ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

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: 11/23/2015 Time: 17:56 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(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		-94,628	-766,959			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-42,561				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		-137,189	-766,959			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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence

not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

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:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. 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 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	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
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		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 payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				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, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		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:	54,780	47,500	361,941	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
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. (see instructions)		166

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the 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 / 2014	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

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 Accnountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	Y			5

		Y/N	Y/N	
Approved Educational Activities		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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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	10/19/2015	Y	10/19/2015	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 Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

Capital Related Cost			
22	Have assets been 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 capitalization 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	Are 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 servcies 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 Report Preparer Contact Information				
41	First name: PATRICK	Last name: NUDO	Title: DIRECTOR OF FINANCIAL SERV	41
42	Employer: ST FRANCIS HOSPITAL			42
43	Phone number: 217-324-8368	E-mail Address: PATRICK.NUDO@HSHS.ORG		43

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A 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		2,930	895	4,364	1
2	HMO and other (see instructions)						256			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						217		256	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	100,632.00		3,147	895	4,620	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						258	404	13
14	Total (see instructions)		25	9,125	100,632.00		3,147	1,153	5,024	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								1,005	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								19	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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)					730	443	1,368	1
2	HMO and other (see instructions)					68			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)		198.00			730	443	1,368	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)		198.00						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

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 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
64	IA2				64

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	
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 catetory. 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

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)	0.278699	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)	5,370,456	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.	780,874	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	780,874	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	1,315,286	454,834	1,770,120	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	366,569	126,762	493,331	21
22	Partial payment by patients approved for charity care	9,301		9,301	22
23	Cost of charity care (line 21 minus line 22)	357,268	126,762	484,030	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)	1,817,224	26
27	Medicare bad debts for the entire hospital complex (see instructions)	586,364	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,230,860	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	343,039	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	827,069	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,607,943	31

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		1,200,140	1,200,140	483,952	1,684,092	-834,621	849,471	1
2	00200	Cap Rel Costs-Mvble Equip		1,212,426	1,212,426		1,212,426		1,212,426	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	82,354	4,407,994	4,490,348	9,134	4,499,482	-775,337	3,724,145	4
5.01	00570	ADMITTING	496,661	106,442	603,103	-231,441	371,662		371,662	5.01
5.02	00590	PATIENT ACCOUNTING	4,436	376,246	380,682		380,682		380,682	5.02
5.03	00591	ADMIN & GENERAL	1,597,413	5,892,265	7,489,678	-426,115	7,063,563	-850,205	6,213,358	5.03
6	00600	Maintenance & Repairs	177,362	19,361	196,723		196,723		196,723	6
7	00700	Operation of Plant	120,686	923,922	1,044,608	-33,964	1,010,644		1,010,644	7
8	00800	Laundry & Linen Service				108,559	108,559		108,559	8
9	00900	Housekeeping	274,183	216,461	490,644		490,644		490,644	9
10	01000	Dietary	348,150	183,036	531,186	-377,726	153,460		153,460	10
11	01100	Cafeteria				377,726	377,726		377,726	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	95,561	26,440	122,001	1,589	123,590	-78	123,512	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	376,723	793,952	1,170,675	-619,078	551,597		551,597	15
16	01600	Medical Records & Library				93,670	93,670		93,670	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 SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,311,140	234,295	2,545,435	-856,067	1,689,368		1,689,368	30
43	04300	Nursery				95,062	95,062		95,062	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,022,412	1,182,005	2,204,417	-1,006,191	1,198,226		1,198,226	50
52	05200	Delivery Room & Labor Room				550,022	550,022		550,022	52
53	05300	Anesthesiology		802,313	802,313	-14,677	787,636	-674,099	113,537	53
54	05400	Radiology-Diagnostic	856,435	500,759	1,357,194	-19,332	1,337,862		1,337,862	54
57	05700	CT Scan	80,801	201,218	282,019	5,493	287,512		287,512	57
58	05800	MRI	83,489	86,995	170,484	4,218	174,702		174,702	58
60	06000	Laboratory	576,402	1,229,139	1,805,541	128,649	1,934,190		1,934,190	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	342,434	210,140	552,574	1,619	554,193	-111,483	442,710	65
66	06600	Physical Therapy	334,839	46,814	381,653	6,378	388,031		388,031	66
71	07100	Medical Supplies Charged to Patients		95,627	95,627	345,421	441,048		441,048	71
72	07200	Impl. Dev. Charged to Patients				701,706	701,706		701,706	72
73	07300	Drugs Charged to Patients				666,970	666,970		666,970	73
76.97	07697	CARDIAC REHABILITATION	101,597	11,265	112,862		112,862	-2,549	110,313	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	58,265	792,543	850,808		850,808		850,808	90
91	09100	Emergency	956,697	787,653	1,744,350	-31,647	1,712,703	-692,820	1,019,883	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	10,298,040	21,539,451	31,837,491	-36,070	31,801,421	-3,941,192	27,860,229	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		35,908	35,908		35,908		35,908	190
192	19200	Physicians' Private Offices	182,647	327,873	510,520	36,070	546,590	-254,743	291,847	192
194	07950	OTHER NONALLOWABLE	134,450	199,965	334,415		334,415		334,415	194
200		TOTAL (sum of lines 118-199)	10,615,137	22,103,197	32,718,334		32,718,334	-4,195,935	28,522,399	200

			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	83,821	11,268	1
2			Delivery Room & Labor Room	52	487,013	65,469	2
500	Total reclassifications				570,834	76,737	500
	Code Letter - A						
1	RECLASSIFY DRUG COSTS	B	Drugs Charged to Patients	73		622,346	1
500	Total reclassifications					622,346	500
	Code Letter - B						
1	RECLASSIFY CAFETERIA COSTS	C	Cafeteria	11	247,569	130,157	1
500	Total reclassifications				247,569	130,157	500
	Code Letter - C						
1	RECLASSIFY LAUNDRY COSTS	D	Laundry & Linen Service	8		108,559	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					108,559	500
	Code Letter - D						
1	RECLASSIFY MEDICAL SUPPLY COSTS	E	Medical Supplies Charged to P	71		345,421	1
2			Impl. Dev. Charged to Patient	72		701,706	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					1,047,127	500
	Code Letter - E						
1	DRUG ADMINISTRATION COSTS	F	Laboratory	60	108,278	7,081	1
2			Drugs Charged to Patients	73		44,809	2
500	Total reclassifications				108,278	51,890	500
	Code Letter - F						
1	RECLASSIFY DEPREC COSTS FOR MOB	G	Physicians' Private Offices	192		39,296	1
500	Total reclassifications					39,296	500
	Code Letter - G						
1	RECLASSIFY SHARED SERVICE COSTS	H	Employee Benefits Department	4		9,134	1
2			ADMITTING	5.01		19,190	2
3			Operation of Plant	7		1,164	3
4			Pharmacy	15		3,268	4
5			Adults & Pediatrics	30		3,836	5
6			Operating Room	50		4,747	6
7			Radiology-Diagnostic	54		5,133	7
8			Laboratory	60		15,387	8
9			Respiratory Therapy	65		24,380	9
10			Physical Therapy	66		7,055	10
11			Nursing Administration	13		1,589	11
12			Emergency	91		124	12
500	Total reclassifications					95,007	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	8,226		1
2			MRI	58	7,366		2

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
500	Total reclassifications				15,592		500
	Code Letter - J						
1	MEDICAL RECORDS	K	Medical Records & Library	16	93,275	395	1
500	Total reclassifications				93,275	395	500
	Code Letter - K						
1	INTEREST EXPENSE	L	Cap Rel Costs-Bldg & Fixt	1		487,865	1
500	Total reclassifications					487,865	500
	Code Letter - L						
1	CASE MANAGEMENT	M	ADMIN & GENERAL	5.03	170,452	80,179	1
500	Total reclassifications				170,452	80,179	500
	Code Letter - M						
	GRAND TOTAL (Increases)				1,206,000	2,774,941	

(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.

			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	570,834	76,737		1
2								2
500	Total reclassifications				570,834	76,737		500
	Code letter - A							
1	RECLASSIFY DRUG COSTS	B	Pharmacy	15		622,346		1
500	Total reclassifications					622,346		500
	Code letter - B							
1	RECLASSIFY CAFETERIA COSTS	C	Dietary	10	247,569	130,157		1
500	Total reclassifications				247,569	130,157		500
	Code letter - C							
1	RECLASSIFY LAUNDRY COSTS	D	Physicians' Private Offices	192		3,175		1
2			Adults & Pediatrics	30		53,676		2
3			Operating Room	50		15,167		3
4			Radiology-Diagnostic	54		8,873		4
5			CT Scan	57		2,733		5
6			MRI	58		2,160		6
7			Laboratory	60		2,097		7
8			Respiratory Therapy	65		2,208		8
9			Physical Therapy	66		618		9
10			Emergency	91		17,852		10
500	Total reclassifications					108,559		500
	Code letter - D							
1	RECLASSIFY MEDICAL SUPPLY COSTS	E	Nursery	43		27		1
2			Operating Room	50		995,771		2
3			Delivery Room & Labor Room	52		2,460		3
4			Anesthesiology	53		14,677		4
5			MRI	58		988		5
6			Respiratory Therapy	65		20,553		6
7			Physical Therapy	66		59		7
8			Drugs Charged to Patients	73		185		8
9			Emergency	91		12,407		9
500	Total reclassifications					1,047,127		500
	Code letter - E							
1	DRUG ADMINISTRATION COSTS	F	Adults & Pediatrics	30	107,434	51,222		1
2			Emergency	91	844	668		2
500	Total reclassifications				108,278	51,890		500
	Code letter - F							
1	RECLASSIFY DEPREC COSTS FOR MOB	G	Cap Rel Costs-Bldg & Fixt	1		39,296	12	1
500	Total reclassifications					39,296		500
	Code letter - G							
1	RECLASSIFY SHARED SERVICE COSTS	H	ADMIN & GENERAL	5.03		95,007		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
500	Total reclassifications					95,007		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	15,592			1

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

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	
2								2
500	Total reclassifications				15,592			500
	Code letter - J							
1	MEDICAL RECORDS	K	ADMIN & GENERAL	5.03	93,275	395		1
500	Total reclassifications				93,275	395		500
	Code letter - K							
1	INTEREST EXPENSE	L	ADMIN & GENERAL	5.03		487,865	11	1
500	Total reclassifications					487,865		500
	Code letter - L							
1	CASE MANAGEMENT	M	ADMITTING	5.01	170,452	80,179		1
500	Total reclassifications				170,452	80,179		500
	Code letter - M							
	GRAND TOTAL (Decreases)				1,206,000	2,774,941		

(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.

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 Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	99,383					99,383		1
2	Land Improvements	1,819,149					1,819,149		2
3	Buildings and Fixtures	32,852,916					32,852,916		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	18,324,430					18,324,430		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	53,095,878					53,095,878		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	53,095,878					53,095,878		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	995,908		204,232				1,200,140	1
2	Cap Rel Costs-Mvble Equip	1,021,400		191,026				1,212,426	2
3	Total (sum of lines 1-2)	2,017,308		395,258				2,412,566	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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				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	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	161,287		692,097	-3,913			849,471	1
2	Cap Rel Costs-Mvble Equip	1,021,400		191,026				1,212,426	2
3	Total (sum of lines 1-2)	1,182,687		883,123	-3,913			2,061,897	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.)

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	-1,480,951				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	726,013				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	-78	Nursing Administration	13		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	MISC	B	-128,207	ADMIN & GENERAL	5.03		33
33.04	ADMIN REVENUE	B	-564	ADMIN & GENERAL	5.03		33.04
34							34
35	FUND DEVELOPMENT	A	-62,508	ADMIN & GENERAL	5.03		35
36	PHYSICIAN RECRUITMENT	A	-62,300	ADMIN & GENERAL	5.03		36
37	MEDICAID TAX ASSESSTMENT	A	-1,154,816	ADMIN & GENERAL	5.03		37
38	SELF-INS TO HOSP/EMPLOYEE CLAIM	A	-740,781	Employee Benefits Department	4		38
39	LOBBYING EXPENSES	A	-18,656	ADMIN & GENERAL	5.03		39
40	ALCOHOLIC BEVERAGE COST	A	-687	ADMIN & GENERAL	5.03		40
41	CHARITY EXPENSE	A	-4,536	ADMIN & GENERAL	5.03		41
42	MEANINGFUL USE DEPRECIATION	A	-834,621	Cap Rel Costs-Bldg & Fixt	1	9	42
43	PURCHASED SERVICES - HSHS MED G	A	-254,743	Physicians' Private Offices	192		43
44	RENTAL REVENUE	B	-178,500	ADMIN & GENERAL	5.03		44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,195,935				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

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.

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	4	Employee Benefits Department	SELF INSURANCE PREMIUMS	2,605,335	2,639,891	-34,556		1
2	4	Employee Benefits Department	RELATED PARTY SERV	159,846	159,846			2
3	5.03	ADMIN & GENERAL	CONTRACT SERV HSHS	3,201,290	2,440,721	760,569		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			7,476,907	6,750,894	726,013		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:

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	53	Anesthesiology VARIOUS	674,099	674,099						1
2	76.97	CARDIAC REHABILITATI VARIOUS	2,549	2,549						2
3	65	Respiratory Therapy VARIOUS	111,483	111,483						3
4	91	Emergency VARIOUS	692,820	692,820						4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,480,951	1,480,951						200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	53	Anesthesiology VARIOUS							674,099	1
2	76.97	CARDIAC REHABILITATI VARIOUS							2,549	2
3	65	Respiratory Therapy VARIOUS							111,483	3
4	91	Emergency VARIOUS							692,820	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,480,951	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NON-PATIENT TELEPHONES	DATA PRO-CESSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	849,471	849,471					1
2	Cap Rel Costs-Mvble Equip	1,212,426		1,212,426				2
4	Employee Benefits Department	3,724,145	3,098	5,092	3,732,335			4
5.01	ADMITTING	371,662	18,513	1,217	115,593	506,985		5.01
5.02	PATIENT ACCOUNTING	380,682	1,122	4,534	1,572		387,910	5.02
5.03	ADMIN & GENERAL	6,213,358	70,652	253,388	593,400			5.03
6	Maintenance & Repairs	196,723			62,849			6
7	Operation of Plant	1,010,644	204,786	18,190	42,766			7
8	Laundry & Linen Service	108,559	7,401					8
9	Housekeeping	490,644	16,167	1,202	97,158			9
10	Dietary	153,460	43,844	14,640	35,641			10
11	Cafeteria	377,726	14,336		87,727			11
12	Maintenance of Personnel							12
13	Nursing Administration	123,512	2,754	22,136	33,862			13
14	Central Services & Supply							14
15	Pharmacy	551,597	9,140	11,592	133,493			15
16	Medical Records & Library	93,670	14,934	7,216	33,052			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	1,689,368	96,095	35,176	578,615	25,539	19,542	30
43	Nursery	95,062	4,274		29,702	1,422	1,088	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,198,226	71,458	234,105	362,296	34,264	26,218	50
52	Delivery Room & Labor Room	550,022	20,727		172,575	5,139	3,932	52
53	Anesthesiology	113,537	2,826	37,145		25,265	19,332	53
54	Radiology-Diagnostic	1,337,862	30,741	209,717	297,956	69,684	53,320	54
57	CT Scan	287,512	2,588	222,013	31,547	83,550	63,912	57
58	MRI	174,702	7,673		32,195	36,406	27,857	58
60	Laboratory	1,934,190	24,020	11,551	242,619	71,038	54,356	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	442,710	10,437	20,786	121,343	19,053	14,578	65
66	Physical Therapy	388,031	24,083	3,534	118,652	14,512	11,104	66
71	Medical Supplies Charged to Patients	441,048	12,277	8,291		18,987	14,528	71
72	Impl. Dev. Charged to Patients	701,706				8,075	6,179	72
73	Drugs Charged to Patients	666,970				27,868	21,324	73
76.97	CARDIAC REHABILITATION	110,313	6,197	17,279	36,001	8,245	6,308	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	850,808	11,515	2,813	20,646	2,844	2,176	90
91	Emergency	1,019,883	39,255	66,496	338,710	55,094	42,156	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,860,229	770,913	1,208,113	3,619,970	506,985	387,910	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	35,908	4,560	370				190
192	Physicians' Private Offices	291,847	73,998	3,943	64,722			192
194	OTHER NONALLOWABLE	334,415			47,643			194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	28,522,399	849,471	1,212,426	3,732,335	506,985	387,910	202

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

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	7,130,798	7,130,798					5.03
6	Maintenance & Repairs	259,572	86,527	346,099				6
7	Operation of Plant	1,276,386	425,478	93,741	1,795,605			7
8	Laundry & Linen Service	115,960	38,655	3,388	24,106	182,109		8
9	Housekeeping	605,171	201,731	7,401	52,657		866,960	9
10	Dietary	247,585	82,531	20,070	142,802	263		10
11	Cafeteria	479,789	159,936	6,562	46,694			11
12	Maintenance of Personnel							12
13	Nursing Administration	182,264	60,757	1,260	8,969		4,069	13
14	Central Services & Supply							14
15	Pharmacy	705,822	235,283	4,184	29,769			15
16	Medical Records & Library	148,872	49,626	6,836	48,639			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	2,444,335	814,802	43,987	312,982	81,593	145,193	30
43	Nursery	131,548	43,851	1,956	13,920	5,131	5,525	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,926,567	642,213	32,710	232,741	24,889	112,985	50
52	Delivery Room & Labor Room	752,395	250,808	9,488	67,510	9,188	63,302	52
53	Anesthesiology	198,105	66,038	1,294	9,206		6,896	53
54	Radiology-Diagnostic	1,999,280	666,452	14,072	100,126	9,947	64,844	54
57	CT Scan	691,122	230,383	1,185	8,431	6,230	5,953	57
58	MRI	278,833	92,948	3,512	24,992	2,660		58
60	Laboratory	2,337,774	779,288	10,995	78,234	3,635	46,256	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	628,907	209,644	4,777	33,992	2,585	23,000	65
66	Physical Therapy	559,916	186,646	11,024	78,440	6,586	11,821	66
71	Medical Supplies Charged to Patients	495,131	165,050	5,620	39,987		6,938	71
72	Impl. Dev. Charged to Patients	715,960	238,662					72
73	Drugs Charged to Patients	716,162	238,730				7,238	73
76.97	CARDIAC REHABILITATION	184,343	61,450	2,837	20,183		19,059	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	890,802	296,945	5,271	37,504	5,948	18,374	90
91	Emergency	1,561,594	520,551	17,969	127,854	23,454	124,335	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,664,993	6,844,985	310,139	1,539,738	182,109	665,788	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	40,838	13,613	2,087	14,853		3,940	190
192	Physicians' Private Offices	434,510	144,842	33,873	241,014		197,232	192
194	OTHER NONALLOWABLE	382,058	127,358					194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	28,522,399	7,130,798	346,099	1,795,605	182,109	866,960	202

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	493,251						10
11	Cafeteria		692,981					11
12	Maintenance of Personnel							12
13	Nursing Administration		3,697	261,016				13
14	Central Services & Supply							14
15	Pharmacy				975,058			15
16	Medical Records & Library		22,748			276,721		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	493,251	176,030	129,526		64,166	4,705,865	30
43	Nursery		6,162	3,930		3,294	215,317	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		82,932	53,061		40,179	3,148,277	50
52	Delivery Room & Labor Room		38,000	24,297		19,139	1,234,127	52
53	Anesthesiology						281,539	53
54	Radiology-Diagnostic		80,313			33,043	2,968,077	54
57	CT Scan		4,776			3,499	951,579	57
58	MRI		5,957			3,570	412,472	58
60	Laboratory		75,743			26,907	3,358,832	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		31,529			13,457	947,891	65
66	Physical Therapy		20,797			13,159	888,389	66
71	Medical Supplies Charged to Patients						712,726	71
72	Impl. Dev. Charged to Patients						954,622	72
73	Drugs Charged to Patients		18,281		975,058		1,955,469	73
76.97	CARDIAC REHABILITATION		12,016			3,993	303,881	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		29,681	2,144		2,290	1,288,959	90
91	Emergency		78,516	48,058		37,563	2,539,894	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	493,251	687,178	261,016	975,058	264,259	26,867,916	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						75,331	190
192	Physicians' Private Offices					7,178	1,058,649	192
194	OTHER NONALLOWABLE		5,803			5,284	520,503	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	493,251	692,981	261,016	975,058	276,721	28,522,399	202

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		4,705,865					30
43	Nursery		215,317					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		3,148,277					50
52	Delivery Room & Labor Room		1,234,127					52
53	Anesthesiology		281,539					53
54	Radiology-Diagnostic		2,968,077					54
57	CT Scan		951,579					57
58	MRI		412,472					58
60	Laboratory		3,358,832					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		947,891					65
66	Physical Therapy		888,389					66
71	Medical Supplies Charged to Patients		712,726					71
72	Impl. Dev. Charged to Patients		954,622					72
73	Drugs Charged to Patients		1,955,469					73
76.97	CARDIAC REHABILITATION		303,881					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		1,288,959					90
91	Emergency		2,539,894					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		26,867,916					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		75,331					190
192	Physicians' Private Offices		1,058,649					192
194	OTHER NONALLOWABLE		520,503					194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		28,522,399					202

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		3,098	5,092	8,190	8,190		4
5.01	ADMITTING		18,513	1,217	19,730	254	19,984	5.01
5.02	PATIENT ACCOUNTING		1,122	4,534	5,656	3		5.02
5.03	ADMIN & GENERAL	1,060	70,652	253,388	325,100	1,299		5.03
6	Maintenance & Repairs					138		6
7	Operation of Plant	3,027	204,786	18,190	226,003	94		7
8	Laundry & Linen Service		7,401		7,401			8
9	Housekeeping		16,167	1,202	17,369	213		9
10	Dietary		43,844	14,640	58,484	78		10
11	Cafeteria		14,336		14,336	193		11
12	Maintenance of Personnel							12
13	Nursing Administration		2,754	22,136	24,890	74		13
14	Central Services & Supply							14
15	Pharmacy	92,922	9,140	11,592	113,654	293		15
16	Medical Records & Library		14,934	7,216	22,150	73		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	35	96,095	35,176	131,306	1,270	1,005	30
43	Nursery		4,274		4,274	65	56	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	238	71,458	234,105	305,801	795	1,349	50
52	Delivery Room & Labor Room		20,727		20,727	379	202	52
53	Anesthesiology	1,285	2,826	37,145	41,256		994	53
54	Radiology-Diagnostic		30,741	209,717	240,458	654	2,743	54
57	CT Scan		2,588	222,013	224,601	69	3,317	57
58	MRI		7,673		7,673	71	1,433	58
60	Laboratory	66,884	24,020	11,551	102,455	533	2,796	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,024	10,437	20,786	44,247	266	750	65
66	Physical Therapy		24,083	3,534	27,617	261	571	66
71	Medical Supplies Charged to Patients	5,409	12,277	8,291	25,977		747	71
72	Impl. Dev. Charged to Patients						318	72
73	Drugs Charged to Patients						1,097	73
76.97	CARDIAC REHABILITATION		6,197	17,279	23,476	79	325	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		11,515	2,813	14,328	45	112	90
91	Emergency		39,255	66,496	105,751	744	2,169	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	183,884	770,913	1,208,113	2,162,910	7,943	19,984	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	120	4,560	370	5,050			190
192	Physicians' Private Offices		73,998	3,943	77,941	142		192
194	OTHER NONALLOWABLE	6,600			6,600	105		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	190,604	849,471	1,212,426	2,252,501	8,190	19,984	202

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	5,659						5.02
5.03	ADMIN & GENERAL		326,399					5.03
6	Maintenance & Repairs		3,961	4,099				6
7	Operation of Plant		19,475	1,108	246,680			7
8	Laundry & Linen Service		1,769	40	3,312	12,522		8
9	Housekeeping		9,234	88	7,234		34,138	9
10	Dietary		3,778	238	19,618	18		10
11	Cafeteria		7,321	78	6,415			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,781	15	1,232		160	13
14	Central Services & Supply							14
15	Pharmacy		10,769	50	4,090			15
16	Medical Records & Library		2,271	81	6,682			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	287	37,301	521	42,999	5,610	5,717	30
43	Nursery	16	2,007	23	1,912	353	218	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	384	29,396	387	31,974	1,711	4,449	50
52	Delivery Room & Labor Room	58	11,480	112	9,274	632	2,493	52
53	Anesthesiology	283	3,023	15	1,265		272	53
54	Radiology-Diagnostic	782	30,505	167	13,755	684	2,553	54
57	CT Scan	908	10,545	14	1,158	428	234	57
58	MRI	408	4,254	42	3,433	183		58
60	Laboratory	797	35,670	130	10,748	250	1,821	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	214	9,596	57	4,670	178	906	65
66	Physical Therapy	163	8,543	131	10,776	453	465	66
71	Medical Supplies Charged to Patients	213	7,555	67	5,493		273	71
72	Impl. Dev. Charged to Patients	91	10,924					72
73	Drugs Charged to Patients	313	10,927				285	73
76.97	CARDIAC REHABILITATION	92	2,813	34	2,773		750	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	32	13,592	62	5,152	409	724	90
91	Emergency	618	23,827	213	17,565	1,613	4,896	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,659	313,317	3,673	211,530	12,522	26,216	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		623	25	2,040		155	190
192	Physicians' Private Offices		6,630	401	33,110		7,767	192
194	OTHER NONALLOWABLE		5,829					194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,659	326,399	4,099	246,680	12,522	34,138	202

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	82,214						10
11	Cafeteria		28,343					11
12	Maintenance of Personnel							12
13	Nursing Administration		151	29,303				13
14	Central Services & Supply							14
15	Pharmacy				128,856			15
16	Medical Records & Library		930			32,187		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	82,214	7,200	14,541		7,465	337,436	30
43	Nursery		252	441		383	10,000	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		3,392	5,957		4,673	390,268	50
52	Delivery Room & Labor Room		1,554	2,728		2,226	51,865	52
53	Anesthesiology						47,108	53
54	Radiology-Diagnostic		3,285			3,843	299,429	54
57	CT Scan		195			407	241,876	57
58	MRI		244			415	18,156	58
60	Laboratory		3,098			3,130	161,428	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,290			1,565	63,739	65
66	Physical Therapy		851			1,531	51,362	66
71	Medical Supplies Charged to Patients						40,325	71
72	Impl. Dev. Charged to Patients						11,333	72
73	Drugs Charged to Patients		748		128,856		142,226	73
76.97	CARDIAC REHABILITATION		491			464	31,297	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		1,214	241		266	36,177	90
91	Emergency		3,211	5,395		4,369	170,371	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	82,214	28,106	29,303	128,856	30,737	2,104,396	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						7,893	190
192	Physicians' Private Offices					835	126,826	192
194	OTHER NONALLOWABLE		237			615	13,386	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	82,214	28,343	29,303	128,856	32,187	2,252,501	202

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		337,436					30
43	Nursery		10,000					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		390,268					50
52	Delivery Room & Labor Room		51,865					52
53	Anesthesiology		47,108					53
54	Radiology-Diagnostic		299,429					54
57	CT Scan		241,876					57
58	MRI		18,156					58
60	Laboratory		161,428					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		63,739					65
66	Physical Therapy		51,362					66
71	Medical Supplies Charged to Patients		40,325					71
72	Impl. Dev. Charged to Patients		11,333					72
73	Drugs Charged to Patients		142,226					73
76.97	CARDIAC REHABILITATION		31,297					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		36,177					90
91	Emergency		170,371					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,104,396					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		7,893					190
192	Physicians' Private Offices		126,826					192
194	OTHER NONALLOWABLE		13,386					194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,252,501					202

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	174,916						1
2	Cap Rel Costs-Mvble Equip		1,206,104					2
4	Employee Benefits Department	638	5,065	10,532,783				4
5.01	ADMITTING	3,812	1,211	326,209	96,404,713			5.01
5.02	PATIENT ACCOUNTING	231	4,510	4,436		96,404,713		5.02
5.03	ADMIN & GENERAL	14,548	252,067	1,674,590			-7,130,798	5.03
6	Maintenance & Repairs			177,362				6
7	Operation of Plant	42,168	18,095	120,686				7
8	Laundry & Linen Service	1,524						8
9	Housekeeping	3,329	1,196	274,183				9
10	Dietary	9,028	14,564	100,581				10
11	Cafeteria	2,952		247,569				11
12	Maintenance of Personnel							12
13	Nursing Administration	567	22,021	95,561				13
14	Central Services & Supply							14
15	Pharmacy	1,882	11,532	376,723				15
16	Medical Records & Library	3,075	7,178	93,275				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,787	34,993	1,632,872	4,856,312	4,856,312		30
43	Nursery	880		83,821	270,328	270,328		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,714	232,884	1,022,412	6,515,296	6,515,296		50
52	Delivery Room & Labor Room	4,268		487,013	977,164	977,164		52
53	Anesthesiology	582	36,951		4,804,226	4,804,226		53
54	Radiology-Diagnostic	6,330	208,623	840,843	13,250,426	13,250,426		54
57	CT Scan	533	220,855	89,027	15,888,488	15,888,488		57
58	MRI	1,580		90,855	6,922,658	6,922,658		58
60	Laboratory	4,946	11,491	684,680	13,507,906	13,507,906		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,149	20,678	342,434	3,622,853	3,622,853		65
66	Physical Therapy	4,959	3,516	334,839	2,759,407	2,759,407		66
71	Medical Supplies Charged to Patients	2,528	8,248		3,610,313	3,610,313		71
72	Impl. Dev. Charged to Patients				1,535,544	1,535,544		72
73	Drugs Charged to Patients				5,299,124	5,299,124		73
76.97	CARDIAC REHABILITATION	1,276	17,189	101,597	1,567,708	1,567,708		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,371	2,798	58,265	540,785	540,785		90
91	Emergency	8,083	66,149	955,853	10,476,175	10,476,175		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	158,740	1,201,814	10,215,686	96,404,713	96,404,713	-7,130,798	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	939	368					190
192	Physicians' Private Offices	15,237	3,922	182,647				192
194	OTHER NONALLOWABLE			134,450				194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	849,471	1,212,426	3,732,335	506,985	387,910		202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.856451	1.005242	0.354354	0.005259	0.004024		203
204	Cost to be allocated (Per Wkst. B, Part II)			8,190	19,984	5,659		204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000778	0.000207	0.000059		205

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	21,391,601						5.03
6	Maintenance & Repairs	259,572	155,687					6
7	Operation of Plant	1,276,386	42,168	113,519				7
8	Laundry & Linen Service	115,960	1,524	1,524	174,694			8
9	Housekeeping	605,171	3,329	3,329		20,242		9
10	Dietary	247,585	9,028	9,028	252		37,743	10
11	Cafeteria	479,789	2,952	2,952				11
12	Maintenance of Personnel							12
13	Nursing Administration	182,264	567	567		95		13
14	Central Services & Supply							14
15	Pharmacy	705,822	1,882	1,882				15
16	Medical Records & Library	148,872	3,075	3,075				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	2,444,335	19,787	19,787	78,270	3,390	37,743	30
43	Nursery	131,548	880	880	4,922	129		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,926,567	14,714	14,714	23,876	2,638		50
52	Delivery Room & Labor Room	752,395	4,268	4,268	8,814	1,478		52
53	Anesthesiology	198,105	582	582		161		53
54	Radiology-Diagnostic	1,999,280	6,330	6,330	9,542	1,514		54
57	CT Scan	691,122	533	533	5,976	139		57
58	MRI	278,833	1,580	1,580	2,552			58
60	Laboratory	2,337,774	4,946	4,946	3,487	1,080		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	628,907	2,149	2,149	2,480	537		65
66	Physical Therapy	559,916	4,959	4,959	6,318	276		66
71	Medical Supplies Charged to Patients	495,131	2,528	2,528		162		71
72	Impl. Dev. Charged to Patients	715,960						72
73	Drugs Charged to Patients	716,162				169		73
76.97	CARDIAC REHABILITATION	184,343	1,276	1,276		445		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	890,802	2,371	2,371	5,706	429		90
91	Emergency	1,561,594	8,083	8,083	22,499	2,903		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,534,195	139,511	97,343	174,694	15,545	37,743	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	40,838	939	939		92		190
192	Physicians' Private Offices	434,510	15,237	15,237		4,605		192
194	OTHER NONALLOWABLE	382,058						194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	7,130,798	346,099	1,795,605	182,109	866,960	493,251	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.333346	2.223044	15.817660	1.042446	42.829760	13.068675	203
204	Cost to be allocated (Per Wkst. B, Part II)	326,399	4,099	246,680	12,522	34,138	82,214	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.015258	0.026328	2.173028	0.071680	1.686493	2.178258	205

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	13,495						11
12	Maintenance of Personnel							12
13	Nursing Administration	72	1,461					13
14	Central Services & Supply							14
15	Pharmacy			100				15
16	Medical Records & Library	443			7,041,608			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	3,428	725		1,632,872			30
43	Nursery	120	22		83,821			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,615	297		1,022,412			50
52	Delivery Room & Labor Room	740	136		487,013			52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,564			840,843			54
57	CT Scan	93			89,027			57
58	MRI	116			90,855			58
60	Laboratory	1,475			684,680			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	614			342,434			65
66	Physical Therapy	405			334,839			66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	356		100				73
76.97	CARDIAC REHABILITATION	234			101,597			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	578	12		58,265			90
91	Emergency	1,529	269		955,853			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	13,382	1,461	100	6,724,511			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices				182,647			192
194	OTHER NONALLOWABLE	113			134,450			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	692,981	261,016	975,058	276,721			202
203	Unit Cost Multiplier (Wkst. B, Part I)	51.350945	178.655715	9,750.580000	0.039298			203
204	Cost to be allocated (Per Wkst. B, Part II)	28,343	29,303	128,856	32,187			204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.100259	20.056810	1,288.560000	0.004571			205

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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 Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,705,865		4,705,865			30
43	Nursery	215,317		215,317			43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,148,277		3,148,277			50
52	Delivery Room & Labor Room	1,234,127		1,234,127			52
53	Anesthesiology	281,539		281,539			53
54	Radiology-Diagnostic	2,968,077		2,968,077			54
57	CT Scan	951,579		951,579			57
58	MRI	412,472		412,472			58
60	Laboratory	3,358,832		3,358,832			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	947,891		947,891			65
66	Physical Therapy	888,389		888,389			66
71	Medical Supplies Charged to Patients	712,726		712,726			71
72	Impl. Dev. Charged to Patients	954,622		954,622			72
73	Drugs Charged to Patients	1,955,469		1,955,469			73
76.97	CARDIAC REHABILITATION	303,881		303,881			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,288,959		1,288,959			90
91	Emergency	2,539,894		2,539,894			91
92	Observation Beds (Non-Distinct Part)	840,783		840,783			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	27,708,699		27,708,699			200
201	Less Observation Beds	840,783		840,783			201
202	Total (line 200 minus line 201)	26,867,916		26,867,916			202

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	4,051,581		4,051,581				30
43	Nursery	270,328		270,328				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	682,375	5,832,921	6,515,296	0.483213			50
52	Delivery Room & Labor Room	575,834	401,330	977,164	1.262968			52
53	Anesthesiology	638,799	4,165,427	4,804,226	0.058602			53
54	Radiology-Diagnostic	976,217	12,274,209	13,250,426	0.223999			54
57	CT Scan	1,355,527	14,532,961	15,888,488	0.059891			57
58	MRI	272,289	6,650,369	6,922,658	0.059583			58
60	Laboratory	3,133,507	10,374,399	13,507,906	0.248657			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,243,087	2,379,766	3,622,853	0.261642			65
66	Physical Therapy	384,394	2,375,013	2,759,407	0.321949			66
71	Medical Supplies Charged to Patients	1,780,822	1,829,491	3,610,313	0.197414			71
72	Impl. Dev. Charged to Patients	1,188,726	346,818	1,535,544	0.621683			72
73	Drugs Charged to Patients	1,471,152	3,827,972	5,299,124	0.369017			73
76.97	CARDIAC REHABILITATION	143,921	1,423,787	1,567,708	0.193838			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		540,785	540,785	2.383496			90
91	Emergency	972,224	9,503,951	10,476,175	0.242445			91
92	Observation Beds (Non-Distinct Part)	136,528	668,203	804,731	1.044800			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	19,277,311	77,127,402	96,404,713				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	19,277,311	77,127,402	96,404,713				202

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/IID**

			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	0.483213		1,836,266			887,308		50
52	Delivery Room & Labor Room	1.262968							52
53	Anesthesiology	0.058602		1,059,161			62,069		53
54	Radiology-Diagnostic	0.223999		5,191,124			1,162,807		54
57	CT Scan	0.059891		5,738,112			343,661		57
58	MRI	0.059583		1,989,493			118,540		58
60	Laboratory	0.248657		4,101,870			1,019,959		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.261642		556,302			145,552		65
66	Physical Therapy	0.321949		659,405			212,295		66
71	Medical Supplies Charged to Pat	0.197414		657,316			129,763		71
72	Impl. Dev. Charged to Patients	0.621683		55,676			34,613		72
73	Drugs Charged to Patients	0.369017		1,873,898	88		691,500	32	73
76.97	CARDIAC REHABILITATION	0.193838		218,735			42,399		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.383496		149,649			356,688		90
91	Emergency	0.242445		3,333,498			808,190		91
92	Observation Beds (Non-Distinct	1.044800		319,356			333,663		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			27,739,861	88		6,349,007	32	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			27,739,861	88		6,349,007	32	202

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z350** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			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	0.483213							50
52	Delivery Room & Labor Room	1.262968							52
53	Anesthesiology	0.058602							53
54	Radiology-Diagnostic	0.223999							54
57	CT Scan	0.059891							57
58	MRI	0.059583							58
60	Laboratory	0.248657							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.261642							65
66	Physical Therapy	0.321949							66
71	Medical Supplies Charged to Pat	0.197414							71
72	Impl. Dev. Charged to Patients	0.621683							72
73	Drugs Charged to Patients	0.369017							73
76.97	CARDIAC REHABILITATION	0.193838							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.383496							90
91	Emergency	0.242445							91
92	Observation Beds (Non-Distinct	1.044800							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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	337,436	15,357	322,079	5,369	59.99	895	53,691	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	10,000		10,000	404	24.75	258	6,386	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	347,436		332,079	5,773		1,153	60,077	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	390,268	6,515,296	0.059900			50
52	Delivery Room & Labor Room	51,865	977,164	0.053077			52
53	Anesthesiology	47,108	4,804,226	0.009806			53
54	Radiology-Diagnostic	299,429	13,250,426	0.022598			54
57	CT Scan	241,876	15,888,488	0.015223			57
58	MRI	18,156	6,922,658	0.002623			58
60	Laboratory	161,428	13,507,906	0.011951			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	63,739	3,622,853	0.017594			65
66	Physical Therapy	51,362	2,759,407	0.018613			66
71	Medical Supplies Charged to Pat	40,325	3,610,313	0.011169			71
72	Impl. Dev. Charged to Patients	11,333	1,535,544	0.007380			72
73	Drugs Charged to Patients	142,226	5,299,124	0.026840			73
76.97	CARDIAC REHABILITATION	31,297	1,567,708	0.019964			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	36,177	540,785	0.066897			90
91	Emergency	170,371	10,476,175	0.016263			91
92	Observation Beds (Non-Distinct	63,163	804,731	0.078490			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,820,123	92,082,804				200

(A) Worksheet A line numbers

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

Check Applicable Boxes: **[ ] Title V** **[ ] PPS** **[ ] Title XVIII, Part A** **[ ] TEFRA** **[XX] Title XIX** **[XX] Other**

		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 SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	5,369		895		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	404		258		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	5,773		1,153		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1350** **WORKSHEET D PART IV**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient 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 Pat							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							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1350** **WORKSHEET D PART IV**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

		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	6,515,296							50
52	Delivery Room & Labor Room	977,164							52
53	Anesthesiology	4,804,226							53
54	Radiology-Diagnostic	13,250,426							54
57	CT Scan	15,888,488							57
58	MRI	6,922,658							58
60	Laboratory	13,507,906							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	3,622,853							65
66	Physical Therapy	2,759,407							66
71	Medical Supplies Charged to Pat	3,610,313							71
72	Impl. Dev. Charged to Patients	1,535,544							72
73	Drugs Charged to Patients	5,299,124							73
76.97	CARDIAC REHABILITATION	1,567,708							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	540,785							90
91	Emergency	10,476,175							91
92	Observation Beds (Non-Distinct	804,731							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	92,082,804							200

(A) Worksheet A line numbers

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/IID

			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	0.483213							50
52	Delivery Room & Labor Room	1.262968							52
53	Anesthesiology	0.058602							53
54	Radiology-Diagnostic	0.223999							54
57	CT Scan	0.059891							57
58	MRI	0.059583							58
60	Laboratory	0.248657							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.261642							65
66	Physical Therapy	0.321949							66
71	Medical Supplies Charged to Pat	0.197414							71
72	Impl. Dev. Charged to Patients	0.621683							72
73	Drugs Charged to Patients	0.369017							73
76.97	CARDIAC REHABILITATION	0.193838							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.383496							90
91	Emergency	0.242445							91
92	Observation Beds (Non-Distinct	1.044800							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

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/IID [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] 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)	5,625	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,369	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)	4,364	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	128	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)	128	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,930	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)	109	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)	108	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	4,705,865	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)	214,170	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,491,695	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,491,695	37

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)	836.60	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,451,238	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)	2,451,238	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 (Wkst. D-3, col. 3, line 200)	2,095,986	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	4,547,224	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (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 etner 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)	91,189	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	90,353	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	181,542	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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,005	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					836.60	88
89	Observation bed cost (line 87 x line 88) (see instructions)					840,783	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	337,436	4,491,695	0.075124	840,783	63,163	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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/IID	[ ] 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)	5,625	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,369	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)	4,364	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	128	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)	128	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	895	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	404	15
16	Nursery days (title V or XIX only)	258	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)	4,705,865	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)	214,170	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,491,695	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,491,695	37

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

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Hospital** **[ ] SUB (Other)** **[ ] PPS**
[ ] Title XVIII, Part A **[ ] IPF** **[ ] TEFRA**
[XX] Title XIX - I/P **[ ] IRF** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					836.60	38
39	Program general inpatient routine service cost (line 9 x line 38)					748,757	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)					748,757	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)	215,317	404	532.96	258	137,504	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 (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					886,261	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					60,077	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					60,077	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 etner 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

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** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,005	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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/IID** **[ ] 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		2,452,670		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.483213	646,896	312,589	50
52	Delivery Room & Labor Room	1.262968			52
53	Anesthesiology	0.058602			53
54	Radiology-Diagnostic	0.223999	685,694	153,595	54
57	CT Scan	0.059891	508,877	30,477	57
58	MRI	0.059583	188,997	11,261	58
60	Laboratory	0.248657	1,501,500	373,358	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.261642	337,647	88,343	65
66	Physical Therapy	0.321949	223,073	71,818	66
71	Medical Supplies Charged to Patients	0.197414	862,459	170,261	71
72	Impl. Dev. Charged to Patients	0.621683	643,808	400,244	72
73	Drugs Charged to Patients	0.369017	1,272,551	469,593	73
76.97	CARDIAC REHABILITATION	0.193838			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.383496			90
91	Emergency	0.242445	59,590	14,447	91
92	Observation Beds (Non-Distinct Part)	1.044800			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		6,931,092	2,095,986	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,931,092		202

(A) Worksheet A line numbers

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/IID [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				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.483213			50
52	Delivery Room & Labor Room	1.262968			52
53	Anesthesiology	0.058602			53
54	Radiology-Diagnostic	0.223999	6,898	1,545	54
57	CT Scan	0.059891	5,056	303	57
58	MRI	0.059583			58
60	Laboratory	0.248657	53,435	13,287	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.261642	34,688	9,076	65
66	Physical Therapy	0.321949	81,179	26,135	66
71	Medical Supplies Charged to Patients	0.197414	6,917	1,366	71
72	Impl. Dev. Charged to Patients	0.621683			72
73	Drugs Charged to Patients	0.369017	47,635	17,578	73
76.97	CARDIAC REHABILITATION	0.193838			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.383496			90
91	Emergency	0.242445			91
92	Observation Beds (Non-Distinct Part)	1.044800			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		235,808	69,290	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		235,808		202

(A) Worksheet A line numbers

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/IID**	**[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	0.483213			50
52	Delivery Room & Labor Room	1.262968			52
53	Anesthesiology	0.058602			53
54	Radiology-Diagnostic	0.223999			54
57	CT Scan	0.059891			57
58	MRI	0.059583			58
60	Laboratory	0.248657			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.261642			65
66	Physical Therapy	0.321949			66
71	Medical Supplies Charged to Patients	0.197414			71
72	Impl. Dev. Charged to Patients	0.621683			72
73	Drugs Charged to Patients	0.369017			73
76.97	CARDIAC REHABILITATION	0.193838			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.383496			90
91	Emergency	0.242445			91
92	Observation Beds (Non-Distinct Part)	1.044800			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

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/IID [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	0.483213			50
52	Delivery Room & Labor Room	1.262968			52
53	Anesthesiology	0.058602			53
54	Radiology-Diagnostic	0.223999			54
57	CT Scan	0.059891			57
58	MRI	0.059583			58
60	Laboratory	0.248657			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.261642			65
66	Physical Therapy	0.321949			66
71	Medical Supplies Charged to Patients	0.197414			71
72	Impl. Dev. Charged to Patients	0.621683			72
73	Drugs Charged to Patients	0.369017			73
76.97	CARDIAC REHABILITATION	0.193838			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.383496			90
91	Emergency	0.242445			91
92	Observation Beds (Non-Distinct Part)	1.044800			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

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)	6,349,039			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	6,349,039			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable 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)	6,412,529			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	44,382			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,786,458			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,581,689			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)	1,581,689			30
31	Primary payer payments	253			31
32	Subtotal (line 30 minus line 31)	1,581,436			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)	713,813			34
35	Adjusted reimbursable bad debts (see instructions)	542,498			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	498,127			36
37	Subtotal (see instructions)	2,123,934			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,123,934			40
40.01	Sequestration adjustment (see instructions)	42,479			40.01
41	Interim payments	2,848,414			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-766,959			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] 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				3,955,637		3,127,581	1
2	Interim payments payable on individual bills, eitehr 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	06/25/2015	32,810			3.01
	amount based on subsequent revision of the interim		.02	02/20/2015	2,862			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			06/25/2015	101,250	3.50
			.51			02/20/2015	177,917	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		35,672		-279,167	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)				3,991,309		2,848,414	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-94,628		-766,959	6.02
7	Total Medicare program liability (see instructions)				3,896,681		2,081,455	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.

				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				274,906			1
2	Interim payments payable on individual bills, eitehr 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	06/25/2015	9,739			3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		9,739			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)				284,645			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-42,561			6.02
7	Total Medicare program liability (see instructions)				242,084			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.

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 (Wkst. S-3, Pt. I, col. 15, line 14)	1,368	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,930	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	256	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	4,364	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	96,404,713	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,770,120	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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

Check Applicable Boxes:
[ ] Title V **[XX] Swing Bed - SNF**
[XX] Title XVIII **[ ] Swing Bed - NF**
[ ] Title XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	183,357		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, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	69,983		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	217		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 through 3 plus lines 6 and 7)	253,340		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	253,340		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	253,340		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,315		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)	247,025		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
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)	247,025		19
19.01	Sequestration adjustment (see instructions)	4,941		19.01
20	Interim payments	284,645		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-42,561		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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

1	Inpatient services	4,547,224	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	4,547,224	4
5	Primary payer payments	8,196	5
6	Total cost (see instructions)	4,584,500	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 physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	4,584,500	19
20	Deductibles (exclude professional component)	652,161	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	3,932,339	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	3,932,339	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	57,718	25
26	Adjusted reimbursable bad debts (see instructions)	43,866	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,118	27
28	Subtotal (sum of lines 24 and 26)	3,976,205	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	3,976,205	30
30.01	Sequestration adjustment (see instructions)	79,524	30.01
31	Interim payments	3,991,309	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-94,628	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	886,261		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	886,261		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	886,261		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 cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	886,261		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	886,261		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)	886,261		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)	886,261		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	886,261		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	886,261		40
41	Interim payments	886,261		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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	4,431,351				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	22,630,548				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-17,735,140				6
7	Inventory	377,727				7
8	Prepaid expenses	235,300				8
9	Other current assets	1,364,818				9
10	Due from other funds	-2,131,708				10
11	Total current assets (sum of lines 1-10)	9,172,896				11
	FIXED ASSETS					
12	Land	99,383				12
13	Land improvements	1,824,801				13
14	Accumulated depreciation	-1,180,148				14
15	Buildings	11,785,761				15
16	Accumulated depreciation	-5,302,149				16
17	Leasehold improvements	23,087,690				17
18	Accumulated depreciation	-15,599,337				18
19	Fixed equipment	15,713,964				19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	20,197,647				23
24	Accumulated depreciation	-15,595,940				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)	35,031,672				30
	OTHER ASSETS					
31	Investments	24,281,212				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	55,113				34
35	Total other assets (sum of lines 31-34)	24,336,325				35
36	Total assets (sum of lines 11, 30 and 35)	68,540,893				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	1,122,630				37
38	Salaries, wages and fees payable	1,617,949				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	3,927,008				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,273,497				44
45	Total current liabilities (sum of lines 37 thru 44)	7,941,084				45
	LONG TERM LIABILITIES					
46	Mortgage payable	8,680,164				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	8,581,466				49
50	Total long term liabilities (sum of lines 46 thru 49)	17,261,630				50
51	Total liabilities (sum of lines 45 and 50)	25,202,714				51
	CAPITAL ACCOUNTS					
52	General fund balance	43,338,179				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

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	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	43,338,179				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	68,540,893				60

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		37,125,332			1
2	Net income (loss) (from Worksheet G-3, line 29)		6,884,343			2
3	Total (sum of line 1 and line 2)		44,009,675			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		44,009,675			11
12	Deductions (debit adjustments) (specify)	671,496				12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		671,496			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		43,338,179			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

ST. FRANCIS HOSPITAL Provider CCN: 14-1350	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/23/2015 Run Time: 17:56 Version: 2015.10 (11/17/2015)

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	6,719,049		6,719,049	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)	6,719,049		6,719,049	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)	6,719,049		6,719,049	17
18	Ancillary services	12,281,114	79,080,968	91,362,082	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	19,000,163	79,080,968	98,081,131	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		32,718,334	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)		32,718,334	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	98,081,131	1
2	Less contractual allowances and discounts on patients' accounts	59,687,837	2
3	Net patient revenues (line 1 minus line 2)	38,393,294	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	32,718,334	4
5	Net income from service to patients (line 3 minus line 4)	5,674,960	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 otehr 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, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	294,736	22
23	Governmental appropriations		23
24	Other (MISC)	914,647	24
25	Total other income (sum of lines 6-24)	1,209,383	25
26	Total (line 5 plus line 25)	6,884,343	26
29	Net income (or loss) for the period (line 26 minus line 28)	6,884,343	29

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 SERVICE 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							
90	Clinic							90
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 Centers							201
202	TOTAL (sum of lines 118-201)							202