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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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: 11/25/2014 TIME: 12:45 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. FRANCIS HOSPITAL (14-1350) {(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		448,190	-240,341	-189,827	515,650	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		75,536				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		523,726	-240,341	-189,827	515,650	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

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: 1215 FRANCISCAN DRIVE	P.O. Box:								1
2	City: LITCHFIELD	State: IL	ZIP Code: 62056			County: MONTGOMERY				2
Hospital and Hospital-Based Component Identification:										
							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. FRANCIS HOSPITAL	14-1350	99914	1	12/01/2005	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	ST. FRANCIS HOSPITAL	14-Z350	99914		05/31/2007	N	O	O	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 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.	N	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.	1	N	23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.							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 Faciltiy 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)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			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.	2			118

		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	68,164		370,828	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N		120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
Transplant Center Information					
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare 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	148005	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: NATIONAL GOVERNMENT SERVICES Contractor's Number: 00131		141
142	Street: 4736 LAVERNA ROAD	P.O. Box:		142
143	City: SPRINGFIELD	State: IL	ZIP Code: 62794	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.	N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, 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			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	4,866,868			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)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2013	09/30/2013	170

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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)	N			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	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)	Y	10/08/2014	Y	10/08/2014	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

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	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.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	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.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	N	33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	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.	N	35

		Y/N	DATE	
HOME OFFICE COSTS		1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	Y		36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	Y		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.	N		38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	Y		39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N		40

COST REORT PREPARER INFORMATION				
41	FIRST NAME: LESLIE	LAST NAME: MEWES	TITLE: DIRECTOR OF FINANCIAL SERV	41
42	EMPLOYER: ST FRANCIS HOSPITAL			42
43	PHONE NUMBER: 217-324-8368	E-MAIL ADDRESS: LESLIE.MEWES@HSHS.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	100,632.00		2,788	409	3,991	1
2	HMO AND OTHER (see instructions)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						247		259	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		25	9,125	100,632.00		3,035	409	4,250	7
8	INTENSIVE CARE UNIT	31								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						183	409	13
14	TOTAL (see instructions)		25	9,125	100,632.00		3,035	592	4,659	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								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		25							27
28	OBSERVATION BED DAYS								450	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)								19	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. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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)					697	181	1,201	1
2	HMO AND OTHER (see instructions)								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)		197.25			697	181	1,201	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)		197.25						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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						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						9
10	EXCLUDED AREA SALARIES (see instructions)							10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)							17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS							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							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)							1
2	EXCLUDED AREA SALARIES (see instructions)							2
3	SUBTOTAL SALARIES (line 1 minus line 2)							3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)							4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)							5

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)							6
7	TOTAL OVERHEAD COST (see instructions)							7

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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)		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)		24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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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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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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				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				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

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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	
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				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).			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)				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)	0.316354	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	4,589,582	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	19,269,736	6
7	MEDICAID COST (line 1 times line 6)	6,096,058	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.	1,506,476	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	28,111	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	1,506,476	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	2,124,706	229,080	2,353,786	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	672,159	72,470	744,629	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	12,367		12,367	22
23	COST OF CHARITY CARE (line 21 minus line 22)	659,792	72,470	732,262	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)	2,424,227	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,063,903	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,360,324	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	430,344	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,162,606	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	2,669,082	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		995,908	995,908	469,941	1,465,849		1,465,849	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,021,400	1,021,400		1,021,400		1,021,400	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	60,814	4,023,942	4,084,756	38,199	4,122,955	-677,268	3,445,687	4
5.01	00570	ADMITTING	389,914	100,423	490,337	-234,936	255,401		255,401	5.01
5.02	00590	PATIENT ACCOUNTING		92,477	92,477	244,747	337,224		337,224	5.02
5.03	00591	ADMIN & GENERAL	1,699,875	6,323,819	8,023,694	-985,782	7,037,912	-1,653,250	5,384,662	5.03
6	00600	MAINTENANCE & REPAIRS	204,619	28,166	232,785		232,785		232,785	6
7	00700	OPERATION OF PLANT	78,003	911,488	989,491	-35,128	954,363		954,363	7
8	00800	LAUNDRY & LINEN SERVICE		-299	-299	102,782	102,483		102,483	8
9	00900	HOUSEKEEPING	276,306	215,003	491,309		491,309		491,309	9
10	01000	DIETARY	355,659	172,918	528,577	-426,410	102,167		102,167	10
11	01100	CAFETERIA				429,420	429,420		429,420	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	116,842	16,301	133,143		133,143		133,143	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY	380,235	789,073	1,169,308	-610,512	558,796		558,796	15
16	01600	MEDICAL RECORDS & LIBRARY				313,816	313,816	-201	313,615	16
17	01700	SOCIAL SERVICE								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	2,230,341	342,110	2,572,451	-943,484	1,628,967		1,628,967	30
43	04300	NURSERY				80,448	80,448		80,448	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	890,203	648,854	1,539,057	-548,634	990,423		990,423	50
52	05200	DELIVERY ROOM & LABOR ROOM				495,421	495,421		495,421	52
53	05300	ANESTHESIOLOGY		752,937	752,937	-12,676	740,261	-646,429	93,832	53
54	05400	RADIOLOGY-DIAGNOSTIC	889,498	447,576	1,337,074	-6,686	1,330,388	-2,497	1,327,891	54
57	05700	CT SCAN	52,522	167,852	220,374	1,262	221,636		221,636	57
58	05800	MRI	67,999	160,837	228,836	2,275	231,111		231,111	58
60	06000	LABORATORY	578,041	1,207,372	1,785,413	106,473	1,891,886	-33,079	1,858,807	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	294,619	210,256	504,875	13,600	518,475	-94,586	423,889	65
66	06600	PHYSICAL THERAPY	197,554	125,374	322,928	70,836	393,764		393,764	66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		91,462	91,462	284,829	376,291		376,291	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				283,473	283,473		283,473	72
73	07300	DRUGS CHARGED TO PATIENTS				852,471	852,471		852,471	73
76.97	07697	CARDIAC REHABILITATION	140,703	12,847	153,550		153,550		153,550	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	EMERGENCY	856,587	1,546,168	2,402,755	-24,592	2,378,163	-1,480,451	897,712	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	9,760,334	20,404,264	30,164,598	-38,847	30,125,751	-4,587,761	25,537,990	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		43,239	43,239		43,239		43,239	190
192	19200	PHYSICIANS' PRIVATE OFFICES	168,552	758,117	926,669	38,847	965,516	-294,297	671,219	192
194	07950	OTHER NONALLOWABLE	62,318	66,591	128,909		128,909		128,909	194
200		TOTAL (sum of lines 118-199)	9,991,204	21,272,211	31,263,415		31,263,415	-4,882,058	26,381,357	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASSIFY L&D AND NURSERY COST	A	NURSERY	43	71,770	8,697	1
2			DELIVERY ROOM & LABOR ROOM	52	443,600	53,756	2
500	TOTAL RECLASSIFICATIONS				515,370	62,453	500
	CODE LETTER - A						
1	RECLASSIFY DRUG COSTS	B	DRUGS CHARGED TO PATIENTS	73		621,139	1
500	TOTAL RECLASSIFICATIONS					621,139	500
	CODE LETTER - B						
1	RECLASSIFY CAFETERIA COSTS	C	CAFETERIA	11	288,940	140,480	1
500	TOTAL RECLASSIFICATIONS				288,940	140,480	500
	CODE LETTER - C						
1	RECLASSIFY LAUNDRY COSTS	D	LAUNDRY & LINEN SERVICE	8		102,782	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
500	TOTAL RECLASSIFICATIONS					102,782	500
	CODE LETTER - D						
1	RECLASSIFY MEDICAL SUPPLY COSTS	E	MEDICAL SUPPLIES CHARGED TO P	71		284,829	1
2			IMPL. DEV. CHARGED TO PATIENT	72		283,473	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					568,302	500
	CODE LETTER - E						
1	DRUG ADMINISTRATION COSTS	F	LABORATORY	60	71,842	9,803	1
2			DRUGS CHARGED TO PATIENTS	73	163,865	67,774	2
500	TOTAL RECLASSIFICATIONS				235,707	77,577	500
	CODE LETTER - F						
1	RECLASSIFY DEPREC COSTS FOR MOB	G	PHYSICIANS' PRIVATE OFFICES	192		43,572	1
500	TOTAL RECLASSIFICATIONS					43,572	500
	CODE LETTER - G						
1	RECLASSIFY SHARED SERVICE COSTS	H	EMPLOYEE BENEFITS DEPARTMENT	4		38,199	1
2			PATIENT ACCOUNTING	5.02		31,736	2
3			DIETARY	10		3,133	3
4			PHARMACY	15		10,627	4
5			ADULTS & PEDIATRICS	30		3,390	5
6			OPERATING ROOM	50		3,892	6
7			RADIOLOGY-DIAGNOSTIC	54		9,976	7
8			LABORATORY	60		26,796	8
9			RESPIRATORY THERAPY	65		15,018	9
10			PHYSICAL THERAPY	66		72,790	10
500	TOTAL RECLASSIFICATIONS					215,557	500
	CODE LETTER - H						
1	RECLASSIFY BUILDING INSURANCE COSTS	I	CAP REL COSTS-BLDG & FIXT	1		35,383	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					35,383	500
	CODE LETTER - I						
1	RECLASSIFY RADIOLOGY MGR COSTS	J	CT SCAN	57	4,546		1
2			MRI	58	5,853		2
500	TOTAL RECLASSIFICATIONS				10,399		500
	CODE LETTER - J						

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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	MEDICAL RECORDS	K	MEDICAL RECORDS & LIBRARY	16	149,199	164,617	1
500	TOTAL RECLASSIFICATIONS				149,199	164,617	500
	CODE LETTER - K						
1	PATIENT ACCOUNTING	L	PATIENT ACCOUNTING	5.02	194,042	18,969	1
500	TOTAL RECLASSIFICATIONS				194,042	18,969	500
	CODE LETTER - L						
1	CASE MANAGEMENT	M	ADMIN & GENERAL	5.03	160,069	74,867	1
500	TOTAL RECLASSIFICATIONS				160,069	74,867	500
	CODE LETTER - M						
1	INTEREST EXPENSE	N	CAP REL COSTS-BLDG & FIXT	1		478,130	1
500	TOTAL RECLASSIFICATIONS					478,130	500
	CODE LETTER - N						
	GRAND TOTAL (INCREASES)				1,553,726	2,603,828	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASSIFY L&D AND NURSERY COST	A	ADULTS & PEDIATRICS	30	515,370	62,453		1
2								2
500	TOTAL RECLASSIFICATIONS				515,370	62,453		500
	CODE LETTER - A							
1	RECLASSIFY DRUG COSTS	B	PHARMACY	15		621,139		1
500	TOTAL RECLASSIFICATIONS					621,139		500
	CODE LETTER - B							
1	RECLASSIFY CAFETERIA COSTS	C	DIETARY	10	288,940	140,480		1
500	TOTAL RECLASSIFICATIONS				288,940	140,480		500
	CODE LETTER - C							
1	RECLASSIFY LAUNDRY COSTS	D	DIETARY	10		123		1
2			ADULTS & PEDIATRICS	30		56,536		2
3			OPERATING ROOM	50		12,884		3
4			RADIOLOGY-DIAGNOSTIC	54		6,263		4
5			CT SCAN	57		3,284		5
6			MRI	58		1,433		6
7			LABORATORY	60		1,968		7
8			RESPIRATORY THERAPY	65		1,418		8
9			PHYSICAL THERAPY	66		1,899		9
10			EMERGENCY	91		12,300		10
11			PHYSICIANS' PRIVATE OFFICES	192		4,674		11
500	TOTAL RECLASSIFICATIONS					102,782		500
	CODE LETTER - D							
1	RECLASSIFY MEDICAL SUPPLY COSTS	E	NURSERY	43		19		1
2			OPERATING ROOM	50		539,642		2
3			DELIVERY ROOM & LABOR ROOM	52		1,935		3
4			ANESTHESIOLOGY	53		12,676		4
5			MRI	58		2,145		5
6								6
7			PHYSICAL THERAPY	66		55		7
8			DRUGS CHARGED TO PATIENTS	73		307		8
9			EMERGENCY	91		11,523		9
500	TOTAL RECLASSIFICATIONS					568,302		500
	CODE LETTER - E							
1	DRUG ADMINISTRATION COSTS	F	ADULTS & PEDIATRICS	30	235,430	77,085		1
2			EMERGENCY	91	277	492		2
500	TOTAL RECLASSIFICATIONS				235,707	77,577		500
	CODE LETTER - F							
1	RECLASSIFY DEPREC COSTS FOR MOB	G	CAP REL COSTS-BLDG & FIXT	1		43,572	12	1
500	TOTAL RECLASSIFICATIONS					43,572		500
	CODE LETTER - G							
1	RECLASSIFY SHARED SERVICE COSTS	H	ADMIN & GENERAL	5.03		215,557		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
500	TOTAL RECLASSIFICATIONS					215,557		500
	CODE LETTER - H							
1	RECLASSIFY BUILDING INSURANCE COSTS	I	ADMIN & GENERAL	5.03		204	12	1
2			OPERATION OF PLANT	7		35,128		2
3			PHYSICIANS' PRIVATE OFFICES	192		51		3
500	TOTAL RECLASSIFICATIONS					35,383		500
	CODE LETTER - I							
1	RECLASSIFY RADIOLOGY MGR COSTS	J	RADIOLOGY-DIAGNOSTIC	54	10,399			1
2								2

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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	
500	TOTAL RECLASSIFICATIONS				10,399			500
	CODE LETTER - J							
1	MEDICAL RECORDS	K	ADMIN & GENERAL	5.03	149,199	164,617		1
500	TOTAL RECLASSIFICATIONS				149,199	164,617		500
	CODE LETTER - K							
1	PATIENT ACCOUNTING	L	ADMIN & GENERAL	5.03	194,042	18,969		1
500	TOTAL RECLASSIFICATIONS				194,042	18,969		500
	CODE LETTER - L							
1	CASE MANAGEMENT	M	ADMITTING	5.01	160,069	74,867		1
500	TOTAL RECLASSIFICATIONS				160,069	74,867		500
	CODE LETTER - M							
1	INTEREST EXPENSE	N	ADMIN & GENERAL	5.03		478,130	11	1
500	TOTAL RECLASSIFICATIONS					478,130		500
	CODE LETTER - N							
	GRAND TOTAL (DECREASES)				1,553,726	2,603,828		

(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	99,383					99,383		1
2	LAND IMPROVEMENTS	1,766,306	52,843		52,843		1,819,149		2
3	BUILDINGS AND FIXTURES	29,574,875	3,278,041		3,278,041		32,852,916		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	17,935,634	388,796		388,796		18,324,430		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	49,376,198	3,719,680		3,719,680		53,095,878		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	49,376,198	3,719,680		3,719,680		53,095,878		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	995,908						995,908	1
2	CAP REL COSTS-MVBLE EQUIP	1,021,400						1,021,400	2
3	TOTAL (sum of lines 1-2)	2,017,308						2,017,308	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	995,908		478,130	-8,189			1,465,849	1
2	CAP REL COSTS-MVBLE EQUIP	1,021,400						1,021,400	2
3	TOTAL (sum of lines 1-2)	2,017,308		478,130	-8,189			2,487,249	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,300,053				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	1,371,507				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	-201	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			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	MISC	B	-43,319	ADMIN & GENERAL	5.03		33
33.04	XRAY REBATES	B	-2,497	RADIOLOGY-DIAGNOSTIC	54		33.04
34							34
35							35
36	PHYSICIAN RECRUITMENT	A	-151,822	ADMIN & GENERAL	5.03		36
37	MEDICAID TAX ASSESSTMENT	A	-1,633,627	ADMIN & GENERAL	5.03		37
38	SELF-INS TO HOSP/EMPLOYEE CLAIM	A	-651,237	EMPLOYEE BENEFITS DEPARTMENT	4		38
39	NON ALLOWABLE LEGAL FEES	A	-18,465	ADMIN & GENERAL	5.03		39
40							40
41	CHARITY EXPENSE	A	-4,536	ADMIN & GENERAL	5.03		41
42	LOBBYING AND ADVERTISING COSTS	A	-87,948	ADMIN & GENERAL	5.03		42
43	PURCHASED SERVICES - HSHS MED G	A	-294,297	PHYSICIANS' PRIVATE OFFICES	192		43
44	PURCHASED SERVICES - HSHS MED G	A	-25,330	ADMIN & GENERAL	5.03		44
45	MEANINGFUL USE DEPRECIATION	A	-1,040,233	ADMIN & GENERAL	5.03		45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,882,058				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

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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	

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	4	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE PREMIUMS	1,962,623	1,988,654	-26,031		1
2	4	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SERV	159,846	159,846			2
3	5.03	ADMIN & GENERAL	CONTRACT SERV HSHS	3,616,517	2,218,979	1,397,538		3
3.01	5.03	ADMIN & GENERAL	RELATED PARTY SERV	804,100	804,100			3.01
3.02	5.01	ADMITTING	RELATED PARTY SERV	15,116	15,116			3.02
3.03	5.02	PATIENT ACCOUNTING	RELATED PARTY SERV	39,057	39,057			3.03
3.04	8	LAUNDRY & LINEN SERVICE	RELATED PARTY SERV	7,426	7,426			3.04
3.05	10	DIETARY	RELATED PARTY SERV	5,003	5,003			3.05
3.06	13	NURSING ADMINISTRATION	RELATED PARTY SERV	8,465	8,465			3.06
3.07	30	ADULTS & PEDIATRICS	RELATED PARTY SERV	46,180	46,180			3.07
3.08	54	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SERV	15,235	15,235			3.08
3.09	60	LABORATORY	RELATED PARTY SERV	209,576	209,576			3.09
3.10	65	RESPIRATORY THERAPY	RELATED PARTY SERV	119,031	119,031			3.10
3.11	66	PHYSICAL THERAPY	RELATED PARTY SERV	47,679	47,679			3.11
3.13	73	DRUGS CHARGED TO PATIENTS	RELATED PARTY SERV	17,970	17,970			3.13
3.14	76.97	CARDIAC REHABILITATION	RELATED PARTY SERV	8,237	8,237			3.14
3.15	91	EMERGENCY	RELATED PARTY SERV	167,361	167,361			3.15
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			7,249,422	5,877,915	1,371,507		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	B			HOSPITAL SISTERS HEALTH SYSTEM		CORPORATE OFFICE	6
7	G			ST. MARY'S HOSPITAL		HOSPITAL	7
8	G			ST. JOHN'S HOSPITAL		HOSPITAL	8
9	G			ST. JOSEPH'S HOSPITAL-BREESE		HOSPITAL	9
10	G			ST. ELIZABETH'S HOSPITAL		HOSPITAL	10

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

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

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	53	ANESTHESIOLOGY VARIOUS	646,429	646,429						1
2	60	LABORATORY VARIOUS	33,079	33,079						2
3	65	RESPIRATORY THERAPY VARIOUS	94,586	94,586						3
4	91	EMERGENCY VARIOUS	1,480,451	1,480,451						4
5										5
6	5.03	ADMIN & GENERAL VARIOUS	45,508	45,508						6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,300,053	2,300,053						200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRAC T-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	53	ANESTHESIOLOGY VARIOUS							646,429	1
2	60	LABORATORY VARIOUS							33,079	2
3	65	RESPIRATORY THERAPY VARIOUS							94,586	3
4	91	EMERGENCY VARIOUS							1,480,451	4
5										5
6	5.03	ADMIN & GENERAL VARIOUS							45,508	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							2,300,053	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NON-PATIENT TELEPHONES	DATA PRO-CESSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,465,849	1,465,849					1
2	CAP REL COSTS-MVBLE EQUIP	1,021,400		1,021,400				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,445,687	30,558	4,764	3,481,009			4
5.01	ADMITTING	255,401	12,061	5,209	80,570	353,241		5.01
5.02	PATIENT ACCOUNTING	337,224	67,512	1,346	68,020		474,102	5.02
5.03	ADMIN & GENERAL	5,384,662	256,151	194,598	531,667			5.03
6	MAINTENANCE & REPAIRS	232,785			71,727			6
7	OPERATION OF PLANT	954,363	294,601	10,885	27,343			7
8	LAUNDRY & LINEN SERVICE	102,483	12,006					8
9	HOUSEKEEPING	491,309	16,362	290	96,857			9
10	DIETARY	102,167	81,865	18,029	23,388			10
11	CAFETERIA	429,420	23,255		101,285			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	133,143	7,169	25,705	40,958			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	558,796	12,069	11,097	133,288			15
16	MEDICAL RECORDS & LIBRARY	313,615	21,593	8,090	52,300			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	1,628,967	187,875	50,784	518,640	14,682	19,705	30
43	NURSERY	80,448	6,932		25,158	1,055	1,416	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	990,423	129,297	201,836	312,053	27,203	36,511	50
52	DELIVERY ROOM & LABOR ROOM	495,421	20,419		155,500	6,475	8,691	52
53	ANESTHESIOLOGY	93,832	1,284	46,657		15,603	20,941	53
54	RADIOLOGY-DIAGNOSTIC	1,327,891	56,743	182,524	308,160	61,439	82,457	54
57	CT SCAN	221,636	4,230	146,609	20,005	57,619	77,333	57
58	MRI	231,111			25,888	23,250	31,206	58
60	LABORATORY	1,858,807	41,129	9,128	227,811	51,289	68,838	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	423,889	21,632	23,194	103,276	11,155	14,971	65
66	PHYSICAL THERAPY	393,764	39,065	6,348	69,251	7,025	9,429	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,291	23,026			9,960	13,368	71
72	IMPL. DEV. CHARGED TO PATIENTS	283,473				1,725	2,315	72
73	DRUGS CHARGED TO PATIENTS	852,471			57,441	23,973	32,176	73
76.97	CARDIAC REHABILITATION	153,550	14,653	20,101	49,322	1,696	2,277	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	897,712	81,290	47,643	300,172	39,092	52,468	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	25,537,990	1,462,777	1,014,837	3,400,080	353,241	474,102	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,239	3,072	409				190
192	PHYSICIANS' PRIVATE OFFICES	671,219		4,118	59,084			192
194	OTHER NONALLOWABLE	128,909		2,036	21,845			194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	26,381,357	1,465,849	1,021,400	3,481,009	353,241	474,102	202

KPMG LLP

COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4)	ADMIN AND GENERA	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	
		4A	5.03	6	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL	6,367,078	6,367,078					5.03
6	MAINTENANCE & REPAIRS	304,512	96,873	401,385				6
7	OPERATION OF PLANT	1,287,192	409,491	107,538	1,804,221			7
8	LAUNDRY & LINEN SERVICE	114,489	36,422	4,383	26,909	182,203		8
9	HOUSEKEEPING	604,818	192,409	5,973	36,673		839,873	9
10	DIETARY	225,449	71,721	29,884	183,489	242		10
11	CAFETERIA	553,960	176,230	8,489	52,123			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	206,975	65,844	2,617	16,068		3,803	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	715,250	227,540	4,406	27,050			15
16	MEDICAL RECORDS & LIBRARY	395,598	125,850	7,882	48,397			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	2,420,653	770,074	68,582	421,096	87,136	140,657	30
43	NURSERY	115,009	36,587	2,531	15,538	4,727	5,369	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,697,323	539,964	47,198	289,800	22,934	109,475	50
52	DELIVERY ROOM & LABOR ROOM	686,506	218,396	7,454	45,766	9,129	61,336	52
53	ANESTHESIOLOGY	178,317	56,727	469	2,878		6,711	53
54	RADIOLOGY-DIAGNOSTIC	2,019,214	642,366	20,713	127,182	10,951	62,813	54
57	CT SCAN	527,432	167,790	1,544	9,482	5,740	5,771	57
58	MRI	311,455	99,082			2,452		58
60	LABORATORY	2,257,002	718,013	15,014	92,186	3,350	44,828	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	598,117	190,277	7,897	48,485	2,382	22,280	65
66	PHYSICAL THERAPY	524,882	166,979	14,260	87,560	6,069	11,453	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	422,645	134,455	8,406	51,611		6,711	71
72	IMPL. DEV. CHARGED TO PATIENTS	287,513	91,466					72
73	DRUGS CHARGED TO PATIENTS	966,061	307,330				7,024	73
76.97	CARDIAC REHABILITATION	241,599	76,859	5,349	32,842		18,477	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,418,377	451,224	29,674	182,200	21,610	120,480	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	25,447,426	6,069,969	400,263	1,797,335	176,722	627,188	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,720	14,863	1,122	6,886		3,847	190
192	PHYSICIANS' PRIVATE OFFICES	734,421	233,639			5,481	208,838	192
194	OTHER NONALLOWABLE	152,790	48,607					194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	26,381,357	6,367,078	401,385	1,804,221	182,203	839,873	202

KPMG LLP

COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		10	11	13	15	16	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL							5.03
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	510,785						10
11	CAFETERIA		790,802					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		4,234	299,541				13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY				974,246			15
16	MEDICAL RECORDS & LIBRARY		25,970			603,697		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	510,785	200,876	148,551		138,934	4,907,344	30
43	NURSERY		7,014	4,514		6,739	198,028	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		94,656	60,917		83,593	2,945,860	50
52	DELIVERY ROOM & LABOR ROOM		43,347	27,896		41,655	1,141,485	52
53	ANESTHESIOLOGY						245,102	53
54	RADIOLOGY-DIAGNOSTIC		91,623			82,550	3,057,412	54
57	CT SCAN		5,434			5,359	728,552	57
58	MRI		6,824			6,935	426,748	58
60	LABORATORY		86,442			61,026	3,277,861	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		35,954			27,666	933,058	65
66	PHYSICAL THERAPY		23,759			18,551	853,513	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						623,828	71
72	IMPL. DEV. CHARGED TO PATIENTS						378,979	72
73	DRUGS CHARGED TO PATIENTS		20,852		974,246	15,387	2,290,900	73
76.97	CARDIAC REHABILITATION		13,712			13,212	402,050	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		89,601	57,663		80,410	2,451,239	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	510,785	750,298	299,541	974,246	582,017	24,861,959	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						73,438	190
192	PHYSICIANS' PRIVATE OFFICES		33,869			15,828	1,232,076	192
194	OTHER NONALLOWABLE		6,635			5,852	213,884	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	510,785	790,802	299,541	974,246	603,697	26,381,357	202

KPMG LLP

COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL							5.03
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		4,907,344					30
43	NURSERY		198,028					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		2,945,860					50
52	DELIVERY ROOM & LABOR ROOM		1,141,485					52
53	ANESTHESIOLOGY		245,102					53
54	RADIOLOGY-DIAGNOSTIC		3,057,412					54
57	CT SCAN		728,552					57
58	MRI		426,748					58
60	LABORATORY		3,277,861					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		933,058					65
66	PHYSICAL THERAPY		853,513					66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		623,828					71
72	IMPL. DEV. CHARGED TO PATIENTS		378,979					72
73	DRUGS CHARGED TO PATIENTS		2,290,900					73
76.97	CARDIAC REHABILITATION		402,050					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		2,451,239					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		24,861,959					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		73,438					190
192	PHYSICIANS' PRIVATE OFFICES		1,232,076					192
194	OTHER NONALLOWABLE		213,884					194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		26,381,357					202

KPMG LLP COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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	NON-PATIENT TELEPHONES	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		30,558	4,764	35,322	35,322		4
5.01	ADMITTING		12,061	5,209	17,270	818	18,088	5.01
5.02	PATIENT ACCOUNTING		67,512	1,346	68,858	690		5.02
5.03	ADMIN & GENERAL		256,151	194,598	450,749	5,393		5.03
6	MAINTENANCE & REPAIRS					728		6
7	OPERATION OF PLANT		294,601	10,885	305,486	277		7
8	LAUNDRY & LINEN SERVICE		12,006		12,006			8
9	HOUSEKEEPING		16,362	290	16,652	983		9
10	DIETARY		81,865	18,029	99,894	237		10
11	CAFETERIA		23,255		23,255	1,028		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		7,169	25,705	32,874	416		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		12,069	11,097	23,166	1,352		15
16	MEDICAL RECORDS & LIBRARY		21,593	8,090	29,683	531		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		187,875	50,784	238,659	5,263	751	30
43	NURSERY		6,932		6,932	255	54	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		129,297	201,836	331,133	3,166	1,392	50
52	DELIVERY ROOM & LABOR ROOM		20,419		20,419	1,578	331	52
53	ANESTHESIOLOGY	1,518	1,284	46,657	49,459		798	53
54	RADIOLOGY-DIAGNOSTIC		56,743	182,524	239,267	3,127	3,158	54
57	CT SCAN		4,230	146,609	150,839	203	2,948	57
58	MRI					263	1,190	58
60	LABORATORY	64,738	41,129	9,128	114,995	2,312	2,624	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	16,685	21,632	23,194	61,511	1,048	571	65
66	PHYSICAL THERAPY		39,065	6,348	45,413	703	359	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,772	23,026		27,798		510	71
72	IMPL. DEV. CHARGED TO PATIENTS						88	72
73	DRUGS CHARGED TO PATIENTS	98,817			98,817	583	1,227	73
76.97	CARDIAC REHABILITATION		14,653	20,101	34,754	500	87	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		81,290	47,643	128,933	3,046	2,000	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	186,530	1,462,777	1,014,837	2,664,144	34,500	18,088	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56	3,072	409	3,537			190
192	PHYSICIANS' PRIVATE OFFICES			4,118	4,118	600		192
194	OTHER NONALLOWABLE	6,600		2,036	8,636	222		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	193,186	1,465,849	1,021,400	2,680,435	35,322	18,088	202

KPMG LLP

COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PRO-CESSING	ADMIN AND GENERA	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	
		5.02	5.03	6	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING	69,548						5.02
5.03	ADMIN & GENERAL		456,142					5.03
6	MAINTENANCE & REPAIRS		6,940	7,668				6
7	OPERATION OF PLANT		29,336	2,054	337,153			7
8	LAUNDRY & LINEN SERVICE		2,609	84	5,028	19,727		8
9	HOUSEKEEPING		13,784	114	6,853		38,386	9
10	DIETARY		5,138	571	34,288	26		10
11	CAFETERIA		12,625	162	9,740			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		4,717	50	3,003		174	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		16,301	84	5,055			15
16	MEDICAL RECORDS & LIBRARY		9,016	151	9,044			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	2,891	55,168	1,310	78,690	9,435	6,429	30
43	NURSERY	208	2,621	48	2,904	512	245	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,356	38,684	902	54,155	2,483	5,003	50
52	DELIVERY ROOM & LABOR ROOM	1,275	15,646	142	8,552	988	2,803	52
53	ANESTHESIOLOGY	3,072	4,064	9	538		307	53
54	RADIOLOGY-DIAGNOSTIC	12,095	46,020	396	23,766	1,186	2,871	54
57	CT SCAN	11,344	12,021	30	1,772	621	264	57
58	MRI	4,578	7,098			265		58
60	LABORATORY	10,098	51,439	287	17,227	363	2,049	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,196	13,632	151	9,060	258	1,018	65
66	PHYSICAL THERAPY	1,383	11,963	272	16,362	657	523	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,961	9,633	161	9,644		307	71
72	IMPL. DEV. CHARGED TO PATIENTS	340	6,553					72
73	DRUGS CHARGED TO PATIENTS	4,720	22,017				321	73
76.97	CARDIAC REHABILITATION	334	5,506	102	6,137		844	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	7,697	32,326	567	34,048	2,340	5,506	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	69,548	434,857	7,647	335,866	19,134	28,664	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,065	21	1,287		176	190
192	PHYSICIANS' PRIVATE OFFICES		16,738			593	9,546	192
194	OTHER NONALLOWABLE		3,482					194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	69,548	456,142	7,668	337,153	19,727	38,386	202

KPMG LLP

COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		10	11	13	15	16	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL							5.03
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	140,154						10
11	CAFETERIA		46,810					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		251	41,485				13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY				45,958			15
16	MEDICAL RECORDS & LIBRARY		1,537			49,962		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	140,154	11,890	20,573		11,503	582,716	30
43	NURSERY		415	625		558	15,377	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		5,603	8,437		6,918	463,232	50
52	DELIVERY ROOM & LABOR ROOM		2,566	3,864		3,447	61,611	52
53	ANESTHESIOLOGY						58,247	53
54	RADIOLOGY-DIAGNOSTIC		5,423			6,831	344,140	54
57	CT SCAN		322			443	180,807	57
58	MRI		404			574	14,372	58
60	LABORATORY		5,117			5,050	211,561	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		2,128			2,289	93,862	65
66	PHYSICAL THERAPY		1,406			1,535	80,576	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						50,014	71
72	IMPL. DEV. CHARGED TO PATIENTS						6,981	72
73	DRUGS CHARGED TO PATIENTS		1,234		45,958	1,273	176,150	73
76.97	CARDIAC REHABILITATION		812			1,093	50,169	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		5,304	7,986		6,654	236,407	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	140,154	44,412	41,485	45,958	48,168	2,626,222	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						6,086	190
192	PHYSICIANS' PRIVATE OFFICES		2,005			1,310	34,910	192
194	OTHER NONALLOWABLE		393			484	13,217	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	140,154	46,810	41,485	45,958	49,962	2,680,435	202

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COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL							5.03
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		582,716					30
43	NURSERY		15,377					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		463,232					50
52	DELIVERY ROOM & LABOR ROOM		61,611					52
53	ANESTHESIOLOGY		58,247					53
54	RADIOLOGY-DIAGNOSTIC		344,140					54
57	CT SCAN		180,807					57
58	MRI		14,372					58
60	LABORATORY		211,561					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		93,862					65
66	PHYSICAL THERAPY		80,576					66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		50,014					71
72	IMPL. DEV. CHARGED TO PATIENTS		6,981					72
73	DRUGS CHARGED TO PATIENTS		176,150					73
76.97	CARDIAC REHABILITATION		50,169					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		236,407					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,626,222					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,086					190
192	PHYSICIANS' PRIVATE OFFICES		34,910					192
194	OTHER NONALLOWABLE		13,217					194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		2,680,435					202

KPMG LLP

COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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	NON-PATIENT TELEPHONES GROSS REVENUE	DATA PRO-CESSING GROSS REVENUE	RECON-CILIATION	
		1	2	4	5.01	5.02	5A.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	186,076						1
2	CAP REL COSTS-MVBLE EQUIP		918,924					2
4	EMPLOYEE BENEFITS DEPARTMENT	3,879	4,286	9,930,390				4
5.01	ADMITTING	1,531	4,686	229,845	78,589,137			5.01
5.02	PATIENT ACCOUNTING	8,570	1,211	194,042		78,589,137		5.02
5.03	ADMIN & GENERAL	32,516	175,074	1,516,703			-6,367,078	5.03
6	MAINTENANCE & REPAIRS			204,619				6
7	OPERATION OF PLANT	37,397	9,793	78,003				7
8	LAUNDRY & LINEN SERVICE	1,524						8
9	HOUSEKEEPING	2,077	261	276,306				9
10	DIETARY	10,392	16,220	66,719				10
11	CAFETERIA	2,952		288,940				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	910	23,126	116,842				13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	1,532	9,984	380,235				15
16	MEDICAL RECORDS & LIBRARY	2,741	7,278	149,199				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	23,849	45,689	1,479,541	3,266,194	3,266,194		30
43	NURSERY	880		71,770	234,782	234,782		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	16,413	181,586	890,203	6,051,809	6,051,809		50
52	DELIVERY ROOM & LABOR ROOM	2,592		443,600	1,440,539	1,440,539		52
53	ANESTHESIOLOGY	163	41,976		3,471,130	3,471,130		53
54	RADIOLOGY-DIAGNOSTIC	7,203	164,212	879,099	13,671,987	13,671,987		54
57	CT SCAN	537	131,900	57,068	12,818,403	12,818,403		57
58	MRI			73,852	5,172,500	5,172,500		58
60	LABORATORY	5,221	8,212	649,883	11,410,303	11,410,303		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,746	20,867	294,619	2,481,538	2,481,538		65
66	PHYSICAL THERAPY	4,959	5,711	197,554	1,562,894	1,562,894		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,923			2,215,766	2,215,766		71
72	IMPL. DEV. CHARGED TO PATIENTS				383,788	383,788		72
73	DRUGS CHARGED TO PATIENTS			163,865	5,333,345	5,333,345		73
76.97	CARDIAC REHABILITATION	1,860	18,084	140,703	377,381	377,381		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	10,319	42,863	856,310	8,696,778	8,696,778		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	185,686	913,019	9,699,520	78,589,137	78,589,137	-6,367,078	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	390	368					190
192	PHYSICIANS' PRIVATE OFFICES		3,705	168,552				192
194	OTHER NONALLOWABLE		1,832	62,318				194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,465,849	1,021,400	3,481,009	353,241	474,102		202
203	UNIT COST MULT-WS B PT I	7.877690	1.111517	0.350541	0.004495	0.006033		203
204	COST TO BE ALLOC PER B PT II			35,322	18,088	69,548		204
205	UNIT COST MULT-WS B PT II			0.003557	0.000230	0.000885		205

KPMG LLP COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	ADMIN AND GENERA ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	
		5.03	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL	20,014,279						5.03
6	MAINTENANCE & REPAIRS	304,512	139,580					6
7	OPERATION OF PLANT	1,287,192	37,397	102,183				7
8	LAUNDRY & LINEN SERVICE	114,489	1,524	1,524	175,910			8
9	HOUSEKEEPING	604,818	2,077	2,077		18,773		9
10	DIETARY	225,449	10,392	10,392	234		35,001	10
11	CAFETERIA	553,960	2,952	2,952				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	206,975	910	910		85		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	715,250	1,532	1,532				15
16	MEDICAL RECORDS & LIBRARY	395,598	2,741	2,741				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	2,420,653	23,849	23,849	84,125	3,144	35,001	30
43	NURSERY	115,009	880	880	4,564	120		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,697,323	16,413	16,413	22,142	2,447		50
52	DELIVERY ROOM & LABOR ROOM	686,506	2,592	2,592	8,814	1,371		52
53	ANESTHESIOLOGY	178,317	163	163		150		53
54	RADIOLOGY-DIAGNOSTIC	2,019,214	7,203	7,203	10,573	1,404		54
57	CT SCAN	527,432	537	537	5,542	129		57
58	MRI	311,455			2,367			58
60	LABORATORY	2,257,002	5,221	5,221	3,234	1,002		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	598,117	2,746	2,746	2,300	498		65
66	PHYSICAL THERAPY	524,882	4,959	4,959	5,859	256		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	422,645	2,923	2,923		150		71
72	IMPL. DEV. CHARGED TO PATIENTS	287,513						72
73	DRUGS CHARGED TO PATIENTS	966,061				157		73
76.97	CARDIAC REHABILITATION	241,599	1,860	1,860		413		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,418,377	10,319	10,319	20,864	2,693		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,080,348	139,190	101,793	170,618	14,019	35,001	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,720	390	390		86		190
192	PHYSICIANS' PRIVATE OFFICES	734,421			5,292	4,668		192
194	OTHER NONALLOWABLE	152,790						194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	6,367,078	401,385	1,804,221	182,203	839,873	510,785	202
203	UNIT COST MULT-WS B PT I	0.318127	2.875663	17.656763	1.035774	44.738348	14.593440	203
204	COST TO BE ALLOC PER B PT II	456,142	7,668	337,153	19,727	38,386	140,154	204
205	UNIT COST MULT-WS B PT II	0.022791	0.054936	3.299502	0.112143	2.044745	4.004286	205

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

	COST CENTER DESCRIPTIONS	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS SALARIES			
		11	13	15	16			
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL							5.03
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	12,515						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	67	7,366					13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY			100				15
16	MEDICAL RECORDS & LIBRARY	411			6,428,937			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	3,179	3,653		1,479,541			30
43	NURSERY	111	111		71,770			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,498	1,498		890,203			50
52	DELIVERY ROOM & LABOR ROOM	686	686		443,600			52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,450			879,099			54
57	CT SCAN	86			57,068			57
58	MRI	108			73,852			58
60	LABORATORY	1,368			649,883			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	569			294,619			65
66	PHYSICAL THERAPY	376			197,554			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	330		100	163,865			73
76.97	CARDIAC REHABILITATION	217			140,703			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,418	1,418		856,310			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	11,874	7,366	100	6,198,067			118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES	536			168,552			192
194	OTHER NONALLOWABLE	105			62,318			194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	790,802	299,541	974,246	603,697			202
203	UNIT COST MULT-WS B PT I	63.188334	40.665354	9,742.460000	0.093903			203
204	COST TO BE ALLOC PER B PT II	46,810	41,485	45,958	49,962			204
205	UNIT COST MULT-WS B PT II	3.740312	5.631958	459.580000	0.007771			205

KPMG LLP COMPU-MAX

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POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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	4,907,344		4,907,344			30
43	NURSERY	198,028		198,028			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,945,860		2,945,860			50
52	DELIVERY ROOM & LABOR ROOM	1,141,485		1,141,485			52
53	ANESTHESIOLOGY	245,102		245,102			53
54	RADIOLOGY-DIAGNOSTIC	3,057,412		3,057,412			54
57	CT SCAN	728,552		728,552			57
58	MRI	426,748		426,748			58
60	LABORATORY	3,277,861		3,277,861			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	933,058		933,058			65
66	PHYSICAL THERAPY	853,513		853,513			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	623,828		623,828			71
72	IMPL. DEV. CHARGED TO PATIENTS	378,979		378,979			72
73	DRUGS CHARGED TO PATIENTS	2,290,900		2,290,900			73
76.97	CARDIAC REHABILITATION	402,050		402,050			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	2,451,239		2,451,239			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	469,854		469,854			92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	25,331,813		25,331,813			200
201	LESS OBSERVATION BEDS	469,854		469,854			201
202	TOTAL (SEE INSTRUCTIONS)	24,861,959		24,861,959			202

KPMG LLP COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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	2,833,541		2,833,541				30
43	NURSERY	234,782		234,782				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	572,533	5,479,276	6,051,809	0.486773			50
52	DELIVERY ROOM & LABOR ROOM	882,504	558,035	1,440,539	0.792401			52
53	ANESTHESIOLOGY	400,177	3,070,953	3,471,130	0.070612			53
54	RADIOLOGY-DIAGNOSTIC	977,287	12,694,700	13,671,987	0.223626			54
57	CT SCAN	923,625	11,894,778	12,818,403	0.056836			57
58	MRI	166,148	5,006,352	5,172,500	0.082503			58
60	LABORATORY	2,330,528	9,079,775	11,410,303	0.287272			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,291,718	1,189,820	2,481,538	0.376000			65
66	PHYSICAL THERAPY	167,419	1,395,475	1,562,894	0.546111			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	585,374	1,630,392	2,215,766	0.281541			71
72	IMPL. DEV. CHARGED TO PATIENTS	315,837	67,951	383,788	0.987470			72
73	DRUGS CHARGED TO PATIENTS	2,345,265	2,988,080	5,333,345	0.429543			73
76.97	CARDIAC REHABILITATION	561	376,820	377,381	1.065369			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	218,000	8,478,778	8,696,778	0.281856			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	17,597	415,056	432,653	1.085983			92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	14,262,896	64,326,241	78,589,137				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		64,326,241	78,589,137				202

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1350** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.486773		1,852,738			901,863		50
52	DELIVERY ROOM & LABOR ROOM	0.792401							52
53	ANESTHESIOLOGY	0.070612		979,210			69,144		53
54	RADIOLOGY-DIAGNOSTIC	0.223626		4,939,863			1,104,682		54
57	CT SCAN	0.056836		5,140,788			292,182		57
58	MRI	0.082503		1,813,968			149,658		58
60	LABORATORY	0.287272		3,941,153			1,132,183		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.376000		470,106			176,760		65
66	PHYSICAL THERAPY	0.546111		502,352			274,340		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281541		595,092			167,543		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.987470		20,348			20,093		72
73	DRUGS CHARGED TO PATIENTS	0.429543		1,560,224	88		670,183	38	73
76.97	CARDIAC REHABILITATION	1.065369		275,483			293,491		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.281856		2,962,167			834,905		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.085983		218,186			236,946		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			25,271,678	88		6,323,973	38	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			25,271,678	88		6,323,973	38	202

(A) Worksheet A line numbers

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z350** **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) [ ] SNF [ ] NF | [XX] 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	0.486773							50
52	DELIVERY ROOM & LABOR ROOM	0.792401							52
53	ANESTHESIOLOGY	0.070612							53
54	RADIOLOGY-DIAGNOSTIC	0.223626							54
57	CT SCAN	0.056836							57
58	MRI	0.082503							58
60	LABORATORY	0.287272							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.376000							65
66	PHYSICAL THERAPY	0.546111							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281541							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.987470							72
73	DRUGS CHARGED TO PATIENTS	0.429543							73
76.97	CARDIAC REHABILITATION	1.065369							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.281856							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.085983							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

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)	582,716	32,112	550,604	4,441	123.98	409	50,708	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	15,377		15,377	409	37.60	183	6,881	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	598,093		565,981	4,850		592	57,589	200

(A) Worksheet A line numbers

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1350** **WORKSHEET D PART II**

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	463,232	6,051,809	0.076544			50
52	DELIVERY ROOM & LABOR ROOM	61,611	1,440,539	0.042769			52
53	ANESTHESIOLOGY	58,247	3,471,130	0.016780			53
54	RADIOLOGY-DIAGNOSTIC	344,140	13,671,987	0.025171			54
57	CT SCAN	180,807	12,818,403	0.014105			57
58	MRI	14,372	5,172,500	0.002779			58
60	LABORATORY	211,561	11,410,303	0.018541			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	93,862	2,481,538	0.037824			65
66	PHYSICAL THERAPY	80,576	1,562,894	0.051556			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,014	2,215,766	0.022572			71
72	IMPL. DEV. CHARGED TO PATIENTS	6,981	383,788	0.018190			72
73	DRUGS CHARGED TO PATIENTS	176,150	5,333,345	0.033028			73
76.97	CARDIAC REHABILITATION	50,169	377,381	0.132940			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	236,407	8,696,778	0.027183			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	59,046	432,653	0.136474			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,087,175	75,520,814				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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)	4,441		409		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	409		183		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	4,850		592		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1350** | **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
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1350** | **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)	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	6,051,809							50
52	DELIVERY ROOM & LABOR ROOM	1,440,539							52
53	ANESTHESIOLOGY	3,471,130							53
54	RADIOLOGY-DIAGNOSTIC	13,671,987							54
57	CT SCAN	12,818,403							57
58	MRI	5,172,500							58
60	LABORATORY	11,410,303							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	2,481,538							65
66	PHYSICAL THERAPY	1,562,894							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,215,766							71
72	IMPL. DEV. CHARGED TO PATIENTS	383,788							72
73	DRUGS CHARGED TO PATIENTS	5,333,345							73
76.97	CARDIAC REHABILITATION	377,381							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	8,696,778							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	432,653							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	75,520,814							200

(A) Worksheet A line numbers

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1350** **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	0.486773							50
52	DELIVERY ROOM & LABOR ROOM	0.792401							52
53	ANESTHESIOLOGY	0.070612							53
54	RADIOLOGY-DIAGNOSTIC	0.223626							54
57	CT SCAN	0.056836							57
58	MRI	0.082503							58
60	LABORATORY	0.287272							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.376000							65
66	PHYSICAL THERAPY	0.546111							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281541							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.987470							72
73	DRUGS CHARGED TO PATIENTS	0.429543							73
76.97	CARDIAC REHABILITATION	1.065369							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.281856							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.085983							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

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1350** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,700	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,441	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)	3,991	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	130	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)	129	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)	2,788	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)	124	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)	123	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	132.03	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,907,344	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)	270,427	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,636,917	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)	4,636,917	37

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1350** **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) | [ ] PPS [ ] TEFRA [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)					1,044.12	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					2,911,007	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)					2,911,007	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						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)					2,045,327	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					4,956,334	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						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)					129,471	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					128,427	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					257,898	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. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1350** **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 | [ ] PPS [ ] TEFRA [XX] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					450	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,044.12	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					469,854	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	582,716	4,636,917	0.125669	469,854	59,046	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1350** **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)	4,700	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,441	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)	3,991	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	130	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)	129	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)	409	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)	409	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	183	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	132.03	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,907,344	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)	270,427	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,636,917	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)	4,636,917	37

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1350** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] PPS [ ] TEFRA [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)					1,044.12	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					427,045	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)					427,045	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)	198,028	409	484.18	183	88,605	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						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)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					515,650	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					57,589	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					57,589	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. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1350** **WORKSHEET D-1**
PARTS III & IV

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 IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					450	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. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1350** **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 | [ ] 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		2,192,377		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.486773	213,173	103,767	50
52	DELIVERY ROOM & LABOR ROOM	0.792401			52
53	ANESTHESIOLOGY	0.070612	156,984	11,085	53
54	RADIOLOGY-DIAGNOSTIC	0.223626	735,975	164,583	54
57	CT SCAN	0.056836	568,973	32,338	57
58	MRI	0.082503	91,496	7,549	58
60	LABORATORY	0.287272	1,498,265	430,410	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.376000	1,016,429	382,177	65
66	PHYSICAL THERAPY	0.546111	115,344	62,991	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281541	260,470	73,333	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.987470	246,311	243,225	72
73	DRUGS CHARGED TO PATIENTS	0.429543	1,238,641	532,050	73
76.97	CARDIAC REHABILITATION	1.065369	561	598	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.281856	4,332	1,221	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.085983			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		6,146,954	2,045,327	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		6,146,954		202

(A) Worksheet A line numbers

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z350** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.486773			50
52	DELIVERY ROOM & LABOR ROOM	0.792401			52
53	ANESTHESIOLOGY	0.070612			53
54	RADIOLOGY-DIAGNOSTIC	0.223626	5,996	1,341	54
57	CT SCAN	0.056836	4,591	261	57
58	MRI	0.082503			58
60	LABORATORY	0.287272	28,721	8,251	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.376000	75,123	28,246	65
66	PHYSICAL THERAPY	0.546111	38,253	20,890	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281541	9,901	2,788	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.987470			72
73	DRUGS CHARGED TO PATIENTS	0.429543	85,236	36,613	73
76.97	CARDIAC REHABILITATION	1.065369			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.281856			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.085983			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		247,821	98,390	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		247,821		202

(A) Worksheet A line numbers

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1350** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.486773			50
52	DELIVERY ROOM & LABOR ROOM	0.792401			52
53	ANESTHESIOLOGY	0.070612			53
54	RADIOLOGY-DIAGNOSTIC	0.223626			54
57	CT SCAN	0.056836			57
58	MRI	0.082503			58
60	LABORATORY	0.287272			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.376000			65
66	PHYSICAL THERAPY	0.546111			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281541			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.987470			72
73	DRUGS CHARGED TO PATIENTS	0.429543			73
76.97	CARDIAC REHABILITATION	1.065369			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.281856			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.085983			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z350** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.486773			50
52	DELIVERY ROOM & LABOR ROOM	0.792401			52
53	ANESTHESIOLOGY	0.070612			53
54	RADIOLOGY-DIAGNOSTIC	0.223626			54
57	CT SCAN	0.056836			57
58	MRI	0.082503			58
60	LABORATORY	0.287272			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.376000			65
66	PHYSICAL THERAPY	0.546111			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281541			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.987470			72
73	DRUGS CHARGED TO PATIENTS	0.429543			73
76.97	CARDIAC REHABILITATION	1.065369			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.281856			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.085983			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1350** **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)	6,324,011			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)	6,324,011			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)				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)	6,387,251			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)	57,204			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	4,354,720			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,975,327			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	1,975,327			30
31	PRIMARY PAYER PAYMENTS	679			31
32	SUBTOTAL (line 30 minus line 31)	1,974,648			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)	1,090,568			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	959,700			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	804,551			36
37	SUBTOTAL (see instructions)	2,934,348			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	2,934,348			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	58,687			40.01
41	INTERIM PAYMENTS	3,116,002			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-240,341			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. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1350** **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				3,567,593		3,150,946	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	02/19/2014	487,508	12/16/2013	117,261	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	06/25/2014	279,369	02/19/2014	236,075	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	12/16/2013	352,408	06/25/2014	388,280	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		414,469		-34,944	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)				3,982,062		3,116,002	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		538,603			6.01
	BASED ON THE COST REPORT (1)		.02				-181,654	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				4,520,665		2,934,348	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. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z350** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [XX] 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				258,480			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	02/19/2014	12,419			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	12/16/2013	570			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		11,849			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)				270,329			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		82,594			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				352,923			7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

KPMG LLP COMPU-MAX

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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	1,201	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,788	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,991	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	78,589,137	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,353,786	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	4,866,868	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	4,478,492	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	89,570	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	4,388,922	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	4,578,749	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-189,827	32

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z350** **WORKSHEET E-2**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX** **[XX] SWING BED - SNF** **[ ] SWING BED - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	260,477		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (see instructions)			2
3	ANCILLARY SERVICES (from Wkst D-3, col. 3, line 200 for Part A, and sum of Wkst D, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)	99,374		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	247		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (sum of lines 1-3 plus lines 6 and 7)	359,851		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	359,851		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	359,851		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	6,928		13
14	80% OF PART B COSTS (line 12 x 80%)			14
15	SUBTOTAL (enter the lesser of line 12 minus line 13, or line 14)	352,923		15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
17	ALLOWABLE BAD DEBTS (see instructions)			17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19	TOTAL (see instructions)	352,923		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	7,058		19.01
20	INTERIM PAYMENTS	270,329		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	75,536		22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART V

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	INPATIENT SERVICES	4,956,334	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	4,956,334	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	5,005,897	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	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)		12
13	RATIO OF LINE 11 TO LINE 12 (not to exceed 1.000000)	0.000000	13
14	TOTAL CUSTOMARY CHARGES (see instructions)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 14 exceeds line 6) (see instructions)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)		16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	5,005,897	19
20	DEDUCTIBLES (exclude professional component)	589,435	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	4,416,462	22
23	COINSURANCE		23
24	SUBTOTAL (line 22 minus line 23)	4,416,462	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	118,413	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	104,203	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	71,056	27
28	SUBTOTAL (sum of lines 24 and 26)	4,520,665	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		29
30	SUBTOTAL (line 28 plus or minus line 29)	4,520,665	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	90,413	30.01
31	INTERIM PAYMENTS	3,982,062	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	448,190	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1350** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	515,650		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	515,650		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	515,650		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)			15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			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)	515,650		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	515,650		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)	515,650		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)	515,650		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	515,650		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)	515,650		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	515,650		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	6,694,146				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	5,194,333				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-4,437,925				6
7	INVENTORY	384,208				7
8	PREPAID EXPENSES	226,370				8
9	OTHER CURRENT ASSETS	99,968				9
10	DUE FROM OTHER FUNDS	1,309,626				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	9,470,726				11
	FIXED ASSETS					
12	LAND	99,383				12
13	LAND IMPROVEMENTS	1,819,149				13
14	ACCUMULATED DEPRECIATION	-1,116,313				14
15	BUILDINGS	12,770,473				15
16	ACCUMULATED DEPRECIATION	-5,097,151				16
17	LEASEHOLD IMPROVEMENTS	21,067,161				17
18	ACCUMULATED AMORTIZATION	-9,615,149				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	18,324,436				23
24	ACCUMULATED DEPRECIATION	-14,651,039				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)	23,600,950				30
	OTHER ASSETS					
31	INVESTMENTS	24,281,212				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	57,039				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	24,338,251				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	57,409,927				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	1,279,271				37
38	SALARIES, WAGES & FEES PAYABLE	1,408,165				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	1,312,026				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	3,530,159				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	7,529,621				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE	8,765,543				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	6,964,903				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	15,730,446				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	23,260,067				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	34,149,860				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

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	34,149,860				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	57,409,927				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		29,067,337			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		5,164,025			2
3	TOTAL (sun of line 1 and line 2)		34,231,362			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		34,231,362			11
12	DEDUCTIONS (debit adjustments)	81,502				12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		81,502			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		34,149,860			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						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 12:45 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	4,213,242		4,213,242	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	4,213,242		4,213,242	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)	4,213,242		4,213,242	17
18	ANCILLARY SERVICES	9,280,750	69,174,549	78,455,299	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	13,493,992	69,174,549	82,668,541	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		31,263,415	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			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)		31,263,415	43

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	82,668,541	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	46,865,719	2
3	NET PATIENT REVENUES (line 1 minus line 2)	35,802,822	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	31,263,415	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	4,539,407	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	55,221	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	202,401	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISC)	366,996	24
25	TOTAL OTHER INCOME (sum of lines 6-24)	624,618	25
26	TOTAL (line 5 plus line 25)	5,164,025	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	5,164,025	29

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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
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	ADMIN & GENERAL							5.03
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
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
194	OTHER NONALLOWABLE							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202