SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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: Time: 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 SAINT ANTHONY HOSPITAL (14-0095) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		474,449	-89,038	-43,965		1
2	SUBPROVIDER - IPF		38,896				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		513,345	-89,038	-43,965		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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 2875 W. 19TH STREET	P.O. Box:			1
2	City: CHICAGO	State: IL	ZIP Code: 60623	County: COOK	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	SAINT ANTHONY HOSPITAL	14-0095	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	SAINT ANTHONY HOSPITAL	14-S095	16974	4	07 / 01 / 1984	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017	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.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		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.	2,338				6,886	1,872	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.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
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	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete 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

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete 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.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N			71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	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.			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.					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.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	383,245			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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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)	N		140

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

141	Name:	Contractor's Name:	Contractor's Number:		141
142	Street:	P.O. Box:			142
143	City:	State:	ZIP Code:		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on 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	N	N	156
157	Subprovider - IRF	N	N	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 transition factor. (see instructions)	0.25			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			01 / 01 / 2016	12 / 31 / 2016 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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)			N	0 171

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for 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	10/22/0147	Y	11/02/2017	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.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: RAJ	Last name: SHAH	Title: MANAGER	41
42	Employer: STRATEGIC REIMBURSEMENT GROUP LLC			42
43	Phone number: 630-530-7100 EXT 107	E-mail Address: RAJ.SHAH@SRGROUPLLC.COM		43

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	94	34,310			2,805	2,994	13,327	1
2	HMO and other (see instructions)							6,886		2
3	HMO IPF Subprovider							2,989		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)		94	34,310			2,805	2,994	13,327	7
8	Intensive Care Unit	31	15	5,475			760	749	2,909	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						169	2,891	13
14	Total (see instructions)		109	39,785			3,565	3,912	19,127	14
15	CAH Visits									15
16	Subprovider - IPF	40	42	15,330			2,205	1,143	10,554	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)		151							27
28	Observation Bed Days							252	2,036	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							298	430	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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)					663	977	4,235	1
2	HMO and other (see instructions)						1,798		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	3.98	679.17			663	977	4,235	14
15	CAH Visits								15
16	Subprovider - IPF		47.48			193	120	1,109	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	3.98	726.65						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	56,272,775		56,272,775	1,603,744.00	35.09	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		2,110,571		2,110,571	12,863.00	164.08	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		7,275,279		7,275,279	62,386.00	116.62	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21	1,987,658		1,987,658	18,495.00	107.47	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		4,333,314		4,333,314	153,681.00	28.20	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		396,285		396,285	4,822.00	82.18	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		9,126,041		9,126,041			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		1,032,356		1,032,356			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		119,908		119,908			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		554,376		554,376			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		152,342		152,342			25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		783,222		783,222	19,904.00	39.35	26
27	Administrative & General		10,189,392		10,189,392	280,253.00	36.36	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs		382,690		382,690	12,096.00	31.64	29
30	Operation of Plant		1,235,836		1,235,836	52,888.00	23.37	30
31	Laundry & Linen Service							31
32	Housekeeping		802,942		802,942	56,935.00	14.10	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		936,912	-537,973	398,939	25,202.00	15.83	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			537,973	537,973	33,985.00	15.83	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,069,583		1,069,583	41,216.00	25.95	38
39	Central Services and Supply		244,734		244,734	13,308.00	18.39	39
40	Pharmacy		1,357,697		1,357,697	32,503.00	41.77	40
41	Medical Records & Medical Records Library		687,609		687,609	26,504.00	25.94	41
42	Social Service		760,692		760,692	22,908.00	33.21	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	47,009,838		47,009,838	1,522,863.00	30.87	1
2	Excluded area salaries (see instructions)	4,333,314		4,333,314	153,681.00	28.20	2
3	Subtotal salarles (line 1 minus line 2)	42,676,524		42,676,524	1,369,182.00	31.17	3
4	Subtotal other wages & related costs (see instructions)	396,285		396,285	4,822.00	82.18	4
5	Subtotal wage-related costs (see instructions)	9,245,949		9,245,949		21.67%	5
6	Total (sum of lines 3 through 5)	52,318,758		52,318,758	1,374,004.00	38.08	6
7	Total overhead cost (see instructions)	18,451,309		18,451,309	617,702.00	29.87	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	880,215	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	4,832,736	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	193,012	10
11	Life Insurance (If employee is owner or beneficiary)	72,707	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	125,639	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	786,148	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	3,845,063	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	70,000	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	179,504	23
24	Total Wage Related cost (Sum of lines 1-23)	10,985,024	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL 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)	0.284875	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	48,205,194	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	158,067,251	6
7	Medicaid cost (line 1 times line 6)	45,029,408	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

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

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

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

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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	14,212,428		14,212,428	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,048,765		4,048,765	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	4,048,765		4,048,765	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	16,261,660	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	520,961	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	801,478	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	15,460,182	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	4,684,736	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	8,733,501	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,733,501	31

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		3,035,827	3,035,827		3,035,827	378,006	3,413,833	1
2	00200	Cap Rel Costs-Mvble Equip								2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	783,222	6,833,817	7,617,039		7,617,039	-1,443	7,615,596	4
5	00500	Administrative & General	10,189,392	21,006,225	31,195,617		31,195,617	-9,723,970	21,471,647	5
6	00600	Maintenance & Repairs	382,690	1,731,484	2,114,174		2,114,174		2,114,174	6
7	00700	Operation of Plant	1,235,836	1,557,155	2,792,991		2,792,991	-18,700	2,774,291	7
8	00800	Laundry & Linen Service				427,909	427,909		427,909	8
9	00900	Housekeeping	802,942	956,876	1,759,818	-427,909	1,331,909		1,331,909	9
10	01000	Dietary	936,912	1,499,938	2,436,850	-1,399,235	1,037,615	-92,237	945,378	10
11	01100	Cafeteria				1,399,235	1,399,235	-694,814	704,421	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,069,583	184,688	1,254,271		1,254,271	-3,500	1,250,771	13
14	01400	Central Services & Supply	244,734	147,150	391,884		391,884		391,884	14
15	01500	Pharmacy	1,357,697	4,747,648	6,105,345	-4,877,833	1,227,512	-110,700	1,116,812	15
16	01600	Medical Records & Library	687,609	791,027	1,478,636		1,478,636	-432	1,478,204	16
17	01700	Social Service	760,692	81,105	841,797		841,797	-3,053	838,744	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	1,987,658		1,987,658		1,987,658	-1,644,728	342,930	21
22	02200	I&R Services-Other Prgm Costs Apprvd		1,094,510	1,094,510		1,094,510	-73,710	1,020,800	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	5,457,782	847,864	6,305,646		6,305,646	-585,137	5,720,509	30
31	03100	Intensive Care Unit	1,683,447	397,492	2,080,939		2,080,939	-17,655	2,063,284	31
40	04000	Subprovider - IPF	2,881,570	304,880	3,186,450		3,186,450	-2,044	3,184,406	40
43	04300	Nursery	1,399,678	250,343	1,650,021		1,650,021	-669,304	980,717	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,423,349	3,203,437	4,626,786	-2,874,710	1,752,076	-3,690	1,748,386	50
51	05100	Recovery Room	316,821	38,719	355,540		355,540		355,540	51
52	05200	Delivery Room & Labor Room	4,380,886	857,022	5,237,908		5,237,908	-2,444,763	2,793,145	52
53	05300	Anesthesiology	1,511,260	535,944	2,047,204		2,047,204	-1,418,357	628,847	53
54	05400	Radiology-Diagnostic	1,907,073	665,871	2,572,944	-84,791	2,488,153	-4,495	2,483,658	54
57	05700	CT Scan	388,725	144,844	533,569		533,569		533,569	57
58	05800	MRI	150,207	23,303	173,510		173,510		173,510	58
60	06000	Laboratory	1,430,895	1,629,139	3,060,034		3,060,034	-5,647	3,054,387	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.	69,365	474,425	543,790		543,790		543,790	63
65	06500	Respiratory Therapy	700,914	237,705	938,619	-175,119	763,500		763,500	65
66	06600	Physical Therapy	962,508	187,173	1,149,681	-55,719	1,093,962	-4,257	1,089,705	66
69	06900	Electrocardiology	387,455	177,972	565,427		565,427	-192,702	372,725	69
70	07000	Electroencephalography	47,105	8,231	55,336		55,336		55,336	70
71	07100	Medical Supplies Charged to Patients				2,352,905	2,352,905		2,352,905	71
72	07200	Impl. Dev. Charged to Patients				1,353,136	1,353,136		1,353,136	72
73	07300	Drugs Charged to Patients				4,877,833	4,877,833		4,877,833	73
75	07500	ASC (Non-Distinct Part)	441,433	54,237	495,670		495,670		495,670	75
76	03951	HEMODIALYSIS		334,415	334,415		334,415		334,415	76
76.01	03952	DIABETES CENTER	4,509	390	4,899		4,899		4,899	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	1,445,726	609,871	2,055,597		2,055,597	-104,776	1,950,821	90
90.01	09001	CHEMOTHERAPY	515,295	182,037	697,332		697,332	-98,104	599,228	90.01
90.02	09002	KEDZIE CLINIC	1,160,666	387,478	1,548,144	-24,796	1,523,348	-536,532	986,816	90.02
90.03	09003	LITTLE VILLAGE CLINIC	491,474	675,591	1,167,065		1,167,065		1,167,065	90.03
91	09100	Emergency	5,223,921	1,397,206	6,621,127	-490,906	6,130,221	-2,039,448	4,090,773	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	54,821,031	57,293,039	112,114,070		112,114,070	-20,116,192	91,997,878	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	42,821	52,763	95,584		95,584		95,584	190
192	19200	Physicians' Private Offices	865,799	370,311	1,236,110		1,236,110		1,236,110	192
192.01	19201	OTHER NON-REIMBURSABLE	85,233	15,567	100,800		100,800		100,800	192.01
192.02	19202	NEPHROLOGY	457,891	754,819	1,212,710		1,212,710		1,212,710	192.02
194	07950	OTHER NONREIMBURSABLE COST CENTERS								194
200		TOTAL (sum of lines 118-199)	56,272,775	58,486,499	114,759,274		114,759,274	-20,116,192	94,643,082	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	LAUNDARY	A	Laundry & Linen Service	8		427,909	1
500	Total reclassifications					427,909	500
	Code Letter - A						
1	CAFETERIA RECLASS	B	Cafeteria	11	537,973	861,262	1
500	Total reclassifications				537,973	861,262	500
	Code Letter - B						
1	COST OF MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		2,352,905	1
2			Impl. Dev. Charged to Patient	72		1,353,136	2
3							3
4							4
5							5
6							6
500	Total reclassifications					3,706,041	500
	Code Letter - C						
1	COST OF DRUGS SOLD	D	Drugs Charged to Patients	73		4,877,833	1
500	Total reclassifications					4,877,833	500
	Code Letter - D						
	GRAND TOTAL (Increases)				537,973	9,873,045	

(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.

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	LAUNDARY	A	Housekeeping	9		427,909		1
500	Total reclassifications					427,909		500
	Code letter - A							
1	CAFETERIA RECLASS	B	Dietary	10	537,973	861,262		1
500	Total reclassifications				537,973	861,262		500
	Code letter - B							
1	COST OF MEDICAL SUPPLIES	C	Operating Room	50		2,874,710		1
2			Radiology-Diagnostic	54		84,791		2
3			Respiratory Therapy	65		175,119		3
4			Physical Therapy	66		55,719		4
5			KEDZIE CLINIC	90.02		24,796		5
6			Emergency	91		490,906		6
500	Total reclassifications					3,706,041		500
	Code letter - C							
1	COST OF DRUGS SOLD	D	Pharmacy	15		4,877,833		1
500	Total reclassifications					4,877,833		500
	Code letter - D							
	GRAND TOTAL (Decreases)				537,973	9,873,045		

(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	472,850					472,850		1
2	Land Improvements	500,937	17,852		17,852		518,789		2
3	Buildings and Fixtures	31,144,492	207,898		207,898		31,352,390		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	38,648,508	1,428,619		1,428,619		40,077,127		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	70,766,787	1,654,369		1,654,369		72,421,156		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	70,766,787	1,654,369		1,654,369		72,421,156		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	3,035,827						3,035,827	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	3,035,827						3,035,827	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	31,871,179		31,871,179	0.442973					1
2	Cap Rel Costs-Mvble Equ	40,077,127		40,077,127	0.557027					2
3	Total (sum of lines 1-2)	71,948,306		71,948,306	1.000000					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	3,413,833						3,413,833	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	3,413,833						3,413,833	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)	B	-9,603	Administrative & General	5		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	-9,447,020				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-694,814	Cafeteria	11		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	-432	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35	OTHER REVENUE	A	-1,443	Employee Benefits Department	4		35
36	OTHER REVENUE	B	-444,592	Administrative & General	5		36
36.01	OTHER REVENUE	B	-18,700	Operation of Plant	7		36.01
36.02	OTHER REVENUE	B	-92,237	Dietary	10		36.02
36.03	OTHER REVENUE	B	-3,500	Nursing Administration	13		36.03
36.04	OTHER REVENUE	B	-110,700	Pharmacy	15		36.04
36.05	OTHER REVENUE	B	-17,220	Adults & Pediatrics	30		36.05
36.06	OTHER REVENUE	B	-2,044	Subprovider - IPF	40		36.06
36.08	OTHER REVENUE	B	-180	Operating Room	50		36.08
36.09	OTHER REVENUE	B	-4,495	Radiology-Diagnostic	54		36.09
36.10	OTHER REVENUE	B	-5,647	Laboratory	60		36.10
36.11	OTHER REVENUE	B	-192,702	Electrocardiology	69		36.11
36.12	OTHER REVENUE	B	-21,890	Clinic	90		36.12
36.13	OTHER REVENUE	B	-31,304	CHEMOTHERAPY	90.01		36.13
37							37
38							38
39	MILLENIUM BLDG NON ALLOW COST	A	-124,052	Cap Rel Costs-Bldg & Fixt	1	9	39
40	AMORTIZATION OF IMPAIRMENT LOSS	A	502,058	Cap Rel Costs-Bldg & Fixt	1	9	40
41	SPONSORSHIP	A	-145,668	Administrative & General	5		41
42	MEDICAID ASSESSMENT TAX	A	-8,118,180	Administrative & General	5		42
43	MID WIFERY PROGRAM	A	-1,119,544	Delivery Room & Labor Room	52		43
44							44
45	IHA MCHC DUE NON ALLOWABLE	A	-12,283	Administrative & General	5		45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-20,116,192				50

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

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

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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

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

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	5	Administrative & Gen AGGREGATE	2,608,432		2,608,432	211,500	15,897	1,616,450	80,823	1
2	21	I&R Services-Salary AGGREGATE	1,644,728	1,644,728						2
3	30	Adults & Pediatrics AGGREGATE	564,956	564,956						3
4	40	Subprovider - IPF AGGREGATE								4
5	43	Nursery AGGREGATE	669,304	669,304						5
6	50	Operating Room AGGREGATE	3,510	3,510						6
7	52	Delivery Room & Labo AGGREGATE	1,325,219	1,325,219						7
8	53	Anesthesiology AGGREGATE	1,418,357	1,418,357						8
9	90	Clinic AGGREGATE	71,258	71,258						9
10	90.01	CHEMOTHERAPY AGGREGATE	66,800	66,800						10
11	90.02	KEDZIE CLINIC AGGREGATE	536,532	536,532						11
12	91	Emergency AGGREGATE	2,039,448	2,039,448						12
13										13
14										14
15										15
16										16
17	5	Administrative & Gen AGGREGATE	10,000		10,000	211,500	82	8,338	417	17
18	17	Social Service AGGREGATE	18,000		18,000	211,500	147	14,947	747	18
19	22	I&R Services-Other P AGGREGATE	437,226		437,226	211,500	3,575	363,516	18,176	19
20	30	Adults & Pediatrics AGGREGATE	17,400		17,400	211,500	142	14,439	722	20
21	31	Intensive Care Unit AGGREGATE	105,000		105,000	211,500	859	87,345	4,367	21
22	60	Laboratory AGGREGATE	6,000		6,000	260,300	49	6,132	307	22
23	66	Physical Therapy AGGREGATE	25,000		25,000	211,500	204	20,743	1,037	23
24	90	Clinic AGGREGATE	68,875		68,875	211,500	563	57,247	2,862	24
200		TOTAL	11,636,045	8,340,112	3,295,933		21,518	2,189,157	109,458	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	5	Administrative & Gen AGGREGATE					1,616,450	991,982	991,982	1
2	21	I&R Services-Salary AGGREGATE							1,644,728	2
3	30	Adults & Pediatrics AGGREGATE							564,956	3
4	40	Subprovider - IPF AGGREGATE								4
5	43	Nursery AGGREGATE							669,304	5
6	50	Operating Room AGGREGATE							3,510	6
7	52	Delivery Room & Labo AGGREGATE							1,325,219	7
8	53	Anesthesiology AGGREGATE							1,418,357	8
9	90	Clinic AGGREGATE							71,258	9
10	90.01	CHEMOTHERAPY AGGREGATE							66,800	10
11	90.02	KEDZIE CLINIC AGGREGATE							536,532	11
12	91	Emergency AGGREGATE							2,039,448	12
13										13
14										14
15										15
16										16
17	5	Administrative & Gen AGGREGATE					8,338	1,662	1,662	17
18	17	Social Service AGGREGATE					14,947	3,053	3,053	18
19	22	I&R Services-Other P AGGREGATE					363,516	73,710	73,710	19
20	30	Adults & Pediatrics AGGREGATE					14,439	2,961	2,961	20
21	31	Intensive Care Unit AGGREGATE					87,345	17,655	17,655	21
22	60	Laboratory AGGREGATE					6,132			22
23	66	Physical Therapy AGGREGATE					20,743	4,257	4,257	23
24	90	Clinic AGGREGATE					57,247	11,628	11,628	24
200		TOTAL					2,189,157	1,106,908	9,447,020	200

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	
		0	1	4	4A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,413,833	3,413,833					1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	7,615,596	13,426	7,629,022				4
5	Administrative & General	21,471,647	421,136	1,400,884	23,293,667	23,293,667		5
6	Maintenance & Repairs	2,114,174	127,571	52,615	2,294,360	749,047	3,043,407	6
7	Operation of Plant	2,774,291	420,934	169,910	3,365,135	1,098,626	449,232	7
8	Laundry & Linen Service	427,909	59,515		487,424	159,131	63,516	8
9	Housekeeping	1,331,909	30,642	110,393	1,472,944	480,876	32,702	9
10	Dietary	945,378	61,772	54,849	1,061,999	346,714	65,925	10
11	Cafeteria	704,421	85,541	73,964	863,926	282,049	91,292	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,250,771	59,751	147,053	1,457,575	475,859	63,768	13
14	Central Services & Supply	391,884	88,102	33,647	513,633	167,687	94,024	14
15	Pharmacy	1,116,812	48,717	186,664	1,352,193	441,455	51,992	15
16	Medical Records & Library	1,478,204	62,244	94,537	1,634,985	533,778	66,428	16
17	Social Service	838,744	16,812	104,585	960,141	313,460	17,942	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	342,930		273,275	616,205	201,174		21
22	I&R Services-Other Prgm Costs Apprvd	1,020,800			1,020,800	333,264		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,720,509	709,952	750,369	7,180,830	2,344,357	757,680	30
31	Intensive Care Unit	2,063,284	96,592	231,450	2,391,326	780,703	103,085	31
40	Subprovider - IPF	3,184,406	212,371	396,176	3,792,953	1,238,297	226,647	40
43	Nursery	980,717	21,360	192,436	1,194,513	389,976	22,796	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,748,386	97,670	195,691	2,041,747	666,575	104,236	50
51	Recovery Room	355,540		43,558	399,098	130,295		51
52	Delivery Room & Labor Room	2,793,145	65,411	602,310	3,460,866	1,129,879	69,808	52
53	Anesthesiology	628,847	12,600	207,777	849,224	277,249	13,447	53
54	Radiology-Diagnostic	2,483,658	181,072	262,196	2,926,926	955,562	193,244	54
57	CT Scan	533,569		53,444	587,013	191,644		57
58	MRI	173,510		20,651	194,161	63,388		58
60	Laboratory	3,054,387	120,091	196,728	3,371,206	1,100,608	128,164	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	543,790		9,537	553,327	180,646		63
65	Respiratory Therapy	763,500	22,118	96,366	881,984	287,944	23,605	65
66	Physical Therapy	1,089,705	29,109	132,331	1,251,145	408,465	31,066	66
69	Electrocardiology	372,725	16,879	53,270	442,874	144,586	18,014	69
70	Electroencephalography	55,336	10,663	6,476	72,475	23,661	11,380	70
71	Medical Supplies Charged to Patients	2,352,905			2,352,905	768,160		71
72	Impl. Dev. Charged to Patients	1,353,136			1,353,136	441,762		72
73	Drugs Charged to Patients	4,877,833			4,877,833	1,592,481		73
75	ASC (Non-Distinct Part)	495,670		60,691	556,361	181,637		75
76	HEMODIALYSIS	334,415			334,415	109,177		76
76.01	DIABETES CENTER	4,899		620	5,519	1,802		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,950,821	101,780	198,767	2,251,368	735,011	108,622	90
90.01	CHEMOTHERAPY	599,228		70,846	670,074	218,761		90.01
90.02	KEDZIE CLINIC	986,816		159,575	1,146,391	374,266		90.02
90.03	LITTLE VILLAGE CLINIC	1,167,065		67,571	1,234,636	403,075		90.03
91	Emergency	4,090,773	62,581	718,216	4,871,570	1,590,436	66,788	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	91,997,878	3,256,412	7,429,428	91,640,863	22,313,523	2,875,403	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	95,584	2,527	5,887	103,998	33,953	2,697	190
192	Physicians' Private Offices	1,236,110	154,894	119,035	1,510,039	492,987	165,307	192
192.01	OTHER NON-REIMBURSABLE	100,800		11,718	112,518	36,734		192.01
192.02	NEPHROLOGY	1,212,710		62,954	1,275,664	416,470		192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	94,643,082	3,413,833	7,629,022	94,643,082	23,293,667	3,043,407	202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	4,912,993						7
8	Laundry & Linen Service	120,290	830,361					8
9	Housekeeping	61,932		2,048,454				9
10	Dietary	124,852		54,062	1,653,552			10
11	Cafeteria	172,893		74,864		1,485,024		11
12	Maintenance of Personnel							12
13	Nursing Administration	120,767		52,293		63,273	2,233,535	13
14	Central Services & Supply	178,069		77,105		20,431		14
15	Pharmacy	98,466		42,636		49,897		15
16	Medical Records & Library	125,806		54,475		40,671		16
17	Social Service	33,979		14,713		35,148		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					7,917		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,434,934	372,838	621,336	835,706	221,104	518,676	30
31	Intensive Care Unit	195,229	81,383	84,535	176,715	71,158	166,925	31
40	Subprovider - IPF	429,237	295,261	185,863	641,131	151,573	355,568	40
43	Nursery	43,172	80,879	18,694		27,390	64,254	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	197,408		85,479		58,452	137,120	50
51	Recovery Room					11,556	27,109	51
52	Delivery Room & Labor Room	132,207		57,246		121,948	286,072	52
53	Anesthesiology	25,468		11,028		1,085	2,546	53
54	Radiology-Diagnostic	365,977		158,470		89,610		54
57	CT Scan					15,228		57
58	MRI					4,310		58
60	Laboratory	242,725		105,101		78,947		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					575		63
65	Respiratory Therapy	44,704		19,357		33,264		65
66	Physical Therapy	58,834		25,476		45,332		66
69	Electrocardiology	34,116		14,772		19,633		69
70	Electroencephalography	21,552		9,332		2,937		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)					17,813	41,788	75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	205,715		89,076		102,379	240,166	90
90.01	CHEMOTHERAPY					26,656	62,531	90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency	126,487		54,770		141,007	330,780	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,594,819	830,361	1,910,683	1,653,552	1,459,294	2,233,535	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,107		2,211		3,192		190
192	Physicians' Private Offices	313,067		135,560				192
192.01	OTHER NON-REIMBURSABLE					22,538		192.01
192.02	NEPHROLOGY							192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,912,993	830,361	2,048,454	1,653,552	1,485,024	2,233,535	202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	1,050,949						14
15	Pharmacy		2,036,639					15
16	Medical Records & Library			2,456,143				16
17	Social Service				1,375,383			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					825,296		21
22	I&R Services-Other Prgm Costs Apprvd						1,354,064	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	63,983	33	208,936	617,557	330,119	541,625	30
31	Intensive Care Unit	28,692	96	78,020	134,800			31
40	Subprovider - IPF	5,407		135,254	489,060			40
43	Nursery	6,880		37,296	133,966			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		105	123,611				50
51	Recovery Room	2,640	33	9,576				51
52	Delivery Room & Labor Room	56,407		76,170				52
53	Anesthesiology	26,886	333	63,819				53
54	Radiology-Diagnostic			164,122				54
57	CT Scan	19,044		153,289				57
58	MRI	590		24,433				58
60	Laboratory	26,955		210,499				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	3,186		25,313				63
65	Respiratory Therapy			69,162				65
66	Physical Therapy			61,405				66
69	Electrocardiology	3,574		47,764				69
70	Electroencephalography	621		10,657				70
71	Medical Supplies Charged to Patients	484,500		52,769				71
72	Impl. Dev. Charged to Patients	278,632		25,206				72
73	Drugs Charged to Patients		2,035,870	405,326				73
75	ASC (Non-Distinct Part)	2,103		5,481				75
76	HEMODIALYSIS			4,954				76
76.01	DIABETES CENTER			92				76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	10,879		29,614		165,059	270,813	90
90.01	CHEMOTHERAPY	13,072		37,219				90.01
90.02	KEDZIE CLINIC			31,976				90.02
90.03	LITTLE VILLAGE CLINIC	1,537		46,332				90.03
91	Emergency		169	317,848		330,118	541,626	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,035,588	2,036,639	2,456,143	1,375,383	825,296	1,354,064	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	4,287						192
192.01	OTHER NON-REIMBURSABLE	13						192.01
192.02	NEPHROLOGY	11,061						192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,050,949	2,036,639	2,456,143	1,375,383	825,296	1,354,064	202

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	16,049,714	-871,744	15,177,970				30
31	Intensive Care Unit	4,292,667		4,292,667				31
40	Subprovider - IPF	7,946,251		7,946,251				40
43	Nursery	2,019,816		2,019,816				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,414,733		3,414,733				50
51	Recovery Room	580,307		580,307				51
52	Delivery Room & Labor Room	5,390,603		5,390,603				52
53	Anesthesiology	1,271,085		1,271,085				53
54	Radiology-Diagnostic	4,853,911		4,853,911				54
57	CT Scan	966,218		966,218				57
58	MRI	286,882		286,882				58
60	Laboratory	5,264,205		5,264,205				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	763,047		763,047				63
65	Respiratory Therapy	1,360,020		1,360,020				65
66	Physical Therapy	1,881,723		1,881,723				66
69	Electrocardiology	725,333		725,333				69
70	Electroencephalography	152,615		152,615				70
71	Medical Supplies Charged to Patients	3,658,334		3,658,334				71
72	Impl. Dev. Charged to Patients	2,098,736		2,098,736				72
73	Drugs Charged to Patients	8,911,510		8,911,510				73
75	ASC (Non-Distinct Part)	805,183		805,183				75
76	HEMODIALYSIS	448,546		448,546				76
76.01	DIABETES CENTER	7,413		7,413				76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,208,702	-435,872	3,772,830				90
90.01	CHEMOTHERAPY	1,028,313		1,028,313				90.01
90.02	KEDZIE CLINIC	1,552,633		1,552,633				90.02
90.03	LITTLE VILLAGE CLINIC	1,685,580		1,685,580				90.03
91	Emergency	8,371,599	-871,744	7,499,855				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	89,995,679	-2,179,360	87,816,319				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	151,158		151,158				190
192	Physicians' Private Offices	2,621,247		2,621,247				192
192.01	OTHER NON-REIMBURSABLE	171,803		171,803				192.01
192.02	NEPHROLOGY	1,703,195		1,703,195				192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	94,643,082	-2,179,360	92,463,722				202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	
		0	1	2A	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		13,426	13,426	13,426			4
5	Administrative & General		421,136	421,136	2,462	423,598		5
6	Maintenance & Repairs		127,571	127,571	93	13,622	141,286	6
7	Operation of Plant		420,934	420,934	299	19,979	20,855	7
8	Laundry & Linen Service		59,515	59,515		2,894	2,949	8
9	Housekeeping		30,642	30,642	194	8,745	1,518	9
10	Dietary		61,772	61,772	97	6,305	3,060	10
11	Cafeteria		85,541	85,541	130	5,129	4,238	11
12	Maintenance of Personnel							12
13	Nursing Administration		59,751	59,751	259	8,654	2,960	13
14	Central Services & Supply		88,102	88,102	59	3,049	4,365	14
15	Pharmacy		48,717	48,717	329	8,028	2,414	15
16	Medical Records & Library		62,244	62,244	166	9,707	3,084	16
17	Social Service		16,812	16,812	184	5,700	833	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				481	3,658		21
22	I&R Services-Other Prgm Costs Apprvd					6,060		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		709,952	709,952	1,321	42,631	35,174	30
31	Intensive Care Unit		96,592	96,592	407	14,197	4,786	31
40	Subprovider - IPF		212,371	212,371	697	22,519	10,522	40
43	Nursery		21,360	21,360	339	7,092	1,058	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		97,670	97,670	344	12,122	4,839	50
51	Recovery Room				77	2,369		51
52	Delivery Room & Labor Room		65,411	65,411	1,060	20,547	3,241	52
53	Anesthesiology		12,600	12,600	366	5,042	624	53
54	Radiology-Diagnostic		181,072	181,072	462	17,377	8,971	54
57	CT Scan				94	3,485		57
58	MRI				36	1,153		58
60	Laboratory		120,091	120,091	346	20,015	5,950	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.				17	3,285		63
65	Respiratory Therapy		22,118	22,118	170	5,236	1,096	65
66	Physical Therapy		29,109	29,109	233	7,428	1,442	66
69	Electrocardiology		16,879	16,879	94	2,629	836	69
70	Electroencephalography		10,663	10,663	11	430	528	70
71	Medical Supplies Charged to Patients					13,969		71
72	Impl. Dev. Charged to Patients					8,034		72
73	Drugs Charged to Patients					28,960		73
75	ASC (Non-Distinct Part)				107	3,303		75
76	HEMODIALYSIS					1,985		76
76.01	DIABETES CENTER				1	33		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		101,780	101,780	350	13,366	5,043	90
90.01	CHEMOTHERAPY				125	3,978		90.01
90.02	KEDZIE CLINIC				281	6,806		90.02
90.03	LITTLE VILLAGE CLINIC				119	7,330		90.03
91	Emergency		62,581	62,581	1,264	28,923	3,101	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,256,412	3,256,412	13,074	405,774	133,487	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,527	2,527	10	617	125	190
192	Physicians' Private Offices		154,894	154,894	210	8,965	7,674	192
192.01	OTHER NON-REIMBURSABLE				21	668		192.01
192.02	NEPHROLOGY				111	7,574		192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,413,833	3,413,833	13,426	423,598	141,286	202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	462,067						7
8	Laundry & Linen Service	11,313	76,671					8
9	Housekeeping	5,825		46,924				9
10	Dietary	11,742		1,238	84,214			10
11	Cafeteria	16,261		1,715		113,014		11
12	Maintenance of Personnel							12
13	Nursing Administration	11,358		1,198		4,815	88,995	13
14	Central Services & Supply	16,747		1,766		1,555		14
15	Pharmacy	9,261		977		3,797		15
16	Medical Records & Library	11,832		1,248		3,095		16
17	Social Service	3,196		337		2,675		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					603		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	134,957	34,426	14,233	42,562	16,825	20,666	30
31	Intensive Care Unit	18,361	7,514	1,936	9,000	5,415	6,651	31
40	Subprovider - IPF	40,370	27,263	4,258	32,652	11,535	14,168	40
43	Nursery	4,060	7,468	428		2,084	2,560	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,566		1,958		4,448	5,464	50
51	Recovery Room					879	1,080	51
52	Delivery Room & Labor Room	12,434		1,311		9,281	11,399	52
53	Anesthesiology	2,395		253		83	101	53
54	Radiology-Diagnostic	34,420		3,630		6,820		54
57	CT Scan					1,159		57
58	MRI					328		58
60	Laboratory	22,828		2,408		6,008		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					44		63
65	Respiratory Therapy	4,204		443		2,532		65
66	Physical Therapy	5,533		584		3,450		66
69	Electrocardiology	3,209		338		1,494		69
70	Electroencephalography	2,027		214		224		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)					1,356	1,665	75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	19,348		2,040		7,791	9,569	90
90.01	CHEMOTHERAPY					2,029	2,492	90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency	11,896		1,255		10,731	13,180	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	432,143	76,671	43,768	84,214	111,056	88,995	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	480		51		243		190
192	Physicians' Private Offices	29,444		3,105				192
192.01	OTHER NON-REIMBURSABLE					1,715		192.01
192.02	NEPHROLOGY							192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	462,067	76,671	46,924	84,214	113,014	88,995	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	115,643						14
15	Pharmacy		73,523					15
16	Medical Records & Library			91,376				16
17	Social Service				29,737			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					4,742		21
22	I&R Services-Other Prgm Costs Apprvd						6,060	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,040	1	7,762	13,353			30
31	Intensive Care Unit	3,157	3	2,898	2,914			31
40	Subprovider - IPF	595		5,024	10,574			40
43	Nursery	757		1,385	2,896			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4	4,592				50
51	Recovery Room	290	1	356				51
52	Delivery Room & Labor Room	6,207		2,830				52
53	Anesthesiology	2,958	12	2,371				53
54	Radiology-Diagnostic			6,097				54
57	CT Scan	2,096		5,694				57
58	MRI	65		908				58
60	Laboratory	2,966		7,820				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	351		940				63
65	Respiratory Therapy			2,569				65
66	Physical Therapy			2,281				66
69	Electrocardiology	393		1,774				69
70	Electroencephalography	68		396				70
71	Medical Supplies Charged to Patients	53,316		1,960				71
72	Impl. Dev. Charged to Patients	30,659		936				72
73	Drugs Charged to Patients		73,496	15,192				73
75	ASC (Non-Distinct Part)	231		204				75
76	HEMODIALYSIS			184				76
76.01	DIABETES CENTER			3				76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,197		1,100				90
90.01	CHEMOTHERAPY	1,438		1,383				90.01
90.02	KEDZIE CLINIC			1,188				90.02
90.03	LITTLE VILLAGE CLINIC	169		1,721				90.03
91	Emergency		6	11,808				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	113,953	73,523	91,376	29,737			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	472						192
192.01	OTHER NON-REIMBURSABLE	1						192.01
192.02	NEPHROLOGY	1,217						192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments					4,742	6,060	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	115,643	73,523	91,376	29,737	4,742	6,060	202

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,080,903		1,080,903				30
31	Intensive Care Unit	173,831		173,831				31
40	Subprovider - IPF	392,548		392,548				40
43	Nursery	51,487		51,487				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	150,007		150,007				50
51	Recovery Room	5,052		5,052				51
52	Delivery Room & Labor Room	133,721		133,721				52
53	Anesthesiology	26,805		26,805				53
54	Radiology-Diagnostic	258,849		258,849				54
57	CT Scan	12,528		12,528				57
58	MRI	2,490		2,490				58
60	Laboratory	188,432		188,432				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	4,637		4,637				63
65	Respiratory Therapy	38,368		38,368				65
66	Physical Therapy	50,060		50,060				66
69	Electrocardiology	27,646		27,646				69
70	Electroencephalography	14,561		14,561				70
71	Medical Supplies Charged to Patients	69,245		69,245				71
72	Impl. Dev. Charged to Patients	39,629		39,629				72
73	Drugs Charged to Patients	117,648		117,648				73
75	ASC (Non-Distinct Part)	6,866		6,866				75
76	HEMODIALYSIS	2,169		2,169				76
76.01	DIABETES CENTER	37		37				76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	161,584		161,584				90
90.01	CHEMOTHERAPY	11,445		11,445				90.01
90.02	KEDZIE CLINIC	8,275		8,275				90.02
90.03	LITTLE VILLAGE CLINIC	9,339		9,339				90.03
91	Emergency	144,745		144,745				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,182,907		3,182,907				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,053		4,053				190
192	Physicians' Private Offices	204,764		204,764				192
192.01	OTHER NON-REIMBURSABLE	2,405		2,405				192.01
192.02	NEPHROLOGY	8,902		8,902				192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments	10,802		10,802				200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,413,833		3,413,833				202

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM. COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		1	4	5A	5	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	202,656						1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	797	55,489,553					4
5	Administrative & General	25,000	10,189,392	-23,293,667	71,349,415			5
6	Maintenance & Repairs	7,573	382,690		2,294,360	169,286		6
7	Operation of Plant	24,988	1,235,836		3,365,135	24,988	144,298	7
8	Laundry & Linen Service	3,533			487,424	3,533	3,533	8
9	Housekeeping	1,819	802,942		1,472,944	1,819	1,819	9
10	Dietary	3,667	398,939		1,061,999	3,667	3,667	10
11	Cafeteria	5,078	537,973		863,926	5,078	5,078	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,547	1,069,583		1,457,575	3,547	3,547	13
14	Central Services & Supply	5,230	244,734		513,633	5,230	5,230	14
15	Pharmacy	2,892	1,357,697		1,352,193	2,892	2,892	15
16	Medical Records & Library	3,695	687,609		1,634,985	3,695	3,695	16
17	Social Service	998	760,692		960,141	998	998	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		1,987,658		616,205			21
22	I&R Services-Other Prgm Costs Apprvd				1,020,800			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,145	5,457,782		7,180,830	42,145	42,145	30
31	Intensive Care Unit	5,734	1,683,447		2,391,326	5,734	5,734	31
40	Subprovider - IPF	12,607	2,881,570		3,792,953	12,607	12,607	40
43	Nursery	1,268	1,399,678		1,194,513	1,268	1,268	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,798	1,423,349		2,041,747	5,798	5,798	50
51	Recovery Room		316,821		399,098			51
52	Delivery Room & Labor Room	3,883	4,380,886		3,460,866	3,883	3,883	52
53	Anesthesiology	748	1,511,260		849,224	748	748	53
54	Radiology-Diagnostic	10,749	1,907,073		2,926,926	10,749	10,749	54
57	CT Scan		388,725		587,013			57
58	MRI		150,207		194,161			58
60	Laboratory	7,129	1,430,895		3,371,206	7,129	7,129	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		69,365		553,327			63
65	Respiratory Therapy	1,313	700,914		881,984	1,313	1,313	65
66	Physical Therapy	1,728	962,508		1,251,145	1,728	1,728	66
69	Electrocardiology	1,002	387,455		442,874	1,002	1,002	69
70	Electroencephalography	633	47,105		72,475	633	633	70
71	Medical Supplies Charged to Patients				2,352,905			71
72	Impl. Dev. Charged to Patients				1,353,136			72
73	Drugs Charged to Patients				4,877,833			73
75	ASC (Non-Distinct Part)		441,433		556,361			75
76	HEMODIALYSIS				334,415			76
76.01	DIABETES CENTER		4,509		5,519			76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	6,042	1,445,726		2,251,368	6,042	6,042	90
90.01	CHEMOTHERAPY		515,295		670,074			90.01
90.02	KEDZIE CLINIC		1,160,666		1,146,391			90.02
90.03	LITTLE VILLAGE CLINIC		491,474		1,234,636			90.03
91	Emergency	3,715	5,223,921		4,871,570	3,715	3,715	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	193,311	54,037,809	-23,293,667	68,347,196	159,941	134,953	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	150	42,821		103,998	150	150	190
192	Physicians' Private Offices	9,195	865,799		1,510,039	9,195	9,195	192
192.01	OTHER NON-REIMBURSABLE		85,233		112,518			192.01
192.02	NEPHROLOGY		457,891		1,275,664			192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,413,833	7,629,022		23,293,667	3,043,407	4,912,993	202
203	Unit Cost Multiplier (Wkst. B, Part I)	16.845457	0.137486		0.326473	17.977901	34.047547	203

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM. COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		1	4	5A	5	6	7	
204	Cost to be allocated (Per Wkst. B, Part II)		13,426		423,598	141,286	462,067	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.000242		0.005937	0.834599	3.202172	205

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA PROD FTE'S	NURSING ADMINIS-TRATION NURS DIRECT FTE	CENTRAL SERVICES * SUPPLY COSTED REQUI	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	29,681						8
9	Housekeeping		138,946					9
10	Dietary		3,667	81,660				10
11	Cafeteria		5,078		46,518			11
12	Maintenance of Personnel							12
13	Nursing Administration		3,547		1,982	29,825		13
14	Central Services & Supply		5,230		640		5,103,785	14
15	Pharmacy		2,892		1,563			15
16	Medical Records & Library		3,695		1,274			16
17	Social Service		998		1,101			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				248			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,327	42,145	41,271	6,926	6,926	310,726	30
31	Intensive Care Unit	2,909	5,734	8,727	2,229	2,229	139,339	31
40	Subprovider - IPF	10,554	12,607	31,662	4,748	4,748	26,256	40
43	Nursery	2,891	1,268		858	858	33,413	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,798		1,831	1,831		50
51	Recovery Room				362	362	12,821	51
52	Delivery Room & Labor Room		3,883		3,820	3,820	273,931	52
53	Anesthesiology		748		34	34	130,568	53
54	Radiology-Diagnostic		10,749		2,807			54
57	CT Scan				477		92,484	57
58	MRI				135		2,865	58
60	Laboratory		7,129		2,473		130,902	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.				18		15,470	63
65	Respiratory Therapy		1,313		1,042			65
66	Physical Therapy		1,728		1,420			66
69	Electrocardiology		1,002		615		17,359	69
70	Electroencephalography		633		92		3,018	70
71	Medical Supplies Charged to Patients						2,352,904	71
72	Impl. Dev. Charged to Patients						1,353,136	72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)				558	558	10,214	75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		6,042		3,207	3,207	52,833	90
90.01	CHEMOTHERAPY				835	835	63,482	90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC						7,465	90.03
91	Emergency		3,715		4,417	4,417		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	29,681	129,601	81,660	45,712	29,825	5,029,186	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		150		100			190
192	Physicians' Private Offices		9,195				20,820	192
192.01	OTHER NON-REIMBURSABLE				706		64	192.01
192.02	NEPHROLOGY						53,715	192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	830,361	2,048,454	1,653,552	1,485,024	2,233,535	1,050,949	202
203	Unit Cost Multiplier (Wkst. B, Part I)	27.976180	14.742807	20.249229	31.923642	74.888013	0.205916	203

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA PROD FTE'S	NURSING ADMINIS-TRATION NURS DIRECT FTE	CENTRAL SERVICES * SUPPLY COSTED REQUI	
		8	9	10	11	13	14	
204	Cost to be allocated (Per Wkst. B, Part II)	76,671	46,924	84,214	113,014	88,995	115,643	204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.583168	0.337714	1.031276	2.429468	2.983906	0.022658	205

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUI	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME		
		15	16	17	21	22		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	4,879,675						15
16	Medical Records & Library		308,262,765					16
17	Social Service			29,681				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				1,000			21
22	I&R Services-Other Prgm Costs Apprvd					1,000		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	78	26,221,924	13,327	400	400		30
31	Intensive Care Unit	231	9,791,665	2,909				31
40	Subprovider - IPF		16,974,590	10,554				40
43	Nursery		4,680,661	2,891				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	252	15,513,410					50
51	Recovery Room	78	1,201,766					51
52	Delivery Room & Labor Room		9,559,535					52
53	Anesthesiology	798	8,009,394					53
54	Radiology-Diagnostic		20,597,699					54
57	CT Scan		19,238,090					57
58	MRI		3,066,333					58
60	Laboratory		26,417,989					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		3,176,828					63
65	Respiratory Therapy		8,680,019					65
66	Physical Therapy		7,706,457					66
69	Electrocardiology		5,994,470					69
70	Electroencephalography		1,337,505					70
71	Medical Supplies Charged to Patients		6,622,651					71
72	Impl. Dev. Charged to Patients		3,163,394					72
73	Drugs Charged to Patients	4,877,833	50,881,331					73
75	ASC (Non-Distinct Part)		687,856					75
76	HEMODIALYSIS		621,741					76
76.01	DIABETES CENTER		11,490					76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		3,716,628		200	200		90
90.01	CHEMOTHERAPY		4,671,043					90.01
90.02	KEDZIE CLINIC		4,013,066					90.02
90.03	LITTLE VILLAGE CLINIC		5,814,713					90.03
91	Emergency	405	39,890,517		400	400		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,879,675	308,262,765	29,681	1,000	1,000		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	OTHER NON-REIMBURSABLE							192.01
192.02	NEPHROLOGY							192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross foot adjustments							200
201	Negative cost centers							201

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUI	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME		
		15	16	17	21	22		
202	Cost to be allocated (Per Wkst. B, Part I)	2,036,639	2,456,143	1,375,383	825,296	1,354,064		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.417372	0.007968	46.338836	825.296000	1,354.064000		203
204	Cost to be allocated (Per Wkst. B, Part II)	73,523	91,376	29,737	4,742	6,060		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.015067	0.000296	1.001887	4.742000	6.060000		205

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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	15,177,970		15,177,970	2,961	15,180,931	30
31	Intensive Care Unit	4,292,667		4,292,667	17,655	4,310,322	31
40	Subprovider - IPF	7,946,251		7,946,251		7,946,251	40
43	Nursery	2,019,816		2,019,816		2,019,816	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,414,733		3,414,733		3,414,733	50
51	Recovery Room	580,307		580,307		580,307	51
52	Delivery Room & Labor Room	5,390,603		5,390,603		5,390,603	52
53	Anesthesiology	1,271,085		1,271,085		1,271,085	53
54	Radiology-Diagnostic	4,853,911		4,853,911		4,853,911	54
57	CT Scan	966,218		966,218		966,218	57
58	MRI	286,882		286,882		286,882	58
60	Laboratory	5,264,205		5,264,205		5,264,205	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	763,047		763,047		763,047	63
65	Respiratory Therapy	1,360,020		1,360,020		1,360,020	65
66	Physical Therapy	1,881,723		1,881,723	4,257	1,885,980	66
69	Electrocardiology	725,333		725,333		725,333	69
70	Electroencephalography	152,615		152,615		152,615	70
71	Medical Supplies Charged to Patients	3,658,334		3,658,334		3,658,334	71
72	Impl. Dev. Charged to Patients	2,098,736		2,098,736		2,098,736	72
73	Drugs Charged to Patients	8,911,510		8,911,510		8,911,510	73
75	ASC (Non-Distinct Part)	805,183		805,183		805,183	75
76	HEMODIALYSIS	448,546		448,546		448,546	76
76.01	DIABETES CENTER	7,413		7,413		7,413	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	3,772,830		3,772,830	11,628	3,784,458	90
90.01	CHEMOTHERAPY	1,028,313		1,028,313		1,028,313	90.01
90.02	KEDZIE CLINIC	1,552,633		1,552,633		1,552,633	90.02
90.03	LITTLE VILLAGE CLINIC	1,685,580		1,685,580		1,685,580	90.03
91	Emergency	7,499,855		7,499,855		7,499,855	91
92	Observation Beds (Non-Distinct Part)	2,011,873		2,011,873		2,011,873	92
	OTHER REIMBURSABLE COST CENTERS						
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	89,828,192		89,828,192	36,501	89,864,693	200
201	Less Observation Beds	2,011,873		2,011,873		2,011,873	201
202	Total (line 200 minus line 201)	87,816,319		87,816,319		87,852,820	202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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	23,139,566		23,139,566				30
31	Intensive Care Unit	9,791,665		9,791,665				31
40	Subprovider - IPF	16,974,590		16,974,590				40
43	Nursery	4,680,661		4,680,661				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,852,043	8,661,367	15,513,410	0.220115	0.220115	0.220115	50
51	Recovery Room	356,674	845,092	1,201,766	0.482879	0.482879	0.482879	51
52	Delivery Room & Labor Room	7,763,448	1,796,087	9,559,535	0.563898	0.563898	0.563898	52
53	Anesthesiology	2,999,166	5,010,228	8,009,394	0.158699	0.158699	0.158699	53
54	Radiology-Diagnostic	3,605,603	16,992,096	20,597,699	0.235653	0.235653	0.235653	54
57	CT Scan	4,788,786	14,449,304	19,238,090	0.050224	0.050224	0.050224	57
58	MRI	542,968	2,523,365	3,066,333	0.093559	0.093559	0.093559	58
60	Laboratory	11,440,425	14,977,564	26,417,989	0.199266	0.199266	0.199266	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	2,524,300	652,528	3,176,828	0.240191	0.240191	0.240191	63
65	Respiratory Therapy	7,945,278	734,741	8,680,019	0.156684	0.156684	0.156684	65
66	Physical Therapy	707,974	6,998,483	7,706,457	0.244175	0.244175	0.244727	66
69	Electrocardiology	2,142,499	3,851,971	5,994,470	0.121000	0.121000	0.121000	69
70	Electroencephalography	165,365	1,172,140	1,337,505	0.114104	0.114104	0.114104	70
71	Medical Supplies Charged to Patients	4,068,680	2,553,971	6,622,651	0.552397	0.552397	0.552397	71
72	Impl. Dev. Charged to Patients	2,123,645	1,039,749	3,163,394	0.663444	0.663444	0.663444	72
73	Drugs Charged to Patients	18,525,027	32,356,304	50,881,331	0.175143	0.175143	0.175143	73
75	ASC (Non-Distinct Part)	6,463	681,393	687,856	1.170569	1.170569	1.170569	75
76	HEMODIALYSIS	555,013	66,728	621,741	0.721435	0.721435	0.721435	76
76.01	DIABETES CENTER		11,490	11,490	0.645170	0.645170	0.645170	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,000	3,715,628	3,716,628	1.015122	1.015122	1.018250	90
90.01	CHEMOTHERAPY	6,907	4,664,136	4,671,043	0.220146	0.220146	0.220146	90.01
90.02	KEDZIE CLINIC	1,000	4,012,066	4,013,066	0.386894	0.386894	0.386894	90.02
90.03	LITTLE VILLAGE CLINIC	1,000	5,813,713	5,814,713	0.289882	0.289882	0.289882	90.03
91	Emergency	6,677,037	33,213,480	39,890,517	0.188011	0.188011	0.188011	91
92	Observation Beds (Non-Distinct Part)	215,013	2,867,345	3,082,358	0.652706	0.652706	0.652706	92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	138,601,796	169,660,969	308,262,765				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	138,601,796	169,660,969	308,262,765				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		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)	1,080,903		1,080,903	15,363	70.36	2,805	197,360	30
31	Intensive Care Unit	173,831		173,831	2,909	59.76	760	45,418	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	392,548		392,548	10,554	37.19	2,205	82,004	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	51,487		51,487	2,891	17.81			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,698,769		1,698,769	31,717		5,770	324,782	200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0095** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	150,007	15,513,410	0.009670	1,148,784	11,109	50
51	Recovery Room	5,052	1,201,766	0.004204	66,634	280	51
52	Delivery Room & Labor Room	133,721	9,559,535	0.013988	12,246	171	52
53	Anesthesiology	26,805	8,009,394	0.003347	414,337	1,387	53
54	Radiology-Diagnostic	258,849	20,597,699	0.012567	967,687	12,161	54
57	CT Scan	12,528	19,238,090	0.000651	948,567	618	57
58	MRI	2,490	3,066,333	0.000812	146,504	119	58
60	Laboratory	188,432	26,417,989	0.007133	2,080,843	14,843	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,637	3,176,828	0.001460	497,126	726	63
65	Respiratory Therapy	38,368	8,680,019	0.004420	2,186,473	9,664	65
66	Physical Therapy	50,060	7,706,457	0.006496	210,809	1,369	66
69	Electrocardiology	27,646	5,994,470	0.004612	678,923	3,131	69
70	Electroencephalography	14,561	1,337,505	0.010887	53,617	584	70
71	Medical Supplies Charged to Pat	69,245	6,622,651	0.010456	1,049,010	10,968	71
72	Impl. Dev. Charged to Patients	39,629	3,163,394	0.012527	456,817	5,723	72
73	Drugs Charged to Patients	117,648	50,881,331	0.002312	3,549,471	8,206	73
75	ASC (Non-Distinct Part)	6,866	687,856	0.009982	430	4	75
76	HEMODIALYSIS	2,169	621,741	0.003489	205,442	717	76
76.01	DIABETES CENTER	37	11,490	0.003220			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	161,584	3,716,628	0.043476	75	3	90
90.01	CHEMOTHERAPY	11,445	4,671,043	0.002450	4,333	11	90.01
90.02	KEDZIE CLINIC	8,275	4,013,066	0.002062	17		90.02
90.03	LITTLE VILLAGE CLINIC	9,339	5,814,713	0.001606	3		90.03
91	Emergency	144,745	39,890,517	0.003629	1,164,295	4,225	91
92	Observation Beds (Non-Distinct	143,247	3,082,358	0.046473	48,321	2,246	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,627,385	253,676,283		15,890,764	88,265	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] PPS** **[ ] TEFRA** **[ ] 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** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] PPS** **[ ] TEFRA** **[ ] 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)	15,363		2,805		30
31	Intensive Care Unit	2,909		760		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	10,554		2,205		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,891				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	31,717		5,770		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0095** | **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	(A)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
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
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
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
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0095** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] 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	15,513,410			1,148,784		791,256		50
51	Recovery Room	1,201,766			66,634		109,256		51
52	Delivery Room & Labor Room	9,559,535			12,246		766		52
53	Anesthesiology	8,009,394			414,337		661,211		53
54	Radiology-Diagnostic	20,597,699			967,687		1,608,478		54
57	CT Scan	19,238,090			948,567		1,909,885		57
58	MRI	3,066,333			146,504		458,625		58
60	Laboratory	26,417,989			2,080,843		1,627,113		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	3,176,828			497,126		59,027		63
65	Respiratory Therapy	8,680,019			2,186,473		178,342		65
66	Physical Therapy	7,706,457			210,809		40,740		66
69	Electrocardiology	5,994,470			678,923		768,186		69
70	Electroencephalography	1,337,505			53,617		264,567		70
71	Medical Supplies Charged to Pat	6,622,651			1,049,010		262,524		71
72	Impl. Dev. Charged to Patients	3,163,394			456,817		55,642		72
73	Drugs Charged to Patients	50,881,331			3,549,471		9,773,614		73
75	ASC (Non-Distinct Part)	687,856			430		95,497		75
76	HEMODIALYSIS	621,741			205,442		33,994		76
76.01	DIABETES CENTER	11,490					621		76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,716,628			75		863,223		90
90.01	CHEMOTHERAPY	4,671,043			4,333		1,669,513		90.01
90.02	KEDZIE CLINIC	4,013,066			17		16,374		90.02
90.03	LITTLE VILLAGE CLINIC	5,814,713			3		122,404		90.03
91	Emergency	39,890,517			1,164,295		1,860,644		91
92	Observation Beds (Non-Distinct	3,082,358			48,321		669,819		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	253,676,283			15,890,764		23,901,321		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0095** **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	0.220115	791,256			174,167			50
51	Recovery Room	0.482879	109,256			52,757			51
52	Delivery Room & Labor Room	0.563898	766			432			52
53	Anesthesiology	0.158699	661,211			104,934			53
54	Radiology-Diagnostic	0.235653	1,608,478			379,043			54
57	CT Scan	0.050224	1,909,885			95,922			57
58	MRI	0.093559	458,625			42,908			58
60	Laboratory	0.199266	1,627,113			324,228			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.240191	59,027			14,178			63
65	Respiratory Therapy	0.156684	178,342			27,943			65
66	Physical Therapy	0.244175	40,740			9,948			66
69	Electrocardiology	0.121000	768,186			92,951			69
70	Electroencephalography	0.114104	264,567			30,188			70
71	Medical Supplies Charged to Pat	0.552397	262,524			145,017			71
72	Impl. Dev. Charged to Patients	0.663444	55,642			36,915			72
73	Drugs Charged to Patients	0.175143	9,773,614		51,802	1,711,780		9,073	73
75	ASC (Non-Distinct Part)	1.170569	95,497			111,786			75
76	HEMODIALYSIS	0.721435	33,994			24,524			76
76.01	DIABETES CENTER	0.645170	621			401			76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.015122	863,223			876,277			90
90.01	CHEMOTHERAPY	0.220146	1,669,513			367,537			90.01
90.02	KEDZIE CLINIC	0.386894	16,374			6,335			90.02
90.03	LITTLE VILLAGE CLINIC	0.289882	122,404			35,483			90.03
91	Emergency	0.188011	1,860,644			349,822			91
92	Observation Beds (Non-Distinct	0.652706	669,819			437,195			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		23,901,321		51,802	5,452,671		9,073	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		23,901,321		51,802	5,452,671		9,073	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S095** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	150,007	15,513,410	0.009670	5,148	50	50
51	Recovery Room	5,052	1,201,766	0.004204	432	2	51
52	Delivery Room & Labor Room	133,721	9,559,535	0.013988			52
53	Anesthesiology	26,805	8,009,394	0.003347	2,260	8	53
54	Radiology-Diagnostic	258,849	20,597,699	0.012567	21,759	273	54
57	CT Scan	12,528	19,238,090	0.000651	48,372	31	57
58	MRI	2,490	3,066,333	0.000812	4,134	3	58
60	Laboratory	188,432	26,417,989	0.007133	270,624	1,930	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,637	3,176,828	0.001460			63
65	Respiratory Therapy	38,368	8,680,019	0.004420	27,398	121	65
66	Physical Therapy	50,060	7,706,457	0.006496	900	6	66
69	Electrocardiology	27,646	5,994,470	0.004612	33,202	153	69
70	Electroencephalography	14,561	1,337,505	0.010887	10,660	116	70
71	Medical Supplies Charged to Pat	69,245	6,622,651	0.010456	2,491	26	71
72	Impl. Dev. Charged to Patients	39,629	3,163,394	0.012527			72
73	Drugs Charged to Patients	117,648	50,881,331	0.002312	302,982	700	73
75	ASC (Non-Distinct Part)	6,866	687,856	0.009982			75
76	HEMODIALYSIS	2,169	621,741	0.003489	23,648	83	76
76.01	DIABETES CENTER	37	11,490	0.003220			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	161,584	3,716,628	0.043476			90
90.01	CHEMOTHERAPY	11,445	4,671,043	0.002450			90.01
90.02	KEDZIE CLINIC	8,275	4,013,066	0.002062			90.02
90.03	LITTLE VILLAGE CLINIC	9,339	5,814,713	0.001606			90.03
91	Emergency	144,745	39,890,517	0.003629	247,125	897	91
92	Observation Beds (Non-Distinct		3,082,358				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,484,138	253,676,283		1,001,135	4,399	200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S095** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] 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
51	Recovery Room							51
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
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
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
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S095** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] 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	15,513,410			5,148				50
51	Recovery Room	1,201,766			432				51
52	Delivery Room & Labor Room	9,559,535							52
53	Anesthesiology	8,009,394			2,260				53
54	Radiology-Diagnostic	20,597,699			21,759				54
57	CT Scan	19,238,090			48,372				57
58	MRI	3,066,333			4,134				58
60	Laboratory	26,417,989			270,624				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	3,176,828							63
65	Respiratory Therapy	8,680,019			27,398				65
66	Physical Therapy	7,706,457			900				66
69	Electrocardiology	5,994,470			33,202				69
70	Electroencephalography	1,337,505			10,660				70
71	Medical Supplies Charged to Pat	6,622,651			2,491				71
72	Impl. Dev. Charged to Patients	3,163,394							72
73	Drugs Charged to Patients	50,881,331			302,982				73
75	ASC (Non-Distinct Part)	687,856							75
76	HEMODIALYSIS	621,741			23,648				76
76.01	DIABETES CENTER	11,490							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,716,628							90
90.01	CHEMOTHERAPY	4,671,043							90.01
90.02	KEDZIE CLINIC	4,013,066							90.02
90.03	LITTLE VILLAGE CLINIC	5,814,713							90.03
91	Emergency	39,890,517			247,125				91
92	Observation Beds (Non-Distinct	3,082,358							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	253,676,283			1,001,135				200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S095** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P [ ] Hospital [ ] SUB (Other) [ ] Swing Bed SNF
[XX] Title XVIII, Part B [XX] IPF [ ] SNF [ ] Swing Bed NF
[ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/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	0.220115							50
51	Recovery Room	0.482879							51
52	Delivery Room & Labor Room	0.563898							52
53	Anesthesiology	0.158699							53
54	Radiology-Diagnostic	0.235653							54
57	CT Scan	0.050224							57
58	MRI	0.093559							58
60	Laboratory	0.199266							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.240191							63
65	Respiratory Therapy	0.156684							65
66	Physical Therapy	0.244175							66
69	Electrocardiology	0.121000							69
70	Electroencephalography	0.114104							70
71	Medical Supplies Charged to Pat	0.552397							71
72	Impl. Dev. Charged to Patients	0.663444							72
73	Drugs Charged to Patients	0.175143							73
75	ASC (Non-Distinct Part)	1.170569							75
76	HEMODIALYSIS	0.721435							76
76.01	DIABETES CENTER	0.645170							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.015122							90
90.01	CHEMOTHERAPY	0.220146							90.01
90.02	KEDZIE CLINIC	0.386894							90.02
90.03	LITTLE VILLAGE CLINIC	0.289882							90.03
91	Emergency	0.188011							91
92	Observation Beds (Non-Distinct	0.652706							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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	150,007	15,513,410	0.009670			50
51	Recovery Room	5,052	1,201,766	0.004204			51
52	Delivery Room & Labor Room	133,721	9,559,535	0.013988			52
53	Anesthesiology	26,805	8,009,394	0.003347			53
54	Radiology-Diagnostic	258,849	20,597,699	0.012567			54
57	CT Scan	12,528	19,238,090	0.000651			57
58	MRI	2,490	3,066,333	0.000812			58
60	Laboratory	188,432	26,417,989	0.007133			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,637	3,176,828	0.001460			63
65	Respiratory Therapy	38,368	8,680,019	0.004420			65
66	Physical Therapy	50,060	7,706,457	0.006496			66
69	Electrocardiology	27,646	5,994,470	0.004612			69
70	Electroencephalography	14,561	1,337,505	0.010887			70
71	Medical Supplies Charged to Pat	69,245	6,622,651	0.010456			71
72	Impl. Dev. Charged to Patients	39,629	3,163,394	0.012527			72
73	Drugs Charged to Patients	117,648	50,881,331	0.002312			73
75	ASC (Non-Distinct Part)	6,866	687,856	0.009982			75
76	HEMODIALYSIS	2,169	621,741	0.003489			76
76.01	DIABETES CENTER	37	11,490	0.003220			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	161,584	3,716,628	0.043476			90
90.01	CHEMOTHERAPY	11,445	4,671,043	0.002450			90.01
90.02	KEDZIE CLINIC	8,275	4,013,066	0.002062			90.02
90.03	LITTLE VILLAGE CLINIC	9,339	5,814,713	0.001606			90.03
91	Emergency	144,745	39,890,517	0.003629			91
92	Observation Beds (Non-Distinct		3,082,358				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,484,138	253,676,283				200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[ ] Hospital** **[ ] IPF** **[XX] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] 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
51	Recovery Room							51
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
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
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
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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:** **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX [ ] Hospital [ ] IPF [XX] IRF [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [XX] PPS [ ] TEFRA [ ] 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	15,513,410							50
51	Recovery Room	1,201,766							51
52	Delivery Room & Labor Room	9,559,535							52
53	Anesthesiology	8,009,394							53
54	Radiology-Diagnostic	20,597,699							54
57	CT Scan	19,238,090							57
58	MRI	3,066,333							58
60	Laboratory	26,417,989							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	3,176,828							63
65	Respiratory Therapy	8,680,019							65
66	Physical Therapy	7,706,457							66
69	Electrocardiology	5,994,470							69
70	Electroencephalography	1,337,505							70
71	Medical Supplies Charged to Pat	6,622,651							71
72	Impl. Dev. Charged to Patients	3,163,394							72
73	Drugs Charged to Patients	50,881,331							73
75	ASC (Non-Distinct Part)	687,856							75
76	HEMODIALYSIS	621,741							76
76.01	DIABETES CENTER	11,490							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,716,628							90
90.01	CHEMOTHERAPY	4,671,043							90.01
90.02	KEDZIE CLINIC	4,013,066							90.02
90.03	LITTLE VILLAGE CLINIC	5,814,713							90.03
91	Emergency	39,890,517							91
92	Observation Beds (Non-Distinct	3,082,358							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	253,676,283							200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.220115							50
51	Recovery Room	0.482879							51
52	Delivery Room & Labor Room	0.563898							52
53	Anesthesiology	0.158699							53
54	Radiology-Diagnostic	0.235653							54
57	CT Scan	0.050224							57
58	MRI	0.093559							58
60	Laboratory	0.199266							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.240191							63
65	Respiratory Therapy	0.156684							65
66	Physical Therapy	0.244175							66
69	Electrocardiology	0.121000							69
70	Electroencephalography	0.114104							70
71	Medical Supplies Charged to Pat	0.552397							71
72	Impl. Dev. Charged to Patients	0.663444							72
73	Drugs Charged to Patients	0.175143							73
75	ASC (Non-Distinct Part)	1.170569							75
76	HEMODIALYSIS	0.721435							76
76.01	DIABETES CENTER	0.645170							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.015122							90
90.01	CHEMOTHERAPY	0.220146							90.01
90.02	KEDZIE CLINIC	0.386894							90.02
90.03	LITTLE VILLAGE CLINIC	0.289882							90.03
91	Emergency	0.188011							91
92	Observation Beds (Non-Distinct	0.652706							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)	1,080,903		1,080,903	15,363	70.36	2,994	210,658	30
31	Intensive Care Unit	173,831		173,831	2,909	59.76	749	44,760	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	392,548		392,548	10,554	37.19	1,143	42,508	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	51,487		51,487	2,891	17.81	169	3,010	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,698,769		1,698,769	31,717		5,055	300,936	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0095** **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	150,007	15,513,410	0.009670	972,040	9,400	50
51	Recovery Room	5,052	1,201,766	0.004204	58,496	246	51
52	Delivery Room & Labor Room	133,721	9,559,535	0.013988	962,956	13,470	52
53	Anesthesiology	26,805	8,009,394	0.003347	446,179	1,493	53
54	Radiology-Diagnostic	258,849	20,597,699	0.012567	569,439	7,156	54
57	CT Scan	12,528	19,238,090	0.000651	801,122	522	57
58	MRI	2,490	3,066,333	0.000812	104,636	85	58
60	Laboratory	188,432	26,417,989	0.007133	1,808,199	12,898	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,637	3,176,828	0.001460	369,992	540	63
65	Respiratory Therapy	38,368	8,680,019	0.004420	1,029,152	4,549	65
66	Physical Therapy	50,060	7,706,457	0.006496	96,206	625	66
69	Electrocardiology	27,646	5,994,470	0.004612	292,393	1,349	69
70	Electroencephalography	14,561	1,337,505	0.010887	15,889	173	70
71	Medical Supplies Charged to Pat	69,245	6,622,651	0.010456	667,819	6,983	71
72	Impl. Dev. Charged to Patients	39,629	3,163,394	0.012527	83,830	1,050	72
73	Drugs Charged to Patients	117,648	50,881,331	0.002312	2,974,083	6,876	73
75	ASC (Non-Distinct Part)	6,866	687,856	0.009982	97	1	75
76	HEMODIALYSIS	2,169	621,741	0.003489	79,812	278	76
76.01	DIABETES CENTER	37	11,490	0.003220			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	161,584	3,716,628	0.043476	546	24	90
90.01	CHEMOTHERAPY	11,445	4,671,043	0.002450	12		90.01
90.02	KEDZIE CLINIC	8,275	4,013,066	0.002062	14		90.02
90.03	LITTLE VILLAGE CLINIC	9,339	5,814,713	0.001606	10		90.03
91	Emergency	144,745	39,890,517	0.003629	908,083	3,295	91
92	Observation Beds (Non-Distinct	143,247	3,082,358	0.046473	37,219	1,730	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,627,385	253,676,283		12,278,224	72,743	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)	15,363		2,994		30
31	Intensive Care Unit	2,909		749		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	10,554		1,143		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,891		169		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	31,717		5,055		200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0095** | **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
51	Recovery Room							51
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
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
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
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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: 14-0095** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [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	15,513,410			972,040				50
51	Recovery Room	1,201,766			58,496				51
52	Delivery Room & Labor Room	9,559,535			962,956				52
53	Anesthesiology	8,009,394			446,179				53
54	Radiology-Diagnostic	20,597,699			569,439				54
57	CT Scan	19,238,090			801,122				57
58	MRI	3,066,333			104,636				58
60	Laboratory	26,417,989			1,808,199				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	3,176,828			369,992				63
65	Respiratory Therapy	8,680,019			1,029,152				65
66	Physical Therapy	7,706,457			96,206				66
69	Electrocardiology	5,994,470			292,393				69
70	Electroencephalography	1,337,505			15,889				70
71	Medical Supplies Charged to Pat	6,622,651			667,819				71
72	Impl. Dev. Charged to Patients	3,163,394			83,830				72
73	Drugs Charged to Patients	50,881,331			2,974,083				73
75	ASC (Non-Distinct Part)	687,856			97				75
76	HEMODIALYSIS	621,741			79,812				76
76.01	DIABETES CENTER	11,490							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,716,628			546				90
90.01	CHEMOTHERAPY	4,671,043			12				90.01
90.02	KEDZIE CLINIC	4,013,066			14				90.02
90.03	LITTLE VILLAGE CLINIC	5,814,713			10				90.03
91	Emergency	39,890,517			908,083				91
92	Observation Beds (Non-Distinct	3,082,358			37,219				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	253,676,283			12,278,224				200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0095** **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 Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.220115							50
51	Recovery Room	0.482879							51
52	Delivery Room & Labor Room	0.563898							52
53	Anesthesiology	0.158699							53
54	Radiology-Diagnostic	0.235653							54
57	CT Scan	0.050224							57
58	MRI	0.093559							58
60	Laboratory	0.199266							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.240191							63
65	Respiratory Therapy	0.156684							65
66	Physical Therapy	0.244175							66
69	Electrocardiology	0.121000							69
70	Electroencephalography	0.114104							70
71	Medical Supplies Charged to Pat	0.552397							71
72	Impl. Dev. Charged to Patients	0.663444							72
73	Drugs Charged to Patients	0.175143							73
75	ASC (Non-Distinct Part)	1.170569							75
76	HEMODIALYSIS	0.721435							76
76.01	DIABETES CENTER	0.645170							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.015122							90
90.01	CHEMOTHERAPY	0.220146							90.01
90.02	KEDZIE CLINIC	0.386894							90.02
90.03	LITTLE VILLAGE CLINIC	0.289882							90.03
91	Emergency	0.188011							91
92	Observation Beds (Non-Distinct	0.652706							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 ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S095** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[ ] Hospital** **[XX] 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	150,007	15,513,410	0.009670	1,139	11	50
51	Recovery Room	5,052	1,201,766	0.004204	432	2	51
52	Delivery Room & Labor Room	133,721	9,559,535	0.013988			52
53	Anesthesiology	26,805	8,009,394	0.003347	1,771	6	53
54	Radiology-Diagnostic	258,849	20,597,699	0.012567	13,532	170	54
57	CT Scan	12,528	19,238,090	0.000651	36,284	24	57
58	MRI	2,490	3,066,333	0.000812			58
60	Laboratory	188,432	26,417,989	0.007133	152,712	1,089	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,637	3,176,828	0.001460			63
65	Respiratory Therapy	38,368	8,680,019	0.004420	35,249	156	65
66	Physical Therapy	50,060	7,706,457	0.006496	3,959	26	66
69	Electrocardiology	27,646	5,994,470	0.004612	12,459	57	69
70	Electroencephalography	14,561	1,337,505	0.010887	2,580	28	70
71	Medical Supplies Charged to Pat	69,245	6,622,651	0.010456	813	9	71
72	Impl. Dev. Charged to Patients	39,629	3,163,394	0.012527			72
73	Drugs Charged to Patients	117,648	50,881,331	0.002312	145,294	336	73
75	ASC (Non-Distinct Part)	6,866	687,856	0.009982			75
76	HEMODIALYSIS	2,169	621,741	0.003489			76
76.01	DIABETES CENTER	37	11,490	0.003220			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	161,584	3,716,628	0.043476			90
90.01	CHEMOTHERAPY	11,445	4,671,043	0.002450			90.01
90.02	KEDZIE CLINIC	8,275	4,013,066	0.002062			90.02
90.03	LITTLE VILLAGE CLINIC	9,339	5,814,713	0.001606			90.03
91	Emergency	144,745	39,890,517	0.003629	140,706	511	91
92	Observation Beds (Non-Distinct		3,082,358				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,484,138	253,676,283		546,930	2,425	200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S095** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [ ] Title XVIII, Part A [XX] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/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
51	Recovery Room							51
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
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
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
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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-S095** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [ ] Hospital [XX] 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	15,513,410			1,139				50
51	Recovery Room	1,201,766			432				51
52	Delivery Room & Labor Room	9,559,535							52
53	Anesthesiology	8,009,394			1,771				53
54	Radiology-Diagnostic	20,597,699			13,532				54
57	CT Scan	19,238,090			36,284				57
58	MRI	3,066,333							58
60	Laboratory	26,417,989			152,712				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	3,176,828							63
65	Respiratory Therapy	8,680,019			35,249				65
66	Physical Therapy	7,706,457			3,959				66
69	Electrocardiology	5,994,470			12,459				69
70	Electroencephalography	1,337,505			2,580				70
71	Medical Supplies Charged to Pat	6,622,651			813				71
72	Impl. Dev. Charged to Patients	3,163,394							72
73	Drugs Charged to Patients	50,881,331			145,294				73
75	ASC (Non-Distinct Part)	687,856							75
76	HEMODIALYSIS	621,741							76
76.01	DIABETES CENTER	11,490							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,716,628							90
90.01	CHEMOTHERAPY	4,671,043							90.01
90.02	KEDZIE CLINIC	4,013,066							90.02
90.03	LITTLE VILLAGE CLINIC	5,814,713							90.03
91	Emergency	39,890,517			140,706				91
92	Observation Beds (Non-Distinct	3,082,358							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	253,676,283			546,930				200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S095** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[XX] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/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	0.220115							50
51	Recovery Room	0.482879							51
52	Delivery Room & Labor Room	0.563898							52
53	Anesthesiology	0.158699							53
54	Radiology-Diagnostic	0.235653							54
57	CT Scan	0.050224							57
58	MRI	0.093559							58
60	Laboratory	0.199266							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.240191							63
65	Respiratory Therapy	0.156684							65
66	Physical Therapy	0.244175							66
69	Electrocardiology	0.121000							69
70	Electroencephalography	0.114104							70
71	Medical Supplies Charged to Pat	0.552397							71
72	Impl. Dev. Charged to Patients	0.663444							72
73	Drugs Charged to Patients	0.175143							73
75	ASC (Non-Distinct Part)	1.170569							75
76	HEMODIALYSIS	0.721435							76
76.01	DIABETES CENTER	0.645170							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.015122							90
90.01	CHEMOTHERAPY	0.220146							90.01
90.02	KEDZIE CLINIC	0.386894							90.02
90.03	LITTLE VILLAGE CLINIC	0.289882							90.03
91	Emergency	0.188011							91
92	Observation Beds (Non-Distinct	0.652706							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 ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN:** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[ ] Hospital** **[ ] IPF** **[XX] 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	150,007	15,513,410	0.009670			50
51	Recovery Room	5,052	1,201,766	0.004204			51
52	Delivery Room & Labor Room	133,721	9,559,535	0.013988			52
53	Anesthesiology	26,805	8,009,394	0.003347			53
54	Radiology-Diagnostic	258,849	20,597,699	0.012567			54
57	CT Scan	12,528	19,238,090	0.000651			57
58	MRI	2,490	3,066,333	0.000812			58
60	Laboratory	188,432	26,417,989	0.007133			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,637	3,176,828	0.001460			63
65	Respiratory Therapy	38,368	8,680,019	0.004420			65
66	Physical Therapy	50,060	7,706,457	0.006496			66
69	Electrocardiology	27,646	5,994,470	0.004612			69
70	Electroencephalography	14,561	1,337,505	0.010887			70
71	Medical Supplies Charged to Pat	69,245	6,622,651	0.010456			71
72	Impl. Dev. Charged to Patients	39,629	3,163,394	0.012527			72
73	Drugs Charged to Patients	117,648	50,881,331	0.002312			73
75	ASC (Non-Distinct Part)	6,866	687,856	0.009982			75
76	HEMODIALYSIS	2,169	621,741	0.003489			76
76.01	DIABETES CENTER	37	11,490	0.003220			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	161,584	3,716,628	0.043476			90
90.01	CHEMOTHERAPY	11,445	4,671,043	0.002450			90.01
90.02	KEDZIE CLINIC	8,275	4,013,066	0.002062			90.02
90.03	LITTLE VILLAGE CLINIC	9,339	5,814,713	0.001606			90.03
91	Emergency	144,745	39,890,517	0.003629			91
92	Observation Beds (Non-Distinct		3,082,358				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,484,138	253,676,283				200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[ ] Hospital** **[ ] IPF** **[XX] 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
51	Recovery Room							51
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
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
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
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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:** **WORKSHEET D PART IV**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[ ] Hospital** **[ ] IPF** **[XX] 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	15,513,410							50
51	Recovery Room	1,201,766							51
52	Delivery Room & Labor Room	9,559,535							52
53	Anesthesiology	8,009,394							53
54	Radiology-Diagnostic	20,597,699							54
57	CT Scan	19,238,090							57
58	MRI	3,066,333							58
60	Laboratory	26,417,989							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	3,176,828							63
65	Respiratory Therapy	8,680,019							65
66	Physical Therapy	7,706,457							66
69	Electrocardiology	5,994,470							69
70	Electroencephalography	1,337,505							70
71	Medical Supplies Charged to Pat	6,622,651							71
72	Impl. Dev. Charged to Patients	3,163,394							72
73	Drugs Charged to Patients	50,881,331							73
75	ASC (Non-Distinct Part)	687,856							75
76	HEMODIALYSIS	621,741							76
76.01	DIABETES CENTER	11,490							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,716,628							90
90.01	CHEMOTHERAPY	4,671,043							90.01
90.02	KEDZIE CLINIC	4,013,066							90.02
90.03	LITTLE VILLAGE CLINIC	5,814,713							90.03
91	Emergency	39,890,517							91
92	Observation Beds (Non-Distinct	3,082,358							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	253,676,283							200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[XX] 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	0.220115							50
51	Recovery Room	0.482879							51
52	Delivery Room & Labor Room	0.563898							52
53	Anesthesiology	0.158699							53
54	Radiology-Diagnostic	0.235653							54
57	CT Scan	0.050224							57
58	MRI	0.093559							58
60	Laboratory	0.199266							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.240191							63
65	Respiratory Therapy	0.156684							65
66	Physical Therapy	0.244175							66
69	Electrocardiology	0.121000							69
70	Electroencephalography	0.114104							70
71	Medical Supplies Charged to Pat	0.552397							71
72	Impl. Dev. Charged to Patients	0.663444							72
73	Drugs Charged to Patients	0.175143							73
75	ASC (Non-Distinct Part)	1.170569							75
76	HEMODIALYSIS	0.721435							76
76.01	DIABETES CENTER	0.645170							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.015122							90
90.01	CHEMOTHERAPY	0.220146							90.01
90.02	KEDZIE CLINIC	0.386894							90.02
90.03	LITTLE VILLAGE CLINIC	0.289882							90.03
91	Emergency	0.188011							91
92	Observation Beds (Non-Distinct	0.652706							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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0095** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,363	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,363	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)	13,327	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,805	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)		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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	15,180,931	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,180,931	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)	15,180,931	37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0095** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] 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)					988.15	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,771,761	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)					2,771,761	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,310,322	2,909	1,481.72	760	1,126,107	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)					3,567,977	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					7,465,845	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					242,778	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					88,265	51
52	Total Program excludable cost (sum of lines 50 and 51)					331,043	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					7,134,802	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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0095** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,036	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					988.15	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,011,873	89
		Cost	Routine Cost (from line 21)	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	1,080,903	15,180,931	0.071201	2,011,873	143,247	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S095** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,554	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,554	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)	10,554	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,205	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)		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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,946,251	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,946,251	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)	7,946,251	37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S095** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	752.91	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,660,167	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,660,167	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	191,280	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,851,447	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	82,004	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,399	51
52	Total Program excludable cost (sum of lines 50 and 51)	86,403	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,765,044	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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)		1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)		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
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		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)		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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)		21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		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)		37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)		38
39	Program general inpatient routine service cost (line 9 x line 38)		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)		41
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)		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)		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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0095** **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)	15,363	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,363	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)	13,327	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,994	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)	2,891	15
16	Nursery days (title V or XIX only)	169	16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	15,177,970	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,177,970	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)	15,177,970	37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0095** **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)					987.96	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,957,952	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)					2,957,952	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)	2,019,816	2,891	698.66	169	118,074	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,292,667	2,909	1,475.65	749	1,105,262	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)					2,910,047	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					7,091,335	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					258,428	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					72,743	51
52	Total Program excludable cost (sum of lines 50 and 51)					331,171	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

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 IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,036	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 21)	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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S095** **WORKSHEET D-1 PART I**

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[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)	10,554	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,554	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)	10,554	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,143	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)		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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,946,251	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,946,251	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)	7,946,251	37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S095** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[XX] 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)	752.91	38
39	Program general inpatient routine service cost (line 9 x line 38)	860,576	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)	860,576	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	96,824	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	957,400	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	42,508	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,425	51
52	Total Program excludable cost (sum of lines 50 and 51)	44,933	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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)		1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)		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
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		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)		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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)		21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		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)		37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes:
[ ] Title V - I/P [ ] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [XX] 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)		38
39	Program general inpatient routine service cost (line 9 x line 38)		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)		41
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)		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)		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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0095** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] 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		5,404,140		30
31	Intensive Care Unit		2,521,939		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220115	1,148,784	252,865	50
51	Recovery Room	0.482879	66,634	32,176	51
52	Delivery Room & Labor Room	0.563898	12,246	6,905	52
53	Anesthesiology	0.158699	414,337	65,755	53
54	Radiology-Diagnostic	0.235653	967,687	228,038	54
57	CT Scan	0.050224	948,567	47,641	57
58	MRI	0.093559	146,504	13,707	58
60	Laboratory	0.199266	2,080,843	414,641	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.240191	497,126	119,405	63
65	Respiratory Therapy	0.156684	2,186,473	342,585	65
66	Physical Therapy	0.244727	210,809	51,591	66
69	Electrocardiology	0.121000	678,923	82,150	69
70	Electroencephalography	0.114104	53,617	6,118	70
71	Medical Supplies Charged to Patients	0.552397	1,049,010	579,470	71
72	Impl. Dev. Charged to Patients	0.663444	456,817	303,072	72
73	Drugs Charged to Patients	0.175143	3,549,471	621,665	73
75	ASC (Non-Distinct Part)	1.170569	430	503	75
76	HEMODIALYSIS	0.721435	205,442	148,213	76
76.01	DIABETES CENTER	0.645170			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.018250	75	76	90
90.01	CHEMOTHERAPY	0.220146	4,333	954	90.01
90.02	KEDZIE CLINIC	0.386894	17	7	90.02
90.03	LITTLE VILLAGE CLINIC	0.289882	3	1	90.03
91	Emergency	0.188011	1,164,295	218,900	91
92	Observation Beds (Non-Distinct Part)	0.652706	48,321	31,539	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		15,890,764	3,567,977	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		15,890,764		202

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S095** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS
[XX] Title XVIII, Part A	[XX] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[ ] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/IID	[ ] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		3,562,937		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220115	5,148	1,133	50
51	Recovery Room	0.482879	432	209	51
52	Delivery Room & Labor Room	0.563898			52
53	Anesthesiology	0.158699	2,260	359	53
54	Radiology-Diagnostic	0.235653	21,759	5,128	54
57	CT Scan	0.050224	48,372	2,429	57
58	MRI	0.093559	4,134	387	58
60	Laboratory	0.199266	270,624	53,926	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.240191			63
65	Respiratory Therapy	0.156684	27,398	4,293	65
66	Physical Therapy	0.244727	900	220	66
69	Electrocardiology	0.121000	33,202	4,017	69
70	Electroencephalography	0.114104	10,660	1,216	70
71	Medical Supplies Charged to Patients	0.552397	2,491	1,376	71
72	Impl. Dev. Charged to Patients	0.663444			72
73	Drugs Charged to Patients	0.175143	302,982	53,065	73
75	ASC (Non-Distinct Part)	1.170569			75
76	HEMODIALYSIS	0.721435	23,648	17,060	76
76.01	DIABETES CENTER	0.645170			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.018250			90
90.01	CHEMOTHERAPY	0.220146			90.01
90.02	KEDZIE CLINIC	0.386894			90.02
90.03	LITTLE VILLAGE CLINIC	0.289882			90.03
91	Emergency	0.188011	247,125	46,462	91
92	Observation Beds (Non-Distinct Part)	0.652706			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,001,135	191,280	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,001,135		202

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS
[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[ ] Title XIX	[XX] IRF	[ ] NF	[ ] ICF/IID	[ ] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220115			50
51	Recovery Room	0.482879			51
52	Delivery Room & Labor Room	0.563898			52
53	Anesthesiology	0.158699			53
54	Radiology-Diagnostic	0.235653			54
57	CT Scan	0.050224			57
58	MRI	0.093559			58
60	Laboratory	0.199266			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.240191			63
65	Respiratory Therapy	0.156684			65
66	Physical Therapy	0.244727			66
69	Electrocardiology	0.121000			69
70	Electroencephalography	0.114104			70
71	Medical Supplies Charged to Patients	0.552397			71
72	Impl. Dev. Charged to Patients	0.663444			72
73	Drugs Charged to Patients	0.175143			73
75	ASC (Non-Distinct Part)	1.170569			75
76	HEMODIALYSIS	0.721435			76
76.01	DIABETES CENTER	0.645170			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.018250			90
90.01	CHEMOTHERAPY	0.220146			90.01
90.02	KEDZIE CLINIC	0.386894			90.02
90.03	LITTLE VILLAGE CLINIC	0.289882			90.03
91	Emergency	0.188011			91
92	Observation Beds (Non-Distinct Part)	0.652706			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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0095** **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		3,610,704		30
31	Intensive Care Unit		1,812,643		31
40	Subprovider - IPF				40
43	Nursery		1,507,730		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220115	972,040	213,961	50
51	Recovery Room	0.482879	58,496	28,246	51
52	Delivery Room & Labor Room	0.563898	962,956	543,009	52
53	Anesthesiology	0.158699	446,179	70,808	53
54	Radiology-Diagnostic	0.235653	569,439	134,190	54
57	CT Scan	0.050224	801,122	40,236	57
58	MRI	0.093559	104,636	9,790	58
60	Laboratory	0.199266	1,808,199	360,313	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.240191	369,992	88,869	63
65	Respiratory Therapy	0.156684	1,029,152	161,252	65
66	Physical Therapy	0.244175	96,206	23,491	66
69	Electrocardiology	0.121000	292,393	35,380	69
70	Electroencephalography	0.114104	15,889	1,813	70
71	Medical Supplies Charged to Patients	0.552397	667,819	368,901	71
72	Impl. Dev. Charged to Patients	0.663444	83,830	55,617	72
73	Drugs Charged to Patients	0.175143	2,974,083	520,890	73
75	ASC (Non-Distinct Part)	1.170569	97	114	75
76	HEMODIALYSIS	0.721435	79,812	57,579	76
76.01	DIABETES CENTER	0.645170			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.015122	546	554	90
90.01	CHEMOTHERAPY	0.220146	12	3	90.01
90.02	KEDZIE CLINIC	0.386894	14	5	90.02
90.03	LITTLE VILLAGE CLINIC	0.289882	10	3	90.03
91	Emergency	0.188011	908,083	170,730	91
92	Observation Beds (Non-Distinct Part)	0.652706	37,219	24,293	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		12,278,224	2,910,047	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		12,278,224		202

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S095** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[XX] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] 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
31	Intensive Care Unit				31
40	Subprovider - IPF		1,827,327		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220115	1,139	251	50
51	Recovery Room	0.482879	432	209	51
52	Delivery Room & Labor Room	0.563898			52
53	Anesthesiology	0.158699	1,771	281	53
54	Radiology-Diagnostic	0.235653	13,532	3,189	54
57	CT Scan	0.050224	36,284	1,822	57
58	MRI	0.093559			58
60	Laboratory	0.199266	152,712	30,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.240191			63
65	Respiratory Therapy	0.156684	35,249	5,523	65
66	Physical Therapy	0.244175	3,959	967	66
69	Electrocardiology	0.121000	12,459	1,508	69
70	Electroencephalography	0.114104	2,580	294	70
71	Medical Supplies Charged to Patients	0.552397	813	449	71
72	Impl. Dev. Charged to Patients	0.663444			72
73	Drugs Charged to Patients	0.175143	145,294	25,447	73
75	ASC (Non-Distinct Part)	1.170569			75
76	HEMODIALYSIS	0.721435			76
76.01	DIABETES CENTER	0.645170			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.015122			90
90.01	CHEMOTHERAPY	0.220146			90.01
90.02	KEDZIE CLINIC	0.386894			90.02
90.03	LITTLE VILLAGE CLINIC	0.289882			90.03
91	Emergency	0.188011	140,706	26,454	91
92	Observation Beds (Non-Distinct Part)	0.652706			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		546,930	96,824	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		546,930		202

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[ ] PPS
[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[XX] Title XIX	[XX] 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
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.220115			50
51	Recovery Room	0.482879			51
52	Delivery Room & Labor Room	0.563898			52
53	Anesthesiology	0.158699			53
54	Radiology-Diagnostic	0.235653			54
57	CT Scan	0.050224			57
58	MRI	0.093559			58
60	Laboratory	0.199266			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.240191			63
65	Respiratory Therapy	0.156684			65
66	Physical Therapy	0.244175			66
69	Electrocardiology	0.121000			69
70	Electroencephalography	0.114104			70
71	Medical Supplies Charged to Patients	0.552397			71
72	Impl. Dev. Charged to Patients	0.663444			72
73	Drugs Charged to Patients	0.175143			73
75	ASC (Non-Distinct Part)	1.170569			75
76	HEMODIALYSIS	0.721435			76
76.01	DIABETES CENTER	0.645170			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.015122			90
90.01	CHEMOTHERAPY	0.220146			90.01
90.02	KEDZIE CLINIC	0.386894			90.02
90.03	LITTLE VILLAGE CLINIC	0.289882			90.03
91	Emergency	0.188011			91
92	Observation Beds (Non-Distinct Part)	0.652706			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 **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,269,244			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,692,579			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	69,279			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	103.42			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	5.59			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	3.46			7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.	0.04			7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.46			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	2.55			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	2.92			10
11	FTE count for residents in dental and podiatric programs	1.06			11
12	Current year allowable FTE (see instructions)	3.61			12
13	Total allowable FTE count for the prior year	2.70			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	3.49			14
15	Sum of lines 12 through 14 divided by 3	3.27			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	3.27			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.031619			19
20	Prior year resident to bed ratio (see instructions)	0.025874			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.025874			21
22	IME payment adjustment (see instructions)	69,659			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	0.37			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	69,659			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1450			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5674			31
32	Sum of lines 30 and 31	0.7124			32
33	Allowable disproportionate share percentage (see instructions)	0.4799			33
34	Disproportionate share adjustment (see instructions)	595,295			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,445,803		2,277,431	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	614,792		1,703,393	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,318,185			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	8,014,241			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	8,014,241			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	472,803			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	61,728			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	1,036			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	8,549,808			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	8,549,808			61
62	Deductibles billed to program beneficiaries	575,092			62
63	Coinsurance billed to program beneficiaries	21,014			63
64	Allowable bad debts (see instructions)	339,901			64
65	Adjusted reimbursable bad debts (see instructions)	220,936			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	276,586			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,174,638			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	33,764			70.93
70.94	HRR adjustment amount (see instructions)	-31,762			70.94
71	Amount due provider (see instructions)	8,176,640			71
71.01	Sequestration adjustment (see instructions)	163,533			71.01
72	Interim payments	7,538,658			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	474,449			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	180,610			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0095** **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)	9,073			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,452,671			2
3	PPS payments	4,949,458			3
4	Outlier payment (see instructions)	12,586			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)	9,073			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	51,802			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)	51,802			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	51,802			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	42,729			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)	9,073			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)	4,962,044			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,037,679			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)	3,933,438			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	36,176			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,969,614			30
31	Primary payer payments	1,345			31
32	Subtotal (line 30 minus line 31)	3,968,269			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)	400,517			34
35	Adjusted reimbursable bad debts (see instructions)	260,336			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	312,006			36
37	Subtotal (see instructions)	4,228,605			37
38	MSP-LCC reconciliation amount from PS&R	-66			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,228,671			40
40.01	Sequestration adjustment (see instructions)	84,573			40.01
41	Interim payments	4,233,136			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-89,038			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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S095** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [XX] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			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)				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)	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)				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)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				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)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check applicable box: [ ] Hospital [ ] IPF [XX] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			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)				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)	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)				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)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				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)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0095** **WORKSHEET E-1 PART I**

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				7,567,420		4,246,105	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					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	02/09/2017	28,762	02/09/2017	12,969	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		-28,762		-12,969	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)				7,538,658		4,233,136	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		474,449			6.01
	based on the cost report (1)		.02				-89,038	6.02
7	Total Medicare program liability (see instructions)				8,013,107		4,144,098	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.

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S095** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [XX] IPF [ ] SNF [ ] IRF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,635,703			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					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,635,703			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		38,896			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,674,599			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.

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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)	4,235	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	3,565	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	16,236	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	308,262,765	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	14,212,428	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)	150,620	8
9	Sequestration adjustment amount (see instructions)	3,012	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	147,608	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	191,573	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-43,965	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.

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S095** **WORKSHEET E-3 PART II**

Check Applicable Box: **[ ] Hospital [XX] Subprovider IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,896,540	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	28.915068	9
10	Teaching adjustment factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,896,540	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	1,896,540	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,896,540	18
19	Deductibles	109,340	19
20	Subtotal (line 18 minus line 19)	1,787,200	20
21	Coinsurance	118,115	21
22	Subtotal (line 20 minus line 21)	1,669,085	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	61,060	23
24	Adjusted reimbursable bad debts (see instructions)	39,689	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	46,472	25
26	Subtotal (sum of lines 22 and 24)	1,708,774	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	1,708,774	31
31.01	Sequestration adjustment (see instructions)	34,175	31.01
32	Interim payments	1,635,703	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	38,896	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0095** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	7,091,335		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	7,091,335		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	7,091,335		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	6,931,077		8
9	Ancillary service charges	12,278,224		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)	19,209,301		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)	19,209,301		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	12,117,966		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)	7,091,335		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)	7,091,335		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)	7,091,335		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)	7,091,335		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	7,091,335		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)	7,091,335		40
41	Interim payments	7,091,335		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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S095** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[ ] Hospital** **[XX] Subprovider IPF** **[ ] 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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	957,400		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	957,400		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	957,400		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	1,827,327		8
9	Ancillary service charges	546,930		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)	2,374,257		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)	2,374,257		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,416,857		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)	957,400		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)	957,400		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)	957,400		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)	957,400		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	957,400		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)	957,400		40
41	Interim payments	957,400		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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[ ] Hospital** **[XX] Subprovider IRF** **[ ] 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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			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)			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)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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

Check Applicable Box:
[ ] Title V
[XX] Title XVIII
[ ] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			5.59	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA			3.46	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			0.04	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			0.46	4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			2.55	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.92	6
7	Enter the lesser of line 5 or line 6			2.55	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	2.27	0.65	2.92	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	1.98	0.57	2.55	9
10	Weighted dental and podiatric resident FTE count for the current year		1.06		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	1.98	1.63		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.10	1.60		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.32	2.19		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	1.47	1.81		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	1.47	1.81		17
18	Per resident amount	145,521.38	136,987.70		18
19	Approved amount for resident costs	213,916	247,948	461,864	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)			0.37	21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			461,864	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,770			26
27	Total inpatient days (see instructions)	27,220			27
28	Ratio of inpatient days to total inpatient days	0.211976	0.000000		28
29	Program direct GME amount	97,904			29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount			97,904	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)			9,317,292	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			9,317,292	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			5,461,744	42
43	Primary payer payments (see instructions)			1,345	43
44	Total Part B reasonable cost (line 42 minus line 43)			5,460,399	44
45	Total reasonable cost (sum of lines 41 and 44)			14,777,691	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.630497	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.369503	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			97,904	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			61,728	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			36,176	50

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

Check Applicable Box:
[ ] Title V
[ ] Title XVIII
[XX] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,184	9,875		26
27	Total inpatient days (see instructions)	27,220	27,220		27
28	Ratio of inpatient days to total inpatient days	0.190448	0.362785		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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	7,864,902				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	106,945,761				4
5	Other receivables	-2,436,046				5
6	Allowances for uncollectible notes and accounts receivable	-83,798,743				6
7	Inventory	1,264,154				7
8	Prepaid expenses					8
9	Other current assets	3,272,635				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	33,112,663				11
	FIXED ASSETS					
12	Land	472,850				12
13	Land improvements	518,789				13
14	Accumulated depreciation					14
15	Buildings	24,982,616				15
16	Accumulated depreciation	-16,269,000				16
17	Leasehold improvements	6,369,774				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	40,077,127				23
24	Accumulated depreciation	-36,230,997				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)	19,921,159				30
	OTHER ASSETS					
31	Investments	29,991,467				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	2,618,500				34
35	Total other assets (sum of lines 31-34)	32,609,967				35
36	Total assets (sum of lines 11, 30 and 35)	85,643,789				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	2,273,852				37
38	Salaries, wages and fees payable	4,307,407				38
39	Payroll taxes payable	128,012				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	7,685,316				44
45	Total current liabilities (sum of lines 37 thru 44)	14,394,587				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	9,553,044				47
48	Unsecured loans					48
49	Other long term liabilities	576,046				49
50	Total long term liabilities (sum of lines 46 thru 49)	10,129,090				50
51	Total liabilities (sum of lines 45 and 50)	24,523,677				51
	CAPITAL ACCOUNTS					
52	General fund balance	61,120,112				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
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)	61,120,112				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	85,643,789				60

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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		60,002,381			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,117,731			2
3	Total (sum of line 1 and line 2)		61,120,112			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)		61,120,112			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)		61,120,112			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

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	23,888,543		23,888,543	1
2	Subprovider IPF	16,974,590		16,974,590	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)	40,863,133		40,863,133	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	9,807,523		9,807,523	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)	9,807,523		9,807,523	16
17	Total inpatient routine care services (sum of lines 10 and 16)	50,670,656		50,670,656	17
18	Ancillary services	97,616,126	211,346,937	308,963,063	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)	148,286,782	211,346,937	359,633,719	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		114,759,274	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)		114,759,274	43

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	359,633,719	1
2	Less contractual allowances and discounts on patients' accounts	248,645,426	2
3	Net patient revenues (line 1 minus line 2)	110,988,293	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	114,759,274	4
5	Net income from service to patients (line 3 minus line 4)	-3,770,981	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	694,814	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	432	16
17	Revenue from sale of drugs to other than patients	1,908	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		22
23	Governmental appropriations		23
24	Other (MEDICAL STUDENTS PROGRAM REV)	1,669,323	24
24.01	Other (CSDC MGMT FEES)	924,861	24.01
24.02	Other (EMR INCENTIVE PYMT)	110,841	24.02
24.03	Other (PHO MGMT FEES)	111,185	24.03
24.04	Other (ESPEREZA RENATL REV)	136,005	24.04
24.05	Other (OTHER OPERATIN REV)	1,239,343	24.05
25	Total other income (sum of lines 6-24)	4,888,712	25
26	Total (line 5 plus line 25)	1,117,731	26
29	Net income (or loss) for the period (line 26 minus line 28)	1,117,731	29

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0095** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	400,684	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	1,759	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	45.66	3
4	Number of interns & residents (see instructions)	3.27	4
5	Indirect medical education percentage (see instructions)	2.04	5
6	Indirect medical education adjustment (see instructions)	8,174	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1450	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5674	8
9	Sum of lines 7 and 8	0.5674	9
10	Allowable disproportionate share percentage (see instructions)	0.1218	10
11	Disproportionate share adjustment (see instructions)	62,186	11
12	Total prospective capital payments (see instructions)	472,803	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
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
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)							75
76	HEMODIALYSIS							76
76.01	DIABETES CENTER							76.01
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
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	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
192.01	OTHER NON-REIMBURSABLE							192.01
192.02	NEPHROLOGY							192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	Non CMS worksheet **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 14:20 Version: 2017.10 (11/19/2017)

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	18.26		19.49				37.75	30
31	Intensive Care Unit	26.13		25.75				51.88	31
43	Nursery			5.85				5.85	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	7.41	5.10	6.27				18.78	50
51	Recovery Room	5.54	9.09	4.87				19.50	51
52	Delivery Room & Labor Room	0.13	0.01	10.07				10.21	52
53	Anesthesiology	5.17	8.26	5.57				19.00	53
54	Radiology-Diagnostic	4.70	7.81	2.76				15.27	54
57	CT Scan	4.93	9.93	4.16				19.02	57
58	MRI	4.78	14.96	3.41				23.15	58
60	Laboratory	7.88	6.16	6.84				20.88	60
63	Blood Storing, Processing & Tra	15.65	1.86	11.65				29.16	63
65	Respiratory Therapy	25.19	2.05	11.86				39.10	65
66	Physical Therapy	2.74	0.53	1.25				4.52	66
69	Electrocardiology	11.33	12.81	4.88				29.02	69
70	Electroencephalography	4.01	19.78	1.19				24.98	70
71	Medical Supplies Charged to Pat	15.84	3.96	10.08				29.88	71
72	Impl. Dev. Charged to Patients	14.44	1.76	2.65				18.85	72
73	Drugs Charged to Patients	6.98	19.31	5.85				32.14	73
75	ASC (Non-Distinct Part)	0.06	13.88	0.01				13.95	75
76	HEMODIALYSIS	33.04	5.47	12.84				51.35	76
76.01	DIABETES CENTER		5.40					5.40	76.01
90	Clinic		23.23	0.01				23.24	90
90.01	CHEMOTHERAPY	0.09	35.74					35.83	90.01
90.02	KEDZIE CLINIC		0.41					0.41	90.02
90.03	LITTLE VILLAGE CLINIC		2.11					2.11	90.03
91	Emergency	2.92	4.66	2.28				9.86	91
92	Observation Beds (Non-Distinct	1.57	21.73	1.21				24.51	92
200	TOTAL CHARGES	6.26	9.44	4.84				20.54	200

REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IPF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
40	Subprovider - IPF	20.89		10.83				31.72	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	0.03		0.01				0.04	50
51	Recovery Room	0.04		0.04				0.08	51
53	Anesthesiology	0.03		0.02				0.05	53
54	Radiology-Diagnostic	0.11		0.07				0.18	54
57	CT Scan	0.25		0.19				0.44	57
58	MRI	0.13						0.13	58
60	Laboratory	1.02		0.58				1.60	60
65	Respiratory Therapy	0.32		0.41				0.73	65
66	Physical Therapy	0.01		0.05				0.06	66
69	Electrocardiology	0.55		0.21				0.76	69
70	Electroencephalography	0.80		0.19				0.99	70
71	Medical Supplies Charged to Pat	0.04		0.01				0.05	71
73	Drugs Charged to Patients	0.60		0.29				0.89	73
76	HEMODIALYSIS	3.80						3.80	76
91	Emergency	0.62		0.35				0.97	91
200	TOTAL CHARGES	0.39		0.22				0.61	200

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,413,833	3.61	-3,413,833	-7.23			1
2	Cap Rel Costs-Mvble Equip							2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	7,615,596	8.05	-7,615,596	-16.12			4
5	Administrative & General	21,471,647	22.69	-21,471,647	-45.45			5
6	Maintenance & Repairs	2,114,174	2.23	-2,114,174	-4.48			6
7	Operation of Plant	2,774,291	2.93	-2,774,291	-5.87			7
8	Laundry & Linen Service	427,909	0.45	-427,909	-0.91			8
9	Housekeeping	1,331,909	1.41	-1,331,909	-2.82			9
10	Dietary	945,378	1.00	-945,378	-2.00			10
11	Cafeteria	704,421	0.74	-704,421	-1.49			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,250,771	1.32	-1,250,771	-2.65			13
14	Central Services & Supply	391,884	0.41	-391,884	-0.83			14
15	Pharmacy	1,116,812	1.18	-1,116,812	-2.36			15
16	Medical Records & Library	1,478,204	1.56	-1,478,204	-3.13			16
17	Social Service	838,744	0.89	-838,744	-1.78			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	342,930	0.36	-342,930	-0.73			21
22	I&R Services-Other Prgm Costs Apprvd	1,020,800	1.08	-1,020,800	-2.16			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	5,720,509	6.04	10,329,205	21.87	16,049,714	16.96	30
31	Intensive Care Unit	2,063,284	2.18	2,229,383	4.72	4,292,667	4.54	31
40	Subprovider - IPF	3,184,406	3.36	4,761,845	10.08	7,946,251	8.40	40
43	Nursery	980,717	1.04	1,039,099	2.20	2,019,816	2.13	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,748,386	1.85	1,666,347	3.53	3,414,733	3.61	50
51	Recovery Room	355,540	0.38	224,767	0.48	580,307	0.61	51
52	Delivery Room & Labor Room	2,793,145	2.95	2,597,458	5.50	5,390,603	5.70	52
53	Anesthesiology	628,847	0.66	642,238	1.36	1,271,085	1.34	53
54	Radiology-Diagnostic	2,483,658	2.62	2,370,253	5.02	4,853,911	5.13	54
57	CT Scan	533,569	0.56	432,649	0.92	966,218	1.02	57
58	MRI	173,510	0.18	113,372	0.24	286,882	0.30	58
60	Laboratory	3,054,387	3.23	2,209,818	4.68	5,264,205	5.56	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	543,790	0.57	219,257	0.46	763,047	0.81	63
65	Respiratory Therapy	763,500	0.81	596,520	1.26	1,360,020	1.44	65
66	Physical Therapy	1,089,705	1.15	792,018	1.68	1,881,723	1.99	66
69	Electrocardiology	372,725	0.39	352,608	0.75	725,333	0.77	69
70	Electroencephalography	55,336	0.06	97,279	0.21	152,615	0.16	70
71	Medical Supplies Charged to Patients	2,352,905	2.49	1,305,429	2.76	3,658,334	3.87	71
72	Impl. Dev. Charged to Patients	1,353,136	1.43	745,600	1.58	2,098,736	2.22	72
73	Drugs Charged to Patients	4,877,833	5.15	4,033,677	8.54	8,911,510	9.42	73
75	ASC (Non-Distinct Part)	495,670	0.52	309,513	0.66	805,183	0.85	75
76	HEMODIALYSIS	334,415	0.35	114,131	0.24	448,546	0.47	76
76.01	DIABETES CENTER	4,899	0.01	2,514	0.01	7,413	0.01	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,950,821	2.06	2,257,881	4.78	4,208,702	4.45	90
90.01	CHEMOTHERAPY	599,228	0.63	429,085	0.91	1,028,313	1.09	90.01
90.02	KEDZIE CLINIC	986,816	1.04	565,817	1.20	1,552,633	1.64	90.02
90.03	LITTLE VILLAGE CLINIC	1,167,065	1.23	518,515	1.10	1,685,580	1.78	90.03
91	Emergency	4,090,773	4.32	4,280,826	9.06	8,371,599	8.85	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	95,584	0.10	55,574	0.12	151,158	0.16	190
192	Physicians' Private Offices	1,236,110	1.31	1,385,137	2.93	2,621,247	2.77	192
192.01	OTHER NON-REIMBURSABLE	100,800	0.11	71,003	0.15	171,803	0.18	192.01
192.02	NEPHROLOGY	1,212,710	1.28	490,485	1.04	1,703,195	1.80	192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	94,643,082	100.00			94,643,082	100.00	202

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	150,007	15,513,410	0.009670	1,148,784	11,109	50
51	Recovery Room	5,052	1,201,766	0.004204	66,634	280	51
52	Delivery Room & Labor Room	133,721	9,559,535	0.013988	12,246	171	52
53	Anesthesiology	26,805	8,009,394	0.003347	414,337	1,387	53
54	Radiology-Diagnostic	258,849	20,597,699	0.012567	967,687	12,161	54
57	CT Scan	12,528	19,238,090	0.000651	948,567	618	57
58	MRI	2,490	3,066,333	0.000812	146,504	119	58
60	Laboratory	188,432	26,417,989	0.007133	2,080,843	14,843	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,637	3,176,828	0.001460	497,126	726	63
65	Respiratory Therapy	38,368	8,680,019	0.004420	2,186,473	9,664	65
66	Physical Therapy	50,060	7,706,457	0.006496	210,809	1,369	66
69	Electrocardiology	27,646	5,994,470	0.004612	678,923	3,131	69
70	Electroencephalography	14,561	1,337,505	0.010887	53,617	584	70
71	Medical Supplies Charged to Pat	69,245	6,622,651	0.010456	1,049,010	10,968	71
72	Impl. Dev. Charged to Patients	39,629	3,163,394	0.012527	456,817	5,723	72
73	Drugs Charged to Patients	117,648	50,881,331	0.002312	3,549,471	8,206	73
75	ASC (Non-Distinct Part)	6,866	687,856	0.009982	430	4	75
76	HEMODIALYSIS	2,169	621,741	0.003489	205,442	717	76
76.01	DIABETES CENTER	37	11,490	0.003220			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	161,584	3,716,628	0.043476	75	3	90
90.01	CHEMOTHERAPY	11,445	4,671,043	0.002450	4,333	11	90.01
90.02	KEDZIE CLINIC	8,275	4,013,066	0.002062	17		90.02
90.03	LITTLE VILLAGE CLINIC	9,339	5,814,713	0.001606	3		90.03
91	Emergency	144,745	39,890,517	0.003629	1,164,295	4,225	91
92	Observation Beds (Non-Distinct	143,247	3,082,358	0.046473	48,321	2,246	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	1,627,385	253,676,283		15,890,764	88,265	200

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	1,080,903		1,080,903	15,363	70.36	2,805	197,360	30
31	Intensive Care Unit	173,831		173,831	2,909	59.76	760	45,418	31
200	TOTAL	1,254,734		1,254,734	18,272		3,565	242,778	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	242,778
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	88,265
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	331,043
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	663
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	3,565
PER DISCHARGE CAPITAL COSTS	499.31

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	7,134,802
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	23,816,843
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.300

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	1,851,447
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	4,564,072
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.406

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	331,043
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.014

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	5,442,723
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	23,860,581
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.228