOR EQUIP					8
9	PRAIRIE REVENUE					9
10	TOTAL ADDITIONS (sum of lines 4-9)		11,959,072			10
11	SUBTOTAL (line 3 plus line 10)		335,131,675			11
12	DEDUCTIONS (debit adjustments)					12
13	TRANSFER (TO)/FROM AFFILIATES					13
14	REV. RECOGN. OF MIN. PENSION LIABIL					14
15	CHG IN TEMP. RESTRICTED NET ASSETS					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)		335,131,675			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	REV. RECOGN. OF MIN. PENSION LIABIL					5
6	NET ASSETS RELEASED FROM RESTRICT.					6
7	CHG IN TEMP. RESTRICTED NET ASSETS					7
8	PROCEEDS FROM GRANT FOR EQUIP					8
9	PRAIRIE REVENUE					9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	TRANSFER (TO)/FROM AFFILIATES					13
14	REV. RECOGN. OF MIN. PENSION LIABIL					14
15	CHG IN TEMP. RESTRICTED NET ASSETS					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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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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	14,930,874		14,930,874	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	492,922		492,922	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	15,423,796		15,423,796	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				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)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	15,423,796		15,423,796	17
18	ANCILLARY SERVICES	79,101,877		79,101,877	18
19	OUTPATIENT SERVICES		175,133,888	175,133,888	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		2,862,395	2,862,395	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES	1,038,745		1,038,745	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	95,564,418	177,996,283	273,560,701	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		98,892,411	29
30	PROVISION FOR BAD DEBT	5,400,421		30
31	PRAIRIE			31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		5,400,421	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		104,292,832	43

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	273,560,701	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	154,720,895	2
3	NET PATIENT REVENUES (line 1 minus line 2)	118,839,806	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	104,292,832	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	14,546,974	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	14,620,520	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	5,683	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	42,899	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	1,800	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	69,336	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (AUXILIARY)	43,533	24
24.01	OTHER (DIABETES INSTRUCTION)	21,974	24.01
24.02	OTHER (HOUSEKEEPING)	50	24.02
24.03	OTHER (PHYSICIAN APPLICATION)	3,100	24.03
24.04	OTHER (RENTAL INCOME-900 W TEMPLE (EMC))	590,442	24.04
24.05	OTHER (RECYCLING)	3,049	24.05
24.06	OTHER (UNCLAIMED PROPERTY)		24.06
24.07	OTHER (PHYSICIAN DUES)	16,000	24.07
24.08	OTHER (PERSONNEL - NAME TAGS)	180	24.08
24.09	OTHER (LIFELINE - HOME CARE)	125	24.09
24.10	OTHER (MEDICAL OFFICE - INHOUSE)		24.10
24.11	OTHER (RENTAL INCOME)	106,514	24.11
24.12	OTHER (HOUSEKEEPING-900 W TEMPLE (EMC))	6,185	24.12
24.13	OTHER (NEUROLOGY - EEG)		24.13
24.14	OTHER (SPIRIT COMMITTEE ACTIVITIES)	23,975	24.14
24.15	OTHER (ASSETS RELEASED FOR OPERATIONS)		24.15
24.16	OTHER (COMMUNITY SERVICES - IN SERVICE)	302	24.16
24.17	OTHER (PATIENT SERVICES)	45	24.17
24.18	OTHER (QUALITY OKALAHOMA STUDY)		24.18
24.19	OTHER (PET SCAN ALLIANCE IMAGING SALARIES)		24.19
24.20	OTHER (RADIATION ONCOLOGY CARLE RN SALARIE)		24.20
24.21	OTHER (RADIATION ONCOLOGY - RN BENEFITS)		24.21
24.22	OTHER (RADIATION ONCOLOGY - RENT)		24.22
24.23	OTHER (ASPR)	30,822	24.23
24.24	OTHER (NUC MED REIMBURSEMENT STUDENT FEES)		24.24
24.25	OTHER (IHA GRANT T1)		24.25
24.26	OTHER (PHYSICAL THERAPY)		24.26
24.27	OTHER (LAB-SURVEILLANCE PROGRAM)	550	24.27
24.28	OTHER (RADIOLOGY FILM/SCRAP)	1,813	24.28
24.29	OTHER (ANESTHESIA LEASE INCOME)	1,805,016	24.29
24.30	OTHER (WOMENS WELLNESS RETAIL)	11,848	24.30
24.31	OTHER (NURSING SERVICE ADMIN)	380	24.31
24.32	OTHER (OCCUPATIONAL THERAPY-IN SERVICE)	4,192	24.32
24.33	OTHER (ADMINISTRATION-MEANINGFUL USE FUNDS)	2,645,965	24.33
24.34	OTHER (ALTAMONT DIAG CTR-MISC)	868	24.34
24.99	OTHER (GAIN/LOSS ON SALE OF FIXED ASSETS)	9,644	24.99
25	TOTAL OTHER INCOME (sum of lines 6-24)	20,066,810	25
26	TOTAL (line 5 plus line 25)	34,613,784	26
27.01	OTHER EXPENSES (RENTAL PROPERTIES DEPRECIATION)	137,564	27.01
27.02	OTHER EXPENSES (RENTAL PROPERTIES EXPENSE)	111,868	27.02
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	249,432	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	34,364,352	29

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7661** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE					27,867	3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	119,764		1,550	6,587	49,390	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	871,933		67,091			6
7	PHYSICAL THERAPY	280,171		13,426			7
8	OCCUPATIONAL THERAPY	21,858		7,813			8
9	SPEECH PATHOLOGY	6,024		2,145			9
10	MEDICAL SOCIAL SERVICES	38,548		5,151			10
11	HOME HEALTH AIDE	104,258		9,789			11
12	SUPPLIES (see instructions)					75,819	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	1,442,556		106,965	6,587	153,076	24

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7661** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE	27,867		27,867		27,867	3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	177,291		177,291		177,291	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	939,024		939,024		939,024	6
7	PHYSICAL THERAPY	293,597		293,597		293,597	7
8	OCCUPATIONAL THERAPY	29,671		29,671		29,671	8
9	SPEECH PATHOLOGY	8,169		8,169		8,169	9
10	MEDICAL SOCIAL SERVICES	43,699		43,699		43,699	10
11	HOME HEALTH AIDE	114,047		114,047		114,047	11
12	SUPPLIES (see instructions)	75,819		75,819		75,819	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	1,709,184		1,709,184		1,709,184	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7661** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE	27,867			27,867	3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	177,291			27,867	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE	939,024				6
7	PHYSICAL THERAPY	293,597				7
8	OCCUPATIONAL THERAPY	29,671				8
9	SPEECH PATHOLOGY	8,169				9
10	MEDICAL SOCIAL SERVICES	43,699				10
11	HOME HEALTH AIDE	114,047				11
12	SUPPLIES (see instructions)	75,819				12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	1,709,184			27,867	24

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7661** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		205,158	205,158		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		939,024	128,089	1,067,113	6
7	PHYSICAL THERAPY		293,597	40,048	333,645	7
8	OCCUPATIONAL THERAPY		29,671	4,047	33,718	8
9	SPEECH PATHOLOGY		8,169	1,114	9,283	9
10	MEDICAL SOCIAL SERVICES		43,699	5,961	49,660	10
11	HOME HEALTH AIDE		114,047	15,557	129,604	11
12	SUPPLIES (see instructions)		75,819	10,342	86,161	12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		1,709,184		1,709,184	24

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7661** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE			31,104				3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL			31,104		-205,158	1,504,026	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						939,024	6
7	PHYSICAL THERAPY						293,597	7
8	OCCUPATIONAL THERAPY						29,671	8
9	SPEECH PATHOLOGY						8,169	9
10	MEDICAL SOCIAL SERVICES						43,699	10
11	HOME HEALTH AIDE						114,047	11
12	SUPPLIES (see instructions)						75,819	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)			31,104		-205,158	1,504,026	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)			27,867			205,158	25
26	UNIT COST MULTIPLIER			0.895930			0.136406	26

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7661** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL		19,614	36,614	55,497	111,725	33,789	1
2	SKILLED NURSING CARE	1,067,113			404,039	1,471,152	444,916	2
3	PHYSICAL THERAPY	333,645			129,827	463,472	140,166	3
4	OCCUPATIONAL THERAPY	33,718			10,129	43,847	13,261	4
5	SPEECH PATHOLOGY	9,283			2,791	12,074	3,652	5
6	MEDICAL SOCIAL SERVICES	49,660			17,863	67,523	20,421	6
7	HOME HEALTH AIDE	129,604			48,311	177,915	53,806	7
8	SUPPLIES	86,161				86,161	26,057	8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	1,709,184	19,614	36,614	668,457	2,433,869	736,068	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7661** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL	6,022	60,149	126,925	23,377		83,698	1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	6,022	60,149	126,925	23,377		83,698	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7661** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL		189,228	1,958	160			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)		189,228	1,958	160			20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7661** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						637,031	1
2	SKILLED NURSING CARE						1,916,068	2
3	PHYSICAL THERAPY						603,638	3
4	OCCUPATIONAL THERAPY						57,108	4
5	SPEECH PATHOLOGY						15,726	5
6	MEDICAL SOCIAL SERVICES						87,944	6
7	HOME HEALTH AIDE						231,721	7
8	SUPPLIES						112,218	8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)						3,661,454	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7661** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (sum of col.4A-23)	ALLOCATED HHA A&G (see Pt.2)	TOTAL HHA COSTS			
		25	26	27	28			
1	ADMINISTRATIVE AND GENERAL		637,031					1
2	SKILLED NURSING CARE		1,916,068	403,579	2,319,647			2
3	PHYSICAL THERAPY		603,638	127,144	730,782			3
4	OCCUPATIONAL THERAPY		57,108	12,029	69,137			4
5	SPEECH PATHOLOGY		15,726	3,312	19,038			5
6	MEDICAL SOCIAL SERVICES		87,944	18,524	106,468			6
7	HOME HEALTH AIDE		231,721	48,807	280,528			7
8	SUPPLIES		112,218	23,636	135,854			8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)		3,661,454	637,031	3,661,454			20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.			0.210629				21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7661** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM. COST	MAIN-TENANCE & REPAIRS MAINT. HOURS	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL	2,107	50,270	119,764		111,725	33	1
2	SKILLED NURSING CARE			871,933		1,471,152		2
3	PHYSICAL THERAPY			280,171		463,472		3
4	OCCUPATIONAL THERAPY			21,858		43,847		4
5	SPEECH PATHOLOGY			6,024		12,074		5
6	MEDICAL SOCIAL SERVICES			38,548		67,523		6
7	HOME HEALTH AIDE			104,258		177,915		7
8	SUPPLIES					86,161		8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	2,107	50,270	1,442,556		2,433,869	33	20
21	TOTAL COST TO BE ALLOCATED	19,614	36,614	668,457		736,068	6,022	21
22	UNIT COST MULTIPLIER	9.308970		0.463384		0.302427		22
22	UNIT COST MULTIPLIER		0.728347				182.484848	22

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7661** **WORKSHEET H-2 PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL	2,107	108,947	18,392		9,549		1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	2,107	108,947	18,392		9,549		20
21	TOTAL COST TO BE ALLOCATED	60,149	126,925	23,377		83,698		21
22	UNIT COST MULTIPLIER	28.547224		1.271042		8.765106		22
22	UNIT COST MULTIPLIER		1.165016					22

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7661** **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL	52,105	75,648	171				1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	52,105	75,648	171				20
21	TOTAL COST TO BE ALLOCATED	189,228	1,958	160				21
22	UNIT COST MULTIPLIER	3.631667		0.935673				22
22	UNIT COST MULTIPLIER		0.025883					22

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7661** **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		20	21	22	23			
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7661** **WORKSHEET H-3 PARTS I & II**

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION

	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PEr VISIT (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	2,319,647		2,319,647	11,988	193.50	1
2	PHYSICAL THERAPY	3	730,782		730,782	3,437	212.62	2
3	OCCUPATIONAL THERAPY	4	69,137		69,137	1,477	46.81	3
4	SPEECH PATHOLOGY	5	19,038		19,038	63	302.19	4
5	MEDICAL SOCIAL SERVICES	6	106,468		106,468	186	572.41	5
6	HOME HEALTH AIDE	7	280,528		280,528	1,200	233.77	6
7	TOTAL (sum of lines 1-6)		3,525,600		3,525,600	18,351		7

LIMITATION COST COMPUTATION

	PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			
				PART B		
			PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
		1	2	3	4	
8	SKILLED NURSING CARE	99914	1,336	8,322		8
9	PHYSICAL THERAPY	99914	353	2,282		9
10	OCCUPATIONAL THERAPY	99914	136	1,005		10
11	SPEECH PATHOLOGY	99914	5	34		11
12	MEDICAL SOCIAL SERVICES	99914	16	110		12
13	HOME HEALTH AIDE	99914	50	896		13
14	TOTAL (sum of lines 8-13)		1,896	12,649		14

SUPPLIES AND DRUGS COSTS COMPUTATIONS

	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	135,854		135,854			15
16	COST OF DRUGS	9						16

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

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED	
			1	2	3	4	
1	PHYSICAL THERAPY	66	0.886877			col. 2, line 2	1
2	OCCUPATIONAL THERAPY	67	0.690159			col. 2, line 3	2
3	SPEECH PATHOLOGY	68				col. 2, line 4	3
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.107580			col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.266584			col. 2, line 16	5

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APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7661** **WORKSHEET H-3 PARTS I & II**

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS			COST OF SERVICES				
			PART B			PART B			
	PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL PROGRAM COST (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	1,336	8,322		258,516	1,610,307		1,868,823	1
2	PHYSICAL THERAPY	353	2,282		75,055	485,199		560,254	2
3	OCCUPATIONAL THERAPY	136	1,005		6,366	47,044		53,410	3
4	SPEECH PATHOLOGY	5	34		1,511	10,274		11,785	4
5	MEDICAL SOCIAL SERVICES	16	110		9,159	62,965		72,124	5
6	HOME HEALTH AIDE	50	896		11,689	209,458		221,147	6
7	TOTAL (sum of lines 1-6)	1,896	12,649		362,296	2,425,247		2,787,543	7

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

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ST. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7661** **WORKSHEET H-4 PARTS I & II**

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

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

			PART B		
		PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
	DESCRIPTION	1	2	3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES				2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE I ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to excced 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)				6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS				9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		PART A SERVICES	PART B SERVICES	
	DESCRIPTION	1	2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	659,627	412,165	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	15,107	18,973	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	16,027	18,300	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	8,486	10,739	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	6,213	8,280	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	705,460	468,457	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	705,460	468,457	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	705,460	468,457	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	705,460	468,457	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	705,460	468,457	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)			31.01
32	INTERIM PAYMENTS (see instructions)	705,460	468,457	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35

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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7661** **WORKSHEET H-5**

				PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				705,460		468,457	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					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					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				705,460		468,457	4
	TO BE COMPLETED BY 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)				705,460		468,457	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. ANTHONY'S MEMORIAL HOSPITAL Provider CCN: 14-0032	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 09:52 Version: 2014.10

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0032** **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	1,437,069	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	18,168	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)	47.05	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)	1,455,237	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
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
44	SKILLED NURSING FACILITY							44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	NUCLEAR MEDICINE-DIAGNOSTIC							54.02
54.04	RADIATION ONC							54.04
54.06	PET SCAN							54.06
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	BACTERIOLOGY & MICROBIOLOGY							76
76.01	VASCULAR LAB							76.01
76.02	CARDIAC REHAB							76.02
76.03	WOUND CARE							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	PHILANTHROPY DEVELOPMENT							194
194.01	VENDING							194.01
194.02	MEALS ON WHEELS							194.02

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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		
194.03	PRAIRIE CARDIOVASCULAR							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202