SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/28/2018 Time: 17:42 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 CHIEF FINANCIAL 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 07/01/2017 and ending 06/30/2018, 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.

[_] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial 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		574,370	-1,014			1
2	SUBPROVIDER - IPF		23,209				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		597,579	-1,014			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.

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	2		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.	2,501	1,367			7,520		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)(i) or (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)(i) or (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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete 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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 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 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a 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

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

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:	70,773			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.		Y		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 care related taxes as defined in §1983(w)(3) of the Act? 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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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)	9.99			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2017	06 / 30 / 2018	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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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			2,106	2,078	13,161	1
2	HMO and other (see instructions)							7,166		2
3	HMO IPF Subprovider							1,713		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			2,106	2,078	13,161	7
8	Intensive Care Unit	31	15	5,475			801	790	3,277	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						986	2,877	13
14	Total (see instructions)		109	39,785			2,907	3,854	19,315	14
15	CAH Visits									15
16	Subprovider - IPF	40	42	15,330			1,343	678	8,270	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							236	2,290	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							368	648	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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)					627	782	4,834	1
2	HMO and other (see instructions)						1,989		2
3	HMO IPF Subprovider						203		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)	4.09	713.33			627	782	4,834	14
15	CAH Visits								15
16	Subprovider - IPF		38.64			136	81	978	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)	4.09	751.97						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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	53,295,538	364,145	53,659,683	1,521,583.00	35.27	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		1,591,126		1,591,126	9,105.00	174.75	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		5,173,271		5,173,271	47,700.00	108.45	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		3,625,070	41,179	3,666,249	119,017.00	30.80	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,109,742		1,109,742	14,437.00	76.87	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)		7,977,836		7,977,836			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		715,929		715,929			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		62,847		62,847			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		309,806		309,806			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		129,167		129,167			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		852,967		852,967	19,112.00	44.63	26
27	Administrative & General		9,684,491	102,847	9,787,338	257,959.00	37.94	27
28	Administrative & General under contract (see instructions)		111,697		111,697	2,559.00	43.65	28
29	Maintenance & Repairs		387,754		387,754	10,875.00	35.66	29
30	Operation of Plant		1,208,293	900	1,209,193	51,722.00	23.38	30
31	Laundry & Linen Service							31
32	Housekeeping		796,269		796,269	54,602.00	14.58	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		932,280	-529,008	403,272	25,357.00	15.90	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			529,008	529,008	33,258.00	15.91	36
37	Maintenance of Personnel							37
38	Nursing Administration		827,080	5,216	832,296	38,135.00	21.82	38
39	Central Services and Supply		255,048		255,048	13,368.00	19.08	39
40	Pharmacy		1,321,181	7,417	1,328,598	31,182.00	42.61	40
41	Medical Records & Medical Records Library		792,402	2,323	794,725	28,362.00	28.02	41
42	Social Service		797,738	1,936	799,674	25,248.00	31.67	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	48,233,964	364,145	48,598,109	1,476,442.00	32.92	1
2	Excluded area salaries (see instructions)	3,625,070	41,179	3,666,249	119,017.00	30.80	2
3	Subtotal salarles (line 1 minus line 2)	44,608,894	322,966	44,931,860	1,357,425.00	33.10	3
4	Subtotal other wages & related costs (see instructions)	1,109,742		1,109,742	14,437.00	76.87	4
5	Subtotal wage-related costs (see instructions)	8,040,683		8,040,683		17.90%	5
6	Total (sum of lines 3 through 5)	53,759,319	322,966	54,082,285	1,371,862.00	39.42	6
7	Total overhead cost (see instructions)	17,967,200	120,639	18,087,839	591,739.00	30.57	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	112,164	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)	4,197,273	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	162,349	10
11	Life Insurance (If employee is owner or beneficiary)	66,551	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	148,952	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	646,804	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	3,593,047	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	116,395	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	152,050	23
24	Total Wage Related cost (Sum of lines 1-23)	9,195,585	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

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	1,109,742	9,195,585	1
2	Hospital	1,109,742	9,195,585	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

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)	0.265368	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	49,821,853	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	176,145,619	6
7	Medicaid cost (line 1 times line 6)	46,743,411	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)	15,431,957		15,431,957	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,095,148		4,095,148	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)	4,095,148		4,095,148	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)	8,520,666	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	521,639	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	802,522	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	7,718,144	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,329,031	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	6,424,179	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,424,179	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		2,905,199	2,905,199		2,905,199	407,225	3,312,424	1
2	00200	Cap Rel Costs-Mvble Equip								2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	852,967	5,038,351	5,891,318		5,891,318		5,891,318	4
5	00500	Administrative & General	9,684,491	21,166,758	30,851,249		30,851,249	-8,631,111	22,220,138	5
6	00600	Maintenance & Repairs	387,754	1,580,119	1,967,873		1,967,873		1,967,873	6
7	00700	Operation of Plant	1,208,293	1,581,458	2,789,751		2,789,751	-17,900	2,771,851	7
8	00800	Laundry & Linen Service				417,583	417,583		417,583	8
9	00900	Housekeeping	796,269	956,647	1,752,916	-417,583	1,335,333		1,335,333	9
10	01000	Dietary	932,280	1,472,436	2,404,716	-1,364,519	1,040,197	-709,222	330,975	10
11	01100	Cafeteria				1,364,519	1,364,519		1,364,519	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	827,080	165,570	992,650		992,650	-3,500	989,150	13
14	01400	Central Services & Supply	255,048	114,334	369,382	-87,323	282,059		282,059	14
15	01500	Pharmacy	1,321,181	3,779,726	5,100,907	-3,962,552	1,138,355	-80,462	1,057,893	15
16	01600	Medical Records & Library	792,402	623,775	1,416,177		1,416,177	-1,220	1,414,957	16
17	01700	Social Service	797,738	89,095	886,833		886,833	-3,459	883,374	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd	1,978,864	1,355,982	3,334,846		3,334,846	-3,235,741	99,105	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	5,229,164	1,094,307	6,323,471		6,323,471	-513,544	5,809,927	30
31	03100	Intensive Care Unit	1,966,535	448,672	2,415,207		2,415,207	-21,129	2,394,078	31
40	04000	Subprovider - IPF	2,127,610	660,271	2,787,881		2,787,881	-1,125	2,786,756	40
43	04300	Nursery	1,395,157	250,757	1,645,914		1,645,914	-684,773	961,141	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,265,787	2,141,770	3,407,557	-1,854,705	1,552,852		1,552,852	50
51	05100	Recovery Room	306,980	40,439	347,419		347,419		347,419	51
52	05200	Delivery Room & Labor Room	4,375,195	860,759	5,235,954		5,235,954	-2,504,743	2,731,211	52
53	05300	Anesthesiology	1,623,926	501,339	2,125,265		2,125,265	-1,344,033	781,232	53
54	05400	Radiology-Diagnostic	1,791,754	997,565	2,789,319	-81,952	2,707,367	-11,043	2,696,324	54
57	05700	CT Scan	423,956	308,437	732,393		732,393		732,393	57
58	05800	MRI	124,923	57,792	182,715		182,715		182,715	58
60	06000	Laboratory	1,447,392	1,644,397	3,091,789		3,091,789	-7,968	3,083,821	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.	71,034	470,335	541,369		541,369		541,369	63
65	06500	Respiratory Therapy	672,032	249,990	922,022	-194,984	727,038		727,038	65
66	06600	Physical Therapy	1,092,019	201,735	1,293,754	-58,848	1,234,906	-4,761	1,230,145	66
69	06900	Electrocardiology	333,057	184,129	517,186		517,186	-182,511	334,675	69
70	07000	Electroencephalography	46,518	7,713	54,231		54,231		54,231	70
71	07100	Medical Supplies Charged to Patients				1,910,293	1,910,293		1,910,293	71
72	07200	Impl. Dev. Charged to Patients				922,400	922,400		922,400	72
73	07300	Drugs Charged to Patients				3,962,552	3,962,552		3,962,552	73
75	07500	ASC (Non-Distinct Part)	430,638	51,533	482,171		482,171		482,171	75
76	03951	HEMODIALYSIS	50	320,152	320,202		320,202		320,202	76
76.01	03952	DIABETES CENTER								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	1,351,998	677,537	2,029,535		2,029,535	-73,874	1,955,661	90
90.01	09001	CHEMOTHERAPY	457,237	152,174	609,411		609,411	-76,875	532,536	90.01
90.02	09002	KEDZIE CLINIC	1,114,064	355,421	1,469,485	-21,342	1,448,143	-504,052	944,091	90.02
90.03	09003	LITTLE VILLAGE CLINIC	663,619	723,054	1,386,673		1,386,673		1,386,673	90.03
91	09100	Emergency	3,653,066	3,073,384	6,726,450	-533,539	6,192,911	-678,455	5,514,456	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)	51,798,078	56,303,112	108,101,190		108,101,190	-18,884,276	89,216,914	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	42,521	49,515	92,036		92,036		92,036	190
192	19200	Physicians' Private Offices	792,224	376,478	1,168,702		1,168,702		1,168,702	192
192.01	19201	OTHER NON-REIMBURSABLE	118,704	22,528	141,232		141,232		141,232	192.01
192.02	19202	NEPHROLOGY	544,011	1,006,771	1,550,782		1,550,782		1,550,782	192.02
194	07950	OTHER NONREIMBURSABLE COST CENTERS								194
200		TOTAL (sum of lines 118-199)	53,295,538	57,758,404	111,053,942		111,053,942	-18,884,276	92,169,666	200

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		417,583	1
500	Total reclassifications					417,583	500
	Code Letter - A						
1	CAFETERIA RECLASS	B	Cafeteria	11	529,008	835,511	1
500	Total reclassifications				529,008	835,511	500
	Code Letter - B						
1	COST OF MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		1,910,293	1
2			Impl. Dev. Charged to Patient	72		922,400	2
3							3
4							4
5							5
6							6
7							7
500	Total reclassifications					2,832,693	500
	Code Letter - C						
1	COST OF DRUGS SOLD	D	Drugs Charged to Patients	73		3,962,552	1
500	Total reclassifications					3,962,552	500
	Code Letter - D						
1	HIRING INCENTIVES	E	Administrative & General	5	102,847		1
2			Operation of Plant	7	900		2
3			Nursing Administration	13	5,216		3
4			Pharmacy	15	7,417		4
5			Medical Records & Library	16	2,323		5
6			Social Service	17	1,936		6
7			I&R Services-Other Prgm Costs	22	44,667		7
8			Adults & Pediatrics	30	16,267		8
9			Intensive Care Unit	31	18,051		9
10			Subprovider - IPF	40	19,392		10
11			Nursery	43	17,152		11
12			Operating Room	50	8,302		12
13			Recovery Room	51	5,626		13
14			Delivery Room & Labor Room	52	13,352		14
15			Radiology-Diagnostic	54	15,390		15
16			CT Scan	57	2,269		16
17			Laboratory	60	1,942		17
18			Physical Therapy	66	5,939		18
19			ASC (Non-Distinct Part)	75	7,895		19
20			Emergency	91	45,475		20
21			Physicians' Private Offices	192	1,662		21
22			OTHER NON-REIMBURSABLE	192.01	875		22
23			NEPHROLOGY	192.02	19,250		23
500	Total reclassifications				364,145		500
	Code Letter - E						
	GRAND TOTAL (Increases)				893,153	8,048,339	

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

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	LAUNDARY	A	Housekeeping	9		417,583		1
500	Total reclassifications					417,583		500
	Code letter - A							
1	CAFETERIA RECLASS	B	Dietary	10	529,008	835,511		1
500	Total reclassifications				529,008	835,511		500
	Code letter - B							
1	COST OF MEDICAL SUPPLIES	C	Central Services & Supply	14		87,323		1
2			Operating Room	50		1,854,705		2
3			Radiology-Diagnostic	54		81,952		3
4			Respiratory Therapy	65		194,984		4
5			Physical Therapy	66		58,848		5
6			KEDZIE CLINIC	90.02		21,342		6
7			Emergency	91		533,539		7
500	Total reclassifications					2,832,693		500
	Code letter - C							
1	COST OF DRUGS SOLD	D	Pharmacy	15		3,962,552		1
500	Total reclassifications					3,962,552		500
	Code letter - D							
1	HIRING INCENTIVES	E	Administrative & General	5		102,847		1
2			Operation of Plant	7		900		2
3			Nursing Administration	13		5,216		3
4			Pharmacy	15		7,417		4
5			Medical Records & Library	16		2,323		5
6			Social Service	17		1,936		6
7			I&R Services-Other Prgm Costs	22		44,667		7
8			Adults & Pediatrics	30		16,267		8
9			Intensive Care Unit	31		18,051		9
10			Subprovider - IPF	40		19,392		10
11			Nursery	43		17,152		11
12			Operating Room	50		8,302		12
13			Recovery Room	51		5,626		13
14			Delivery Room & Labor Room	52		13,352		14
15			Radiology-Diagnostic	54		15,390		15
16			CT Scan	57		2,269		16
17			Laboratory	60		1,942		17
18			Physical Therapy	66		5,939		18
19			ASC (Non-Distinct Part)	75		7,895		19
20			Emergency	91		45,475		20
21			Physicians' Private Offices	192		1,662		21
22			OTHER NON-REIMBURSABLE	192.01		875		22
23			NEPHROLOGY	192.02		19,250		23
500	Total reclassifications					364,145		500
	Code letter - E							
	GRAND TOTAL (Decreases)				529,008	8,412,484		

(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	518,789					518,789		2
3	Buildings and Fixtures	31,352,390	398,208		398,208		31,750,598		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	40,077,127	375,187		375,187		40,452,314		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	72,421,156	773,395		773,395		73,194,551		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	72,421,156	773,395		773,395		73,194,551		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	2,905,199						2,905,199	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	2,905,199						2,905,199	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	32,269,386		32,269,386	0.443738					1
2	Cap Rel Costs-Mvble Equ	40,452,314		40,452,314	0.556262					2
3	Total (sum of lines 1-2)	72,721,700		72,721,700	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	3,312,424						3,312,424	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	3,312,424						3,312,424	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.)

				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	-7,893	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	-7,757,931				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	-641,235	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-325	Medical Records & Library	16		18
19	Nursing and allied health education (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							35
36	OTHER REVENUE	B	-562,346	Administrative & General	5		36
36.01	OTHER REVENUE	B	-17,900	Operation of Plant	7		36.01
36.02	OTHER REVENUE	B	-67,987	Dietary	10		36.02
36.03	OTHER REVENUE	B	-3,500	Nursing Administration	13		36.03
36.04	OTHER REVENUE	B	-80,462	Pharmacy	15		36.04
36.05	OTHER REVENUE	B	-895	Medical Records & Library	16		36.05
36.06	OTHER REVENUE	B	-281,434	I&R Services-Other Prgm Costs Apprvd	22		36.06
36.07	OTHER REVENUE	B	-1,282,921	I&R Services-Other Prgm Costs Apprvd	22		36.07
36.08	OTHER REVENUE	B	-7,020	Adults & Pediatrics	30		36.08
36.10	OTHER REVENUE	B	-11,043	Radiology-Diagnostic	54		36.10
36.11	OTHER REVENUE	B	-7,968	Laboratory	60		36.11
36.12	OTHER REVENUE	B	-182,511	Electrocardiology	69		36.12
36.13	OTHER REVENUE	B	-14,146	Clinic	90		36.13
37							37
38							38
39	MILLENIUM BLDG NON ALLOW COST	A	-94,833	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	-7,024,968	Administrative & General	5		42
43	MID WIFERY PROGRAM	A	-1,180,697	Delivery Room & Labor Room	52		43
44							44
45	IHA MCHC DUE NON ALLOWABLE	A	-12,651	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)		-18,884,276				50

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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.

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	2,092,912		2,092,912	211,500	11,977	1,217,854	60,893	1
2	22	I&R Services-Other P AGGREGATE	1,598,325	1,598,325						2
3	30	Adults & Pediatrics AGGREGATE	506,524	506,524						3
4	40	Subprovider - IPF AGGREGATE	1,125	1,125						4
5	43	Nursery AGGREGATE	684,773	684,773						5
6										6
7	52	Delivery Room & Labo AGGREGATE	1,324,046	1,324,046						7
8	53	Anesthesiology AGGREGATE	1,344,033	1,344,033						8
9	90	Clinic AGGREGATE	46,244	46,244						9
10	90.01	CHEMOTHERAPY AGGREGATE	76,875	76,875						10
11	90.02	KEDZIE CLINIC AGGREGATE	504,052	504,052						11
12	91	Emergency AGGREGATE	296,316	296,316						12
13										13
14										14
15										15
16										16
17	5	Administrative & Gen AGGREGATE	13,000		13,000	211,500	103	10,473	524	17
18	17	Social Service AGGREGATE	18,000		18,000	211,500	143	14,541	727	18
19	22	I&R Services-Other P AGGREGATE	379,533		379,533	211,500	3,014	306,472	15,324	19
20										20
21	31	Intensive Care Unit AGGREGATE	110,000		110,000	211,500	874	88,871	4,444	21
22	60	Laboratory AGGREGATE	6,000		6,000	260,300	48	6,007	300	22
23	66	Physical Therapy AGGREGATE	24,996		24,996	211,500	199	20,235	1,012	23
24	90	Clinic AGGREGATE	70,325		70,325	211,500	559	56,841	2,842	24
25	91	Emergency AGGREGATE	1,985,980		1,985,980	211,500	15,773	1,603,841	80,192	25
200		TOTAL	11,083,059	6,382,313	4,700,746		32,690	3,325,135	166,258	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					1,217,854	875,058	875,058	1
2	22	I&R Services-Other P AGGREGATE							1,598,325	2
3	30	Adults & Pediatrics AGGREGATE							506,524	3
4	40	Subprovider - IPF AGGREGATE							1,125	4
5	43	Nursery AGGREGATE							684,773	5
6										6
7	52	Delivery Room & Labo AGGREGATE							1,324,046	7
8	53	Anesthesiology AGGREGATE							1,344,033	8
9	90	Clinic AGGREGATE							46,244	9
10	90.01	CHEMOTHERAPY AGGREGATE							76,875	10
11	90.02	KEDZIE CLINIC AGGREGATE							504,052	11
12	91	Emergency AGGREGATE							296,316	12
13										13
14										14
15										15
16										16
17	5	Administrative & Gen AGGREGATE					10,473	2,527	2,527	17
18	17	Social Service AGGREGATE					14,541	3,459	3,459	18
19	22	I&R Services-Other P AGGREGATE					306,472	73,061	73,061	19
20										20
21	31	Intensive Care Unit AGGREGATE					88,871	21,129	21,129	21
22	60	Laboratory AGGREGATE					6,007			22
23	66	Physical Therapy AGGREGATE					20,235	4,761	4,761	23
24	90	Clinic AGGREGATE					56,841	13,484	13,484	24
25	91	Emergency AGGREGATE					1,603,841	382,139	382,139	25
200		TOTAL					3,325,135	1,375,618	7,757,931	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	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	3,312,424	3,312,424					1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	5,891,318	13,027	5,904,345				4
5	Administrative & General	22,220,138	408,626	1,094,349	23,723,113	23,723,113		5
6	Maintenance & Repairs	1,967,873	123,781	43,355	2,135,009	739,979	2,874,988	6
7	Operation of Plant	2,771,851	408,430	135,200	3,315,481	1,149,123	424,372	7
8	Laundry & Linen Service	417,583	57,747		475,330	164,746	60,001	8
9	Housekeeping	1,335,333	29,732	89,031	1,454,096	503,979	30,892	9
10	Dietary	330,975	59,937	45,090	436,002	151,115	62,277	10
11	Cafeteria	1,364,519	83,000	59,148	1,506,667	522,200	86,240	11
12	Maintenance of Personnel							12
13	Nursing Administration	989,150	57,976	93,059	1,140,185	395,180	60,239	13
14	Central Services & Supply	282,059	85,485	28,517	396,061	137,272	88,821	14
15	Pharmacy	1,057,893	47,270	148,551	1,253,714	434,528	49,115	15
16	Medical Records & Library	1,414,957	60,395	88,858	1,564,210	542,144	62,752	16
17	Social Service	883,374	16,312	89,412	989,098	342,814	16,949	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	99,105		226,251	325,356	112,766		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,809,927	688,862	586,492	7,085,281	2,455,728	715,749	30
31	Intensive Care Unit	2,394,078	93,723	221,897	2,709,698	939,162	97,381	31
40	Subprovider - IPF	2,786,756	206,062	240,056	3,232,874	1,120,491	214,105	40
43	Nursery	961,141	20,726	157,910	1,139,777	395,039	21,534	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,552,852	94,769	142,456	1,790,077	620,428	98,468	50
51	Recovery Room	347,419		34,952	382,371	132,527		51
52	Delivery Room & Labor Room	2,731,211	63,468	490,683	3,285,362	1,138,683	65,945	52
53	Anesthesiology	781,232	12,226	181,571	975,029	337,938	12,703	53
54	Radiology-Diagnostic	2,696,324	175,693	202,057	3,074,074	1,065,453	182,551	54
57	CT Scan	732,393		47,656	780,049	270,360		57
58	MRI	182,715		13,968	196,683	68,169		58
60	Laboratory	3,083,821	116,524	162,050	3,362,395	1,165,383	121,072	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	541,369		7,942	549,311	190,387		63
65	Respiratory Therapy	727,038	21,461	75,140	823,639	285,468	22,299	65
66	Physical Therapy	1,230,145	28,244	122,763	1,381,152	478,698	29,347	66
69	Electrocardiology	334,675	16,378	37,239	388,292	134,579	17,017	69
70	Electroencephalography	54,231	10,346	5,201	69,778	24,185	10,750	70
71	Medical Supplies Charged to Patients	1,910,293			1,910,293	662,094		71
72	Impl. Dev. Charged to Patients	922,400			922,400	319,697		72
73	Drugs Charged to Patients	3,962,552			3,962,552	1,373,393		73
75	ASC (Non-Distinct Part)	482,171		49,032	531,203	184,111		75
76	HEMODIALYSIS	320,202		6	320,208	110,982		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	1,955,661	98,757	151,167	2,205,585	764,440	102,611	90
90.01	CHEMOTHERAPY	532,536		51,124	583,660	202,292		90.01
90.02	KEDZIE CLINIC	944,091		124,563	1,068,654	370,388		90.02
90.03	LITTLE VILLAGE CLINIC	1,386,673		74,199	1,460,872	506,328		90.03
91	Emergency	5,514,456	60,722	413,534	5,988,712	2,075,646	63,092	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)	89,216,914	3,159,679	5,734,479	88,894,303	22,587,895	2,716,282	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	92,036	2,452	4,754	99,242	34,397	2,547	190
192	Physicians' Private Offices	1,168,702	150,293	88,764	1,407,759	487,919	156,159	192
192.01	OTHER NON-REIMBURSABLE	141,232		13,370	154,602	53,584		192.01
192.02	NEPHROLOGY	1,550,782		62,978	1,613,760	559,318		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)	92,169,666	3,312,424	5,904,345	92,169,666	23,723,113	2,874,988	202

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	4,888,976						7
8	Laundry & Linen Service	119,702	819,779					8
9	Housekeeping	61,630		2,050,597				9
10	Dietary	124,242		54,118	827,754			10
11	Cafeteria	172,048		74,942		2,362,097		11
12	Maintenance of Personnel							12
13	Nursing Administration	120,176		52,347		91,532	1,859,659	13
14	Central Services & Supply	177,198		77,186		32,109		14
15	Pharmacy	97,984		42,681		74,853		15
16	Medical Records & Library	125,191		54,532		68,112		16
17	Social Service	33,813		14,729		60,622		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					48,188		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,427,920	391,122	621,986	440,913	352,145	430,526	30
31	Intensive Care Unit	194,274	97,387	84,624	109,784	94,528	115,569	31
40	Subprovider - IPF	427,139	245,770	186,057	277,057	187,707	229,489	40
43	Nursery	42,961	85,500	18,713		60,122	73,505	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	196,443		85,568		80,895	98,902	50
51	Recovery Room					16,329	19,964	51
52	Delivery Room & Labor Room	131,560		57,306		193,350	236,388	52
53	Anesthesiology	25,343		11,039		24,069	29,426	53
54	Radiology-Diagnostic	364,188		158,636		146,411		54
57	CT Scan					26,016		57
58	MRI					4,994		58
60	Laboratory	241,538		105,211		112,355		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					399		63
65	Respiratory Therapy	44,486		19,378		53,031		65
66	Physical Therapy	58,547		25,502		55,328		66
69	Electrocardiology	33,949		14,788		24,868		69
70	Electroencephalography	21,447		9,342		4,294		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)					27,315	33,395	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	204,710		89,169		193,001	235,960	90
90.01	CHEMOTHERAPY					43,644	53,358	90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency	125,868		54,827		247,979	303,177	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)	4,572,357	819,779	1,912,681	827,754	2,324,196	1,859,659	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,082		2,214		4,794		190
192	Physicians' Private Offices	311,537		135,702				192
192.01	OTHER NON-REIMBURSABLE							192.01
192.02	NEPHROLOGY					33,107		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)	4,888,976	819,779	2,050,597	827,754	2,362,097	1,859,659	202

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	908,647						14
15	Pharmacy		1,952,875					15
16	Medical Records & Library			2,416,941				16
17	Social Service				1,458,025			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					486,310		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	71,634		202,681	695,634	194,524	15,085,843	30
31	Intensive Care Unit	35,040	481	83,703	173,208		4,734,839	31
40	Subprovider - IPF	5,561		98,344	437,117		6,661,711	40
43	Nursery	6,502		34,246	152,066		2,029,965	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		246	222,393			3,193,420	50
51	Recovery Room	2,563	55	7,813			561,622	51
52	Delivery Room & Labor Room	63,555		72,111			5,244,260	52
53	Anesthesiology	26,578	633	50,481			1,493,239	53
54	Radiology-Diagnostic			147,462			5,138,775	54
57	CT Scan	16,398		153,829			1,246,652	57
58	MRI	2,621		19,026			291,493	58
60	Laboratory			197,283			5,305,237	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			19,110			759,207	63
65	Respiratory Therapy			96,701			1,345,002	65
66	Physical Therapy			65,743			2,094,317	66
69	Electrocardiology	3,705		43,961			661,159	69
70	Electroencephalography	678		9,261			149,735	70
71	Medical Supplies Charged to Patients	415,518		49,854			3,037,759	71
72	Impl. Dev. Charged to Patients	200,638		17,415			1,460,150	72
73	Drugs Charged to Patients		1,950,918	347,201			7,634,064	73
75	ASC (Non-Distinct Part)	1,358		4,599			781,981	75
76	HEMODIALYSIS			3,416			434,606	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	13,493		30,519		97,262	3,936,750	90
90.01	CHEMOTHERAPY	10,983		28,463			922,400	90.01
90.02	KEDZIE CLINIC			32,058			1,471,100	90.02
90.03	LITTLE VILLAGE CLINIC	3,586		56,202			2,026,988	90.03
91	Emergency		542	323,066		194,524	9,377,433	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)	880,411	1,952,875	2,416,941	1,458,025	486,310	87,079,707	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						148,276	190
192	Physicians' Private Offices	5,338					2,504,414	192
192.01	OTHER NON-REIMBURSABLE	43					208,229	192.01
192.02	NEPHROLOGY	22,855					2,229,040	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)	908,647	1,952,875	2,416,941	1,458,025	486,310	92,169,666	202

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	-194,524	14,891,319					30
31	Intensive Care Unit		4,734,839					31
40	Subprovider - IPF		6,661,711					40
43	Nursery		2,029,965					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		3,193,420					50
51	Recovery Room		561,622					51
52	Delivery Room & Labor Room		5,244,260					52
53	Anesthesiology		1,493,239					53
54	Radiology-Diagnostic		5,138,775					54
57	CT Scan		1,246,652					57
58	MRI		291,493					58
60	Laboratory		5,305,237					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		759,207					63
65	Respiratory Therapy		1,345,002					65
66	Physical Therapy		2,094,317					66
69	Electrocardiology		661,159					69
70	Electroencephalography		149,735					70
71	Medical Supplies Charged to Patients		3,037,759					71
72	Impl. Dev. Charged to Patients		1,460,150					72
73	Drugs Charged to Patients		7,634,064					73
75	ASC (Non-Distinct Part)		781,981					75
76	HEMODIALYSIS		434,606					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	-97,262	3,839,488					90
90.01	CHEMOTHERAPY		922,400					90.01
90.02	KEDZIE CLINIC		1,471,100					90.02
90.03	LITTLE VILLAGE CLINIC		2,026,988					90.03
91	Emergency	-194,524	9,182,909					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)	-486,310	86,593,397					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		148,276					190
192	Physicians' Private Offices		2,504,414					192
192.01	OTHER NON-REIMBURSABLE		208,229					192.01
192.02	NEPHROLOGY		2,229,040					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)	-486,310	91,683,356					202

	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		13,027	13,027	13,027			4
5	Administrative & General		408,626	408,626	2,399	411,025		5
6	Maintenance & Repairs		123,781	123,781	96	12,821	136,698	6
7	Operation of Plant		408,430	408,430	299	19,909	20,178	7
8	Laundry & Linen Service		57,747	57,747		2,854	2,853	8
9	Housekeeping		29,732	29,732	197	8,732	1,469	9
10	Dietary		59,937	59,937	100	2,618	2,961	10
11	Cafeteria		83,000	83,000	131	9,048	4,100	11
12	Maintenance of Personnel							12
13	Nursing Administration		57,976	57,976	206	6,847	2,864	13
14	Central Services & Supply		85,485	85,485	63	2,378	4,223	14
15	Pharmacy		47,270	47,270	328	7,529	2,335	15
16	Medical Records & Library		60,395	60,395	196	9,393	2,984	16
17	Social Service		16,312	16,312	198	5,940	806	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				500	1,954		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		688,862	688,862	1,296	42,549	34,032	30
31	Intensive Care Unit		93,723	93,723	490	16,272	4,630	31
40	Subprovider - IPF		206,062	206,062	530	19,413	10,180	40
43	Nursery		20,726	20,726	349	6,844	1,024	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		94,769	94,769	315	10,749	4,682	50
51	Recovery Room				77	2,296		51
52	Delivery Room & Labor Room		63,468	63,468	1,084	19,729	3,136	52
53	Anesthesiology		12,226	12,226	401	5,855	604	53
54	Radiology-Diagnostic		175,693	175,693	446	18,460	8,680	54
57	CT Scan				105	4,684		57
58	MRI				31	1,181		58
60	Laboratory		116,524	116,524	358	20,191	5,757	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.				18	3,299		63
65	Respiratory Therapy		21,461	21,461	166	4,946	1,060	65
66	Physical Therapy		28,244	28,244	271	8,294	1,395	66
69	Electrocardiology		16,378	16,378	82	2,332	809	69
70	Electroencephalography		10,346	10,346	11	419	511	70
71	Medical Supplies Charged to Patients					11,471		71
72	Impl. Dev. Charged to Patients					5,539		72
73	Drugs Charged to Patients					23,795		73
75	ASC (Non-Distinct Part)				108	3,190		75
76	HEMODIALYSIS					1,923		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		98,757	98,757	334	13,245	4,879	90
90.01	CHEMOTHERAPY				113	3,505		90.01
90.02	KEDZIE CLINIC				275	6,417		90.02
90.03	LITTLE VILLAGE CLINIC				164	8,773		90.03
91	Emergency		60,722	60,722	914	35,962	3,000	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)		3,159,679	3,159,679	12,651	391,356	129,152	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,452	2,452	11	596	121	190
192	Physicians' Private Offices		150,293	150,293	196	8,454	7,425	192
192.01	OTHER NON-REIMBURSABLE				30	928		192.01
192.02	NEPHROLOGY				139	9,691		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)		3,312,424	3,312,424	13,027	411,025	136,698	202

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	448,816						7
8	Laundry & Linen Service	10,989	74,443					8
9	Housekeeping	5,658		45,788				9
10	Dietary	11,406		1,208	78,230			10
11	Cafeteria	15,794		1,673		113,746		11
12	Maintenance of Personnel							12
13	Nursing Administration	11,032		1,169		4,408	84,502	13
14	Central Services & Supply	16,267		1,723		1,546		14
15	Pharmacy	8,995		953		3,605		15
16	Medical Records & Library	11,493		1,218		3,280		16
17	Social Service	3,104		329		2,919		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					2,320		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	131,082	35,517	13,890	41,670	16,959	19,564	30
31	Intensive Care Unit	17,835	8,844	1,890	10,376	4,552	5,251	31
40	Subprovider - IPF	39,212	22,318	4,154	26,184	9,039	10,428	40
43	Nursery	3,944	7,764	418		2,895	3,340	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,034		1,911		3,895	4,494	50
51	Recovery Room					786	907	51
52	Delivery Room & Labor Room	12,077		1,280		9,311	10,741	52
53	Anesthesiology	2,327		246		1,159	1,337	53
54	Radiology-Diagnostic	33,433		3,542		7,050		54
57	CT Scan					1,253		57
58	MRI					240		58
60	Laboratory	22,174		2,349		5,410		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.					19		63
65	Respiratory Therapy	4,084		433		2,554		65
66	Physical Therapy	5,375		569		2,664		66
69	Electrocardiology	3,117		330		1,198		69
70	Electroencephalography	1,969		209		207		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)					1,315	1,517	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	18,793		1,991		9,294	10,722	90
90.01	CHEMOTHERAPY					2,102	2,425	90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
91	Emergency	11,555		1,224		11,941	13,776	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)	419,749	74,443	42,709	78,230	111,921	84,502	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	467		49		231		190
192	Physicians' Private Offices	28,600		3,030				192
192.01	OTHER NON-REIMBURSABLE							192.01
192.02	NEPHROLOGY					1,594		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)	448,816	74,443	45,788	78,230	113,746	84,502	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	111,685						14
15	Pharmacy		71,015					15
16	Medical Records & Library			88,959				16
17	Social Service				29,608			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					4,774		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,805		7,470	14,127		1,055,823	30
31	Intensive Care Unit	4,307	17	3,085	3,517		174,789	31
40	Subprovider - IPF	684		3,625	8,876		360,705	40
43	Nursery	799		1,262	3,088		52,453	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		9	8,197			147,055	50
51	Recovery Room	315	2	288			4,671	51
52	Delivery Room & Labor Room	7,812		2,658			131,296	52
53	Anesthesiology	3,267	23	1,861			29,306	53
54	Radiology-Diagnostic			5,435			252,739	54
57	CT Scan	2,015		5,670			13,727	57
58	MRI	322		701			2,475	58
60	Laboratory			7,271			180,034	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			704			4,040	63
65	Respiratory Therapy			3,564			38,268	65
66	Physical Therapy			2,423			49,235	66
69	Electrocardiology	455		1,620			26,321	69
70	Electroencephalography	83		341			14,096	70
71	Medical Supplies Charged to Patients	51,074		1,837			64,382	71
72	Impl. Dev. Charged to Patients	24,661		642			30,842	72
73	Drugs Charged to Patients		70,944	12,676			107,415	73
75	ASC (Non-Distinct Part)	167		169			6,466	75
76	HEMODIALYSIS			126			2,049	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	1,658		1,125			160,798	90
90.01	CHEMOTHERAPY	1,350		1,049			10,544	90.01
90.02	KEDZIE CLINIC			1,182			7,874	90.02
90.03	LITTLE VILLAGE CLINIC	441		2,071			11,449	90.03
91	Emergency		20	11,907			151,021	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)	108,215	71,015	88,959	29,608		3,089,873	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						3,927	190
192	Physicians' Private Offices	656					198,654	192
192.01	OTHER NON-REIMBURSABLE	5					963	192.01
192.02	NEPHROLOGY	2,809					14,233	192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments					4,774	4,774	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	111,685	71,015	88,959	29,608	4,774	3,312,424	202

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,055,823					30
31	Intensive Care Unit		174,789					31
40	Subprovider - IPF		360,705					40
43	Nursery		52,453					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		147,055					50
51	Recovery Room		4,671					51
52	Delivery Room & Labor Room		131,296					52
53	Anesthesiology		29,306					53
54	Radiology-Diagnostic		252,739					54
57	CT Scan		13,727					57
58	MRI		2,475					58
60	Laboratory		180,034					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		4,040					63
65	Respiratory Therapy		38,268					65
66	Physical Therapy		49,235					66
69	Electrocardiology		26,321					69
70	Electroencephalography		14,096					70
71	Medical Supplies Charged to Patients		64,382					71
72	Impl. Dev. Charged to Patients		30,842					72
73	Drugs Charged to Patients		107,415					73
75	ASC (Non-Distinct Part)		6,466					75
76	HEMODIALYSIS		2,049					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		160,798					90
90.01	CHEMOTHERAPY		10,544					90.01
90.02	KEDZIE CLINIC		7,874					90.02
90.03	LITTLE VILLAGE CLINIC		11,449					90.03
91	Emergency		151,021					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)		3,089,873					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3,927					190
192	Physicians' Private Offices		198,654					192
192.01	OTHER NON-REIMBURSABLE		963					192.01
192.02	NEPHROLOGY		14,233					192.02
194	OTHER NONREIMBURSABLE COST CENTERS							194
200	Cross Foot Adjustments		4,774					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,312,424					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	52,806,716					4
5	Administrative & General	25,000	9,787,338	-23,723,113	68,446,553			5
6	Maintenance & Repairs	7,573	387,754		2,135,009	169,286		6
7	Operation of Plant	24,988	1,209,193		3,315,481	24,988	144,298	7
8	Laundry & Linen Service	3,533			475,330	3,533	3,533	8
9	Housekeeping	1,819	796,269		1,454,096	1,819	1,819	9
10	Dietary	3,667	403,272		436,002	3,667	3,667	10
11	Cafeteria	5,078	529,008		1,506,667	5,078	5,078	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,547	832,296		1,140,185	3,547	3,547	13
14	Central Services & Supply	5,230	255,048		396,061	5,230	5,230	14
15	Pharmacy	2,892	1,328,598		1,253,714	2,892	2,892	15
16	Medical Records & Library	3,695	794,725		1,564,210	3,695	3,695	16
17	Social Service	998	799,674		989,098	998	998	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		2,023,531		325,356			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,145	5,245,431		7,085,281	42,145	42,145	30
31	Intensive Care Unit	5,734	1,984,586		2,709,698	5,734	5,734	31
40	Subprovider - IPF	12,607	2,147,002		3,232,874	12,607	12,607	40
43	Nursery	1,268	1,412,309		1,139,777	1,268	1,268	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,798	1,274,089		1,790,077	5,798	5,798	50
51	Recovery Room		312,606		382,371			51
52	Delivery Room & Labor Room	3,883	4,388,547		3,285,362	3,883	3,883	52
53	Anesthesiology	748	1,623,926		975,029	748	748	53
54	Radiology-Diagnostic	10,749	1,807,144		3,074,074	10,749	10,749	54
57	CT Scan		426,225		780,049			57
58	MRI		124,923		196,683			58
60	Laboratory	7,129	1,449,334		3,362,395	7,129	7,129	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		71,034		549,311			63
65	Respiratory Therapy	1,313	672,032		823,639	1,313	1,313	65
66	Physical Therapy	1,728	1,097,958		1,381,152	1,728	1,728	66
69	Electrocardiology	1,002	333,057		388,292	1,002	1,002	69
70	Electroencephalography	633	46,518		69,778	633	633	70
71	Medical Supplies Charged to Patients				1,910,293			71
72	Impl. Dev. Charged to Patients				922,400			72
73	Drugs Charged to Patients				3,962,552			73
75	ASC (Non-Distinct Part)		438,533		531,203			75
76	HEMODIALYSIS		50		320,208			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	1,351,998		2,205,585	6,042	6,042	90
90.01	CHEMOTHERAPY		457,237		583,660			90.01
90.02	KEDZIE CLINIC		1,114,064		1,068,654			90.02
90.03	LITTLE VILLAGE CLINIC		663,619		1,460,872			90.03
91	Emergency	3,715	3,698,541		5,988,712	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	51,287,469	-23,723,113	65,171,190	159,941	134,953	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	150	42,521		99,242	150	150	190
192	Physicians' Private Offices	9,195	793,886		1,407,759	9,195	9,195	192
192.01	OTHER NON-REIMBURSABLE		119,579		154,602			192.01
192.02	NEPHROLOGY		563,261		1,613,760			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)	3,312,424	5,904,345		23,723,113	2,874,988	4,888,976	202
203	Unit Cost Multiplier (Wkst. B, Part I)	16.345058	0.111810		0.346593	16.983023	33.881107	203

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)		13,027		411,025	136,698	448,816	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.000247		0.006005	0.807497	3.110341	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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	27,585						8
9	Housekeeping		138,946					9
10	Dietary		3,667	74,124				10
11	Cafeteria		5,078		47,303			11
12	Maintenance of Personnel							12
13	Nursing Administration		3,547		1,833	30,461		13
14	Central Services & Supply		5,230		643		4,177,357	14
15	Pharmacy		2,892		1,499			15
16	Medical Records & Library		3,695		1,364			16
17	Social Service		998		1,214			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				965			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,161	42,145	39,483	7,052	7,052	329,324	30
31	Intensive Care Unit	3,277	5,734	9,831	1,893	1,893	161,092	31
40	Subprovider - IPF	8,270	12,607	24,810	3,759	3,759	25,565	40
43	Nursery	2,877	1,268		1,204	1,204	29,892	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,798		1,620	1,620		50
51	Recovery Room				327	327	11,781	51
52	Delivery Room & Labor Room		3,883		3,872	3,872	292,182	52
53	Anesthesiology		748		482	482	122,187	53
54	Radiology-Diagnostic		10,749		2,932			54
57	CT Scan				521		75,385	57
58	MRI				100		12,050	58
60	Laboratory		7,129		2,250			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.				8			63
65	Respiratory Therapy		1,313		1,062			65
66	Physical Therapy		1,728		1,108			66
69	Electrocardiology		1,002		498		17,031	69
70	Electroencephalography		633		86		3,117	70
71	Medical Supplies Charged to Patients						1,910,293	71
72	Impl. Dev. Charged to Patients						922,400	72
73	Drugs Charged to Patients							73
75	ASC (Non-Distinct Part)				547	547	6,243	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		3,865	3,865	62,032	90
90.01	CHEMOTHERAPY				874	874	50,491	90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC						16,484	90.03
91	Emergency		3,715		4,966	4,966		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)	27,585	129,601	74,124	46,544	30,461	4,047,549	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		150		96			190
192	Physicians' Private Offices		9,195				24,539	192
192.01	OTHER NON-REIMBURSABLE						196	192.01
192.02	NEPHROLOGY				663		105,073	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)	819,779	2,050,597	827,754	2,362,097	1,859,659	908,647	202
203	Unit Cost Multiplier (Wkst. B, Part I)	29.718289	14.758230	11.167152	49.935459	61.050491	0.217517	203

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)	74,443	45,788	78,230	113,746	84,502	111,685	204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.698677	0.329538	1.055394	2.404625	2.774105	0.026736	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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		
	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	3,966,527						15
16	Medical Records & Library		326,314,849					16
17	Social Service			27,585				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		27,363,393	13,161	400	400		30
31	Intensive Care Unit	977	11,300,498	3,277				31
40	Subprovider - IPF		13,277,115	8,270				40
43	Nursery		4,623,452	2,877				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	500	30,024,754					50
51	Recovery Room	112	1,054,787					51
52	Delivery Room & Labor Room		9,735,545					52
53	Anesthesiology	1,286	6,815,377					53
54	Radiology-Diagnostic		19,908,474					54
57	CT Scan		20,768,097					57
58	MRI		2,568,648					58
60	Laboratory		26,634,641					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		2,580,051					63
65	Respiratory Therapy		13,055,297					65
66	Physical Therapy		8,875,834					66
69	Electrocardiology		5,935,108					69
70	Electroencephalography		1,250,278					70
71	Medical Supplies Charged to Patients		6,730,674					71
72	Impl. Dev. Charged to Patients		2,351,150					72
73	Drugs Charged to Patients	3,962,552	46,884,498					73
75	ASC (Non-Distinct Part)		620,851					75
76	HEMODIALYSIS		461,136					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		4,120,349		200	200		90
90.01	CHEMOTHERAPY		3,842,767					90.01
90.02	KEDZIE CLINIC		4,328,120					90.02
90.03	LITTLE VILLAGE CLINIC		7,587,693					90.03
91	Emergency	1,100	43,616,262		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)	3,966,527	326,314,849	27,585	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

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)	1,952,875	2,416,941	1,458,025		486,310		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.492339	0.007407	52.855719		486.310000		203
204	Cost to be allocated (Per Wkst. B, Part II)	71,015	88,959	29,608		4,774		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.017904	0.000273	1.073337		4.774000		205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	14,891,319		14,891,319		14,891,319	30
31	Intensive Care Unit	4,734,839		4,734,839	21,129	4,755,968	31
40	Subprovider - IPF	6,661,711		6,661,711		6,661,711	40
43	Nursery	2,029,965		2,029,965		2,029,965	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,193,420		3,193,420		3,193,420	50
51	Recovery Room	561,622		561,622		561,622	51
52	Delivery Room & Labor Room	5,244,260		5,244,260		5,244,260	52
53	Anesthesiology	1,493,239		1,493,239		1,493,239	53
54	Radiology-Diagnostic	5,138,775		5,138,775		5,138,775	54
57	CT Scan	1,246,652		1,246,652		1,246,652	57
58	MRI	291,493		291,493		291,493	58
60	Laboratory	5,305,237		5,305,237		5,305,237	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	759,207		759,207		759,207	63
65	Respiratory Therapy	1,345,002		1,345,002		1,345,002	65
66	Physical Therapy	2,094,317		2,094,317	4,761	2,099,078	66
69	Electrocardiology	661,159		661,159		661,159	69
70	Electroencephalography	149,735		149,735		149,735	70
71	Medical Supplies Charged to Patients	3,037,759		3,037,759		3,037,759	71
72	Impl. Dev. Charged to Patients	1,460,150		1,460,150		1,460,150	72
73	Drugs Charged to Patients	7,634,064		7,634,064		7,634,064	73
75	ASC (Non-Distinct Part)	781,981		781,981		781,981	75
76	HEMODIALYSIS	434,606		434,606		434,606	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	3,839,488		3,839,488	13,484	3,852,972	90
90.01	CHEMOTHERAPY	922,400		922,400		922,400	90.01
90.02	KEDZIE CLINIC	1,471,100		1,471,100		1,471,100	90.02
90.03	LITTLE VILLAGE CLINIC	2,026,988		2,026,988		2,026,988	90.03
91	Emergency	9,182,909		9,182,909	382,139	9,565,048	91
92	Observation Beds (Non-Distinct Part)	2,207,056		2,207,056		2,207,056	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)	88,800,453		88,800,453	421,513	89,221,966	200
201	Less Observation Beds	2,207,056		2,207,056		2,207,056	201
202	Total (line 200 minus line 201)	86,593,397		86,593,397		87,014,910	202

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	23,877,009		23,877,009				30
31	Intensive Care Unit	11,300,498		11,300,498				31
40	Subprovider - IPF	13,277,115		13,277,115				40
43	Nursery	4,623,452		4,623,452				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,186,490	18,838,264	30,024,754	0.106360	0.106360	0.106360	50
51	Recovery Room	300,706	754,081	1,054,787	0.532451	0.532451	0.532451	51
52	Delivery Room & Labor Room	8,014,567	1,720,978	9,735,545	0.538671	0.538671	0.538671	52
53	Anesthesiology	2,586,883	4,228,494	6,815,377	0.219099	0.219099	0.219099	53
54	Radiology-Diagnostic	3,118,086	16,790,388	19,908,474	0.258120	0.258120	0.258120	54
57	CT Scan	5,298,502	15,469,595	20,768,097	0.060027	0.060027	0.060027	57
58	MRI	570,197	1,998,451	2,568,648	0.113481	0.113481	0.113481	58
60	Laboratory	11,325,682	15,308,959	26,634,641	0.199186	0.199186	0.199186	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,947,549	632,502	2,580,051	0.294260	0.294260	0.294260	63
65	Respiratory Therapy	11,768,701	1,286,596	13,055,297	0.103023	0.103023	0.103023	65
66	Physical Therapy	667,105	8,208,729	8,875,834	0.235957	0.235957	0.236494	66
69	Electrocardiology	2,250,824	3,684,284	5,935,108	0.111398	0.111398	0.111398	69
70	Electroencephalography	141,444	1,108,834	1,250,278	0.119761	0.119761	0.119761	70
71	Medical Supplies Charged to Patients	3,738,624	2,992,050	6,730,674	0.451331	0.451331	0.451331	71
72	Impl. Dev. Charged to Patients	1,505,093	846,057	2,351,150	0.621037	0.621037	0.621037	72
73	Drugs Charged to Patients	16,549,556	30,334,942	46,884,498	0.162827	0.162827	0.162827	73
75	ASC (Non-Distinct Part)	2,168	618,683	620,851	1.259531	1.259531	1.259531	75
76	HEMODIALYSIS	416,796	44,340	461,136	0.942468	0.942468	0.942468	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	2,000	4,118,349	4,120,349	0.931836	0.931836	0.935108	90
90.01	CHEMOTHERAPY	3,195	3,839,572	3,842,767	0.240035	0.240035	0.240035	90.01
90.02	KEDZIE CLINIC		4,328,120	4,328,120	0.339894	0.339894	0.339894	90.02
90.03	LITTLE VILLAGE CLINIC		7,587,693	7,587,693	0.267142	0.267142	0.267142	90.03
91	Emergency	7,362,035	36,254,227	43,616,262	0.210539	0.210539	0.219300	91
92	Observation Beds (Non-Distinct Part)		3,486,384	3,486,384	0.633050	0.633050	0.633050	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)	141,834,277	184,480,572	326,314,849				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	141,834,277	184,480,572	326,314,849				202

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	14,891,319		14,891,319		14,891,319	30
31	Intensive Care Unit	4,734,839		4,734,839	21,129	4,755,968	31
40	Subprovider - IPF	6,661,711		6,661,711		6,661,711	40
43	Nursery	2,029,965		2,029,965		2,029,965	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,193,420		3,193,420		3,193,420	50
51	Recovery Room	561,622		561,622		561,622	51
52	Delivery Room & Labor Room	5,244,260		5,244,260		5,244,260	52
53	Anesthesiology	1,493,239		1,493,239		1,493,239	53
54	Radiology-Diagnostic	5,138,775		5,138,775		5,138,775	54
57	CT Scan	1,246,652		1,246,652		1,246,652	57
58	MRI	291,493		291,493		291,493	58
60	Laboratory	5,305,237		5,305,237		5,305,237	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	759,207		759,207		759,207	63
65	Respiratory Therapy	1,345,002		1,345,002		1,345,002	65
66	Physical Therapy	2,094,317		2,094,317	4,761	2,099,078	66
69	Electrocardiology	661,159		661,159		661,159	69
70	Electroencephalography	149,735		149,735		149,735	70
71	Medical Supplies Charged to Patients	3,037,759		3,037,759		3,037,759	71
72	Impl. Dev. Charged to Patients	1,460,150		1,460,150		1,460,150	72
73	Drugs Charged to Patients	7,634,064		7,634,064		7,634,064	73
75	ASC (Non-Distinct Part)	781,981		781,981		781,981	75
76	HEMODIALYSIS	434,606		434,606		434,606	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	3,839,488		3,839,488	13,484	3,852,972	90
90.01	CHEMOTHERAPY	922,400		922,400		922,400	90.01
90.02	KEDZIE CLINIC	1,471,100		1,471,100		1,471,100	90.02
90.03	LITTLE VILLAGE CLINIC	2,026,988		2,026,988		2,026,988	90.03
91	Emergency	9,182,909		9,182,909	382,139	9,565,048	91
92	Observation Beds (Non-Distinct Part)	2,207,056		2,207,056		2,207,056	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)	88,800,453		88,800,453	421,513	89,221,966	200
201	Less Observation Beds	2,207,056		2,207,056		2,207,056	201
202	Total (line 200 minus line 201)	86,593,397		86,593,397	421,513	87,014,910	202

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **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	23,877,009		23,877,009				30
31	Intensive Care Unit	11,300,498		11,300,498				31
40	Subprovider - IPF	13,277,115		13,277,115				40
43	Nursery	4,623,452		4,623,452				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,186,490	18,838,264	30,024,754	0.106360	0.106360	0.106360	50
51	Recovery Room	300,706	754,081	1,054,787	0.532451	0.532451	0.532451	51
52	Delivery Room & Labor Room	8,014,567	1,720,978	9,735,545	0.538671	0.538671	0.538671	52
53	Anesthesiology	2,586,883	4,228,494	6,815,377	0.219099	0.219099	0.219099	53
54	Radiology-Diagnostic	3,118,086	16,790,388	19,908,474	0.258120	0.258120	0.258120	54
57	CT Scan	5,298,502	15,469,595	20,768,097	0.060027	0.060027	0.060027	57
58	MRI	570,197	1,998,451	2,568,648	0.113481	0.113481	0.113481	58
60	Laboratory	11,325,682	15,308,959	26,634,641	0.199186	0.199186	0.199186	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,947,549	632,502	2,580,051	0.294260	0.294260	0.294260	63
65	Respiratory Therapy	11,768,701	1,286,596	13,055,297	0.103023	0.103023	0.103023	65
66	Physical Therapy	667,105	8,208,729	8,875,834	0.235957	0.235957	0.236494	66
69	Electrocardiology	2,250,824	3,684,284	5,935,108	0.111398	0.111398	0.111398	69
70	Electroencephalography	141,444	1,108,834	1,250,278	0.119761	0.119761	0.119761	70
71	Medical Supplies Charged to Patients	3,738,624	2,992,050	6,730,674	0.451331	0.451331	0.451331	71
72	Impl. Dev. Charged to Patients	1,505,093	846,057	2,351,150	0.621037	0.621037	0.621037	72
73	Drugs Charged to Patients	16,549,556	30,334,942	46,884,498	0.162827	0.162827	0.162827	73
75	ASC (Non-Distinct Part)	2,168	618,683	620,851	1.259531	1.259531	1.259531	75
76	HEMODIALYSIS	416,796	44,340	461,136	0.942468	0.942468	0.942468	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	2,000	4,118,349	4,120,349	0.931836	0.931836	0.935108	90
90.01	CHEMOTHERAPY	3,195	3,839,572	3,842,767	0.240035	0.240035	0.240035	90.01
90.02	KEDZIE CLINIC		4,328,120	4,328,120	0.339894	0.339894	0.339894	90.02
90.03	LITTLE VILLAGE CLINIC		7,587,693	7,587,693	0.267142	0.267142	0.267142	90.03
91	Emergency	7,362,035	36,254,227	43,616,262	0.210539	0.210539	0.219300	91
92	Observation Beds (Non-Distinct Part)		3,486,384	3,486,384	0.633050	0.633050	0.633050	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)	141,834,277	184,480,572	326,314,849				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	141,834,277	184,480,572	326,314,849				202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	3,193,420	147,055	3,046,365		50
51	Recovery Room	561,622	4,671	556,951		51
52	Delivery Room & Labor Room	5,244,260	131,296	5,112,964		52
53	Anesthesiology	1,493,239	29,306	1,463,933		53
54	Radiology-Diagnostic	5,138,775	252,739	4,886,036		54
57	CT Scan	1,246,652	13,727	1,232,925		57
58	MRI	291,493	2,475	289,018		58
60	Laboratory	5,305,237	180,034	5,125,203		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	Blood Storing, Processing & Trans.	759,207	4,040	755,167		63
65	Respiratory Therapy	1,345,002	38,268	1,306,734		65
66	Physical Therapy	2,094,317	49,235	2,045,082		66
69	Electrocardiology	661,159	26,321	634,838		69
70	Electroencephalography	149,735	14,096	135,639		70
71	Medical Supplies Charged to Patients	3,037,759	64,382	2,973,377		71
72	Impl. Dev. Charged to Patients	1,460,150	30,842	1,429,308		72
73	Drugs Charged to Patients	7,634,064	107,415	7,526,649		73
75	ASC (Non-Distinct Part)	781,981	6,466	775,515		75
76	HEMODIALYSIS	434,606	2,049	432,557		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	3,839,488	160,798	3,678,690		90
90.01	CHEMOTHERAPY	922,400	10,544	911,856		90.01
90.02	KEDZIE CLINIC	1,471,100	7,874	1,463,226		90.02
90.03	LITTLE VILLAGE CLINIC	2,026,988	11,449	2,015,539		90.03
91	Emergency	9,182,909	151,021	9,031,888		91
92	Observation Beds (Non-Distinct Part)	2,207,056	156,485	2,050,571		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	60,482,619	1,602,588	58,880,031		200
201	Less Observation Beds	2,207,056	156,485	2,050,571		201
202	Total	58,275,563	1,446,103	56,829,460		202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		3,193,420	30,024,754	0.106360	50
51	Recovery Room		561,622	1,054,787	0.532451	51
52	Delivery Room & Labor Room		5,244,260	9,735,545	0.538671	52
53	Anesthesiology		1,493,239	6,815,377	0.219099	53
54	Radiology-Diagnostic		5,138,775	19,908,474	0.258120	54
57	CT Scan		1,246,652	20,768,097	0.060027	57
58	MRI		291,493	2,568,648	0.113481	58
60	Laboratory		5,305,237	26,634,641	0.199186	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	Blood Storing, Processing & Trans.		759,207	2,580,051	0.294260	63
65	Respiratory Therapy		1,345,002	13,055,297	0.103023	65
66	Physical Therapy		2,094,317	8,875,834	0.235957	66
69	Electrocardiology		661,159	5,935,108	0.111398	69
70	Electroencephalography		149,735	1,250,278	0.119761	70
71	Medical Supplies Charged to Patients		3,037,759	6,730,674	0.451331	71
72	Impl. Dev. Charged to Patients		1,460,150	2,351,150	0.621037	72
73	Drugs Charged to Patients		7,634,064	46,884,498	0.162827	73
75	ASC (Non-Distinct Part)		781,981	620,851	1.259531	75
76	HEMODIALYSIS		434,606	461,136	0.942468	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		3,839,488	4,120,349	0.931836	90
90.01	CHEMOTHERAPY		922,400	3,842,767	0.240035	90.01
90.02	KEDZIE CLINIC		1,471,100	4,328,120	0.339894	90.02
90.03	LITTLE VILLAGE CLINIC		2,026,988	7,587,693	0.267142	90.03
91	Emergency		9,182,909	43,616,262	0.210539	91
92	Observation Beds (Non-Distinct Part)		2,207,056	3,486,384	0.633050	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		60,482,619	273,236,775		200
201	Less Observation Beds		2,207,056	3,486,384		201
202	Total		58,275,563	269,750,391		202

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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)	1,055,823		1,055,823	15,451	68.33	2,106	143,903	30
31	Intensive Care Unit	174,789		174,789	3,277	53.34	801	42,725	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	360,705		360,705	8,270	43.62	1,343	58,582	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	52,453		52,453	2,877	18.23			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,643,770		1,643,770	29,875		4,250	245,210	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** **[ ] 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	147,055	30,024,754	0.004898	711,547	3,485	50
51	Recovery Room	4,671	1,054,787	0.004428	45,310	201	51
52	Delivery Room & Labor Room	131,296	9,735,545	0.013486	15,951	215	52
53	Anesthesiology	29,306	6,815,377	0.004300	264,472	1,137	53
54	Radiology-Diagnostic	252,739	19,908,474	0.012695	665,522	8,449	54
57	CT Scan	13,727	20,768,097	0.000661	1,051,588	695	57
58	MRI	2,475	2,568,648	0.000964	122,581	118	58
60	Laboratory	180,034	26,634,641	0.006759	1,837,171	12,417	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,040	2,580,051	0.001566	315,125	493	63
65	Respiratory Therapy	38,268	13,055,297	0.002931	2,999,614	8,792	65
66	Physical Therapy	49,235	8,875,834	0.005547	201,629	1,118	66
69	Electrocardiology	26,321	5,935,108	0.004435	578,649	2,566	69
70	Electroencephalography	14,096	1,250,278	0.011274	33,849	382	70
71	Medical Supplies Charged to Pat	64,382	6,730,674	0.009565	876,950	8,388	71
72	Impl. Dev. Charged to Patients	30,842	2,351,150	0.013118	317,035	4,159	72
73	Drugs Charged to Patients	107,415	46,884,498	0.002291	2,775,192	6,358	73
75	ASC (Non-Distinct Part)	6,466	620,851	0.010415	1,541	16	75
76	HEMODIALYSIS	2,049	461,136	0.004443	141,888	630	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	160,798	4,120,349	0.039025	1,235	48	90
90.01	CHEMOTHERAPY	10,544	3,842,767	0.002744	2,427	7	90.01
90.02	KEDZIE CLINIC	7,874	4,328,120	0.001819			90.02
90.03	LITTLE VILLAGE CLINIC	11,449	7,587,693	0.001509			90.03
91	Emergency	151,021	43,616,262	0.003462	1,220,105	4,224	91
92	Observation Beds (Non-Distinct	156,485	3,486,384	0.044885			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,602,588	273,236,775		14,179,381	63,898	200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	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

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] 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)	15,451		2,106		30
31	Intensive Care Unit	3,277		801		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	8,270		1,343		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,877				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	29,875		4,250		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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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] 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	30,024,754			711,547		845,130		50
51	Recovery Room	1,054,787			45,310		86,453		51
52	Delivery Room & Labor Room	9,735,545			15,951		3,177		52
53	Anesthesiology	6,815,377			264,472		524,386		53
54	Radiology-Diagnostic	19,908,474			665,522		1,429,569		54
57	CT Scan	20,768,097			1,051,588		1,870,500		57
58	MRI	2,568,648			122,581		368,974		58
60	Laboratory	26,634,641			1,837,171		1,350,001		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,580,051			315,125		74,153		63
65	Respiratory Therapy	13,055,297			2,999,614		223,130		65
66	Physical Therapy	8,875,834			201,629		29,755		66
69	Electrocardiology	5,935,108			578,649		653,932		69
70	Electroencephalography	1,250,278			33,849		209,328		70
71	Medical Supplies Charged to Pat	6,730,674			876,950		218,887		71
72	Impl. Dev. Charged to Patients	2,351,150			317,035		58,664		72
73	Drugs Charged to Patients	46,884,498			2,775,192		9,872,415		73
75	ASC (Non-Distinct Part)	620,851			1,541		82,068		75
76	HEMODIALYSIS	461,136			141,888		16,258		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	4,120,349			1,235		777,951		90
90.01	CHEMOTHERAPY	3,842,767			2,427		1,366,214		90.01
90.02	KEDZIE CLINIC	4,328,120					15,368		90.02
90.03	LITTLE VILLAGE CLINIC	7,587,693					314,124		90.03
91	Emergency	43,616,262			1,220,105		1,722,279		91
92	Observation Beds (Non-Distinct	3,486,384					445,980		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	273,236,775			14,179,381		22,558,696		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	0.106360	845,130			89,888			50
51	Recovery Room	0.532451	86,453			46,032			51
52	Delivery Room & Labor Room	0.538671	3,177			1,711			52
53	Anesthesiology	0.219099	524,386			114,892			53
54	Radiology-Diagnostic	0.258120	1,429,569			369,000			54
57	CT Scan	0.060027	1,870,500			112,281			57
58	MRI	0.113481	368,974			41,872			58
60	Laboratory	0.199186	1,350,001			268,901			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.294260	74,153			21,820			63
65	Respiratory Therapy	0.103023	223,130		291	22,988		30	65
66	Physical Therapy	0.235957	29,755			7,021			66
69	Electrocardiology	0.111398	653,932			72,847			69
70	Electroencephalography	0.119761	209,328			25,069			70
71	Medical Supplies Charged to Pat	0.451331	218,887			98,790			71
72	Impl. Dev. Charged to Patients	0.621037	58,664			36,433			72
73	Drugs Charged to Patients	0.162827	9,872,415		59,712	1,607,496		9,723	73
75	ASC (Non-Distinct Part)	1.259531	82,068			103,367			75
76	HEMODIALYSIS	0.942468	16,258			15,323			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	0.931836	777,951		244	724,923		227	90
90.01	CHEMOTHERAPY	0.240035	1,366,214			327,939			90.01
90.02	KEDZIE CLINIC	0.339894	15,368			5,223			90.02
90.03	LITTLE VILLAGE CLINIC	0.267142	314,124			83,916			90.03
91	Emergency	0.210539	1,722,279			362,607			91
92	Observation Beds (Non-Distinct	0.633050	445,980			282,328			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		22,558,696		60,247	4,842,667		9,980	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		22,558,696		60,247	4,842,667		9,980	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**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	(A)
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	147,055	30,024,754	0.004898	1,834	9	50
51	Recovery Room	4,671	1,054,787	0.004428	335	1	51
52	Delivery Room & Labor Room	131,296	9,735,545	0.013486			52
53	Anesthesiology	29,306	6,815,377	0.004300	1,771	8	53
54	Radiology-Diagnostic	252,739	19,908,474	0.012695	11,818	150	54
57	CT Scan	13,727	20,768,097	0.000661	19,187	13	57
58	MRI	2,475	2,568,648	0.000964	2,067	2	58
60	Laboratory	180,034	26,634,641	0.006759	201,435	1,361	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,040	2,580,051	0.001566	195		63
65	Respiratory Therapy	38,268	13,055,297	0.002931	21,990	64	65
66	Physical Therapy	49,235	8,875,834	0.005547	2,411	13	66
69	Electrocardiology	26,321	5,935,108	0.004435	21,083	94	69
70	Electroencephalography	14,096	1,250,278	0.011274	3,070	35	70
71	Medical Supplies Charged to Pat	64,382	6,730,674	0.009565			71
72	Impl. Dev. Charged to Patients	30,842	2,351,150	0.013118			72
73	Drugs Charged to Patients	107,415	46,884,498	0.002291	222,590	510	73
75	ASC (Non-Distinct Part)	6,466	620,851	0.010415			75
76	HEMODIALYSIS	2,049	461,136	0.004443	7,390	33	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	160,798	4,120,349	0.039025			90
90.01	CHEMOTHERAPY	10,544	3,842,767	0.002744			90.01
90.02	KEDZIE CLINIC	7,874	4,328,120	0.001819			90.02
90.03	LITTLE VILLAGE CLINIC	11,449	7,587,693	0.001509			90.03
91	Emergency	151,021	43,616,262	0.003462	160,883	557	91
92	Observation Beds (Non-Distinct		3,486,384				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,446,103	273,236,775		678,059	2,850	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 [ ] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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 [ ] 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	30,024,754			1,834				50
51	Recovery Room	1,054,787			335				51
52	Delivery Room & Labor Room	9,735,545							52
53	Anesthesiology	6,815,377			1,771				53
54	Radiology-Diagnostic	19,908,474			11,818				54
57	CT Scan	20,768,097			19,187				57
58	MRI	2,568,648			2,067				58
60	Laboratory	26,634,641			201,435				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,580,051			195				63
65	Respiratory Therapy	13,055,297			21,990				65
66	Physical Therapy	8,875,834			2,411				66
69	Electrocardiology	5,935,108			21,083				69
70	Electroencephalography	1,250,278			3,070				70
71	Medical Supplies Charged to Pat	6,730,674							71
72	Impl. Dev. Charged to Patients	2,351,150							72
73	Drugs Charged to Patients	46,884,498			222,590				73
75	ASC (Non-Distinct Part)	620,851							75
76	HEMODIALYSIS	461,136			7,390				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	4,120,349							90
90.01	CHEMOTHERAPY	3,842,767							90.01
90.02	KEDZIE CLINIC	4,328,120							90.02
90.03	LITTLE VILLAGE CLINIC	7,587,693							90.03
91	Emergency	43,616,262			160,883				91
92	Observation Beds (Non-Distinct	3,486,384							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	273,236,775			678,059				200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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	0.106360							50
51	Recovery Room	0.532451							51
52	Delivery Room & Labor Room	0.538671							52
53	Anesthesiology	0.219099							53
54	Radiology-Diagnostic	0.258120							54
57	CT Scan	0.060027							57
58	MRI	0.113481							58
60	Laboratory	0.199186							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.294260							63
65	Respiratory Therapy	0.103023							65
66	Physical Therapy	0.235957							66
69	Electrocardiology	0.111398							69
70	Electroencephalography	0.119761							70
71	Medical Supplies Charged to Pat	0.451331							71
72	Impl. Dev. Charged to Patients	0.621037							72
73	Drugs Charged to Patients	0.162827							73
75	ASC (Non-Distinct Part)	1.259531							75
76	HEMODIALYSIS	0.942468							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	0.931836							90
90.01	CHEMOTHERAPY	0.240035							90.01
90.02	KEDZIE CLINIC	0.339894							90.02
90.03	LITTLE VILLAGE CLINIC	0.267142							90.03
91	Emergency	0.210539							91
92	Observation Beds (Non-Distinct	0.633050							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)	1,055,823		1,055,823	15,451	68.33	2,078	141,990	30
31	Intensive Care Unit	174,789		174,789	3,277	53.34	790	42,139	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	360,705		360,705	8,270	43.62	678	29,574	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	52,453		52,453	2,877	18.23	986	17,975	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,643,770		1,643,770	29,875		4,532	231,678	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	147,055	30,024,754	0.004898			50
51	Recovery Room	4,671	1,054,787	0.004428			51
52	Delivery Room & Labor Room	131,296	9,735,545	0.013486			52
53	Anesthesiology	29,306	6,815,377	0.004300			53
54	Radiology-Diagnostic	252,739	19,908,474	0.012695			54
57	CT Scan	13,727	20,768,097	0.000661			57
58	MRI	2,475	2,568,648	0.000964			58
60	Laboratory	180,034	26,634,641	0.006759			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,040	2,580,051	0.001566			63
65	Respiratory Therapy	38,268	13,055,297	0.002931			65
66	Physical Therapy	49,235	8,875,834	0.005547			66
69	Electrocardiology	26,321	5,935,108	0.004435			69
70	Electroencephalography	14,096	1,250,278	0.011274			70
71	Medical Supplies Charged to Pat	64,382	6,730,674	0.009565			71
72	Impl. Dev. Charged to Patients	30,842	2,351,150	0.013118			72
73	Drugs Charged to Patients	107,415	46,884,498	0.002291			73
75	ASC (Non-Distinct Part)	6,466	620,851	0.010415			75
76	HEMODIALYSIS	2,049	461,136	0.004443			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	160,798	4,120,349	0.039025			90
90.01	CHEMOTHERAPY	10,544	3,842,767	0.002744			90.01
90.02	KEDZIE CLINIC	7,874	4,328,120	0.001819			90.02
90.03	LITTLE VILLAGE CLINIC	11,449	7,587,693	0.001509			90.03
91	Emergency	151,021	43,616,262	0.003462			91
92	Observation Beds (Non-Distinct	156,485	3,486,384	0.044885			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,602,588	273,236,775				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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	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)	15,451		2,078		30
31	Intensive Care Unit	3,277		790		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	8,270		678		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,877		986		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	29,875		4,532		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 [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [ ] PPS [ ] TEFRA [XX] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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	30,024,754							50
51	Recovery Room	1,054,787							51
52	Delivery Room & Labor Room	9,735,545							52
53	Anesthesiology	6,815,377							53
54	Radiology-Diagnostic	19,908,474							54
57	CT Scan	20,768,097							57
58	MRI	2,568,648							58
60	Laboratory	26,634,641							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,580,051							63
65	Respiratory Therapy	13,055,297							65
66	Physical Therapy	8,875,834							66
69	Electrocardiology	5,935,108							69
70	Electroencephalography	1,250,278							70
71	Medical Supplies Charged to Pat	6,730,674							71
72	Impl. Dev. Charged to Patients	2,351,150							72
73	Drugs Charged to Patients	46,884,498							73
75	ASC (Non-Distinct Part)	620,851							75
76	HEMODIALYSIS	461,136							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	4,120,349							90
90.01	CHEMOTHERAPY	3,842,767							90.01
90.02	KEDZIE CLINIC	4,328,120							90.02
90.03	LITTLE VILLAGE CLINIC	7,587,693							90.03
91	Emergency	43,616,262							91
92	Observation Beds (Non-Distinct	3,486,384							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	273,236,775							200

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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 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	0.106360							50
51	Recovery Room	0.532451							51
52	Delivery Room & Labor Room	0.538671							52
53	Anesthesiology	0.219099							53
54	Radiology-Diagnostic	0.258120							54
57	CT Scan	0.060027							57
58	MRI	0.113481							58
60	Laboratory	0.199186							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.294260							63
65	Respiratory Therapy	0.103023							65
66	Physical Therapy	0.235957							66
69	Electrocardiology	0.111398							69
70	Electroencephalography	0.119761							70
71	Medical Supplies Charged to Pat	0.451331							71
72	Impl. Dev. Charged to Patients	0.621037							72
73	Drugs Charged to Patients	0.162827							73
75	ASC (Non-Distinct Part)	1.259531							75
76	HEMODIALYSIS	0.942468							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	0.931836							90
90.01	CHEMOTHERAPY	0.240035							90.01
90.02	KEDZIE CLINIC	0.339894							90.02
90.03	LITTLE VILLAGE CLINIC	0.267142							90.03
91	Emergency	0.210539							91
92	Observation Beds (Non-Distinct	0.633050							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	147,055	30,024,754	0.004898			50
51	Recovery Room	4,671	1,054,787	0.004428			51
52	Delivery Room & Labor Room	131,296	9,735,545	0.013486			52
53	Anesthesiology	29,306	6,815,377	0.004300			53
54	Radiology-Diagnostic	252,739	19,908,474	0.012695			54
57	CT Scan	13,727	20,768,097	0.000661			57
58	MRI	2,475	2,568,648	0.000964			58
60	Laboratory	180,034	26,634,641	0.006759			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	4,040	2,580,051	0.001566			63
65	Respiratory Therapy	38,268	13,055,297	0.002931			65
66	Physical Therapy	49,235	8,875,834	0.005547			66
69	Electrocardiology	26,321	5,935,108	0.004435			69
70	Electroencephalography	14,096	1,250,278	0.011274			70
71	Medical Supplies Charged to Pat	64,382	6,730,674	0.009565			71
72	Impl. Dev. Charged to Patients	30,842	2,351,150	0.013118			72
73	Drugs Charged to Patients	107,415	46,884,498	0.002291			73
75	ASC (Non-Distinct Part)	6,466	620,851	0.010415			75
76	HEMODIALYSIS	2,049	461,136	0.004443			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	160,798	4,120,349	0.039025			90
90.01	CHEMOTHERAPY	10,544	3,842,767	0.002744			90.01
90.02	KEDZIE CLINIC	7,874	4,328,120	0.001819			90.02
90.03	LITTLE VILLAGE CLINIC	11,449	7,587,693	0.001509			90.03
91	Emergency	151,021	43,616,262	0.003462			91
92	Observation Beds (Non-Distinct		3,486,384				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,446,103	273,236,775				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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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 [ ] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [XX] 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	30,024,754							50
51	Recovery Room	1,054,787							51
52	Delivery Room & Labor Room	9,735,545							52
53	Anesthesiology	6,815,377							53
54	Radiology-Diagnostic	19,908,474							54
57	CT Scan	20,768,097							57
58	MRI	2,568,648							58
60	Laboratory	26,634,641							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,580,051							63
65	Respiratory Therapy	13,055,297							65
66	Physical Therapy	8,875,834							66
69	Electrocardiology	5,935,108							69
70	Electroencephalography	1,250,278							70
71	Medical Supplies Charged to Pat	6,730,674							71
72	Impl. Dev. Charged to Patients	2,351,150							72
73	Drugs Charged to Patients	46,884,498							73
75	ASC (Non-Distinct Part)	620,851							75
76	HEMODIALYSIS	461,136							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	4,120,349							90
90.01	CHEMOTHERAPY	3,842,767							90.01
90.02	KEDZIE CLINIC	4,328,120							90.02
90.03	LITTLE VILLAGE CLINIC	7,587,693							90.03
91	Emergency	43,616,262							91
92	Observation Beds (Non-Distinct	3,486,384							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	273,236,775							200

(A) Worksheet A line numbers

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	0.106360							50
51	Recovery Room	0.532451							51
52	Delivery Room & Labor Room	0.538671							52
53	Anesthesiology	0.219099							53
54	Radiology-Diagnostic	0.258120							54
57	CT Scan	0.060027							57
58	MRI	0.113481							58
60	Laboratory	0.199186							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.294260							63
65	Respiratory Therapy	0.103023							65
66	Physical Therapy	0.235957							66
69	Electrocardiology	0.111398							69
70	Electroencephalography	0.119761							70
71	Medical Supplies Charged to Pat	0.451331							71
72	Impl. Dev. Charged to Patients	0.621037							72
73	Drugs Charged to Patients	0.162827							73
75	ASC (Non-Distinct Part)	1.259531							75
76	HEMODIALYSIS	0.942468							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	0.931836							90
90.01	CHEMOTHERAPY	0.240035							90.01
90.02	KEDZIE CLINIC	0.339894							90.02
90.03	LITTLE VILLAGE CLINIC	0.267142							90.03
91	Emergency	0.210539							91
92	Observation Beds (Non-Distinct	0.633050							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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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)	15,451	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,451	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)	13,161	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)	2,106	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)	14,891,319	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)	14,891,319	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)	14,891,319	37

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)	963.78	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,029,721	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)	2,029,721	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	4,755,968	3,277	1,451.32	801	1,162,507	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)	2,748,592	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,940,820	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	186,628	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	63,898	51
52	Total Program excludable cost (sum of lines 50 and 51)	250,526	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	5,690,294	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] Title XVIII, Part A [ ] Title XIX - I/P | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,290	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					963.78	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,207,056	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	1,055,823	14,891,319	0.070902	2,207,056	156,485	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[XX] 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)	8,270	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,270	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)	8,270	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)	1,343	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)	6,661,711	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)	6,661,711	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)	6,661,711	37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[ ] Title XIX - I/P** **[ ] Hospital** **[XX] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA** **[ ] 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)	805.53	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,081,827	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)	1,081,827	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	129,421	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,211,248	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	58,582	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,850	51
52	Total Program excludable cost (sum of lines 50 and 51)	61,432	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,149,816	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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)	15,451	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,451	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)	13,161	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)	2,078	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)	2,877	15
16	Nursery days (title V or XIX only)	986	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)	14,891,319	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)	14,891,319	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)	14,891,319	37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	963.78	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,002,735	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)	2,002,735	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)	2,029,965	2,877	705.58	986	695,702	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,734,839	3,277	1,444.87	790	1,141,447	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,839,884	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	202,104	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)	202,104	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)					2,290	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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)	8,270	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,270	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)	8,270	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)	678	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)	6,661,711	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)	6,661,711	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)	6,661,711	37

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	805.53	38
39	Program general inpatient routine service cost (line 9 x line 38)	546,149	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)	546,149	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)	546,149	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	29,574	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)	29,574	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** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		4,118,869		30
31	Intensive Care Unit		2,686,294		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.106360	711,547	75,680	50
51	Recovery Room	0.532451	45,310	24,125	51
52	Delivery Room & Labor Room	0.538671	15,951	8,592	52
53	Anesthesiology	0.219099	264,472	57,946	53
54	Radiology-Diagnostic	0.258120	665,522	171,785	54
57	CT Scan	0.060027	1,051,588	63,124	57
58	MRI	0.113481	122,581	13,911	58
60	Laboratory	0.199186	1,837,171	365,939	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.294260	315,125	92,729	63
65	Respiratory Therapy	0.103023	2,999,614	309,029	65
66	Physical Therapy	0.236494	201,629	47,684	66
69	Electrocardiology	0.111398	578,649	64,460	69
70	Electroencephalography	0.119761	33,849	4,054	70
71	Medical Supplies Charged to Patients	0.451331	876,950	395,795	71
72	Impl. Dev. Charged to Patients	0.621037	317,035	196,890	72
73	Drugs Charged to Patients	0.162827	2,775,192	451,876	73
75	ASC (Non-Distinct Part)	1.259531	1,541	1,941	75
76	HEMODIALYSIS	0.942468	141,888	133,725	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	0.935108	1,235	1,155	90
90.01	CHEMOTHERAPY	0.240035	2,427	583	90.01
90.02	KEDZIE CLINIC	0.339894			90.02
90.03	LITTLE VILLAGE CLINIC	0.267142			90.03
91	Emergency	0.219300	1,220,105	267,569	91
92	Observation Beds (Non-Distinct Part)	0.633050			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		14,179,381	2,748,592	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		14,179,381		202

(A) Worksheet A line numbers

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		2,159,214		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.106360	1,834	195	50
51	Recovery Room	0.532451	335	178	51
52	Delivery Room & Labor Room	0.538671			52
53	Anesthesiology	0.219099	1,771	388	53
54	Radiology-Diagnostic	0.258120	11,818	3,050	54
57	CT Scan	0.060027	19,187	1,152	57
58	MRI	0.113481	2,067	235	58
60	Laboratory	0.199186	201,435	40,123	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.294260	195	57	63
65	Respiratory Therapy	0.103023	21,990	2,265	65
66	Physical Therapy	0.236494	2,411	570	66
69	Electrocardiology	0.111398	21,083	2,349	69
70	Electroencephalography	0.119761	3,070	368	70
71	Medical Supplies Charged to Patients	0.451331			71
72	Impl. Dev. Charged to Patients	0.621037			72
73	Drugs Charged to Patients	0.162827	222,590	36,244	73
75	ASC (Non-Distinct Part)	1.259531			75
76	HEMODIALYSIS	0.942468	7,390	6,965	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	0.935108			90
90.01	CHEMOTHERAPY	0.240035			90.01
90.02	KEDZIE CLINIC	0.339894			90.02
90.03	LITTLE VILLAGE CLINIC	0.267142			90.03
91	Emergency	0.219300	160,883	35,282	91
92	Observation Beds (Non-Distinct Part)	0.633050			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		678,059	129,421	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		678,059		202

(A) Worksheet A line numbers

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.106360			50
51	Recovery Room	0.532451			51
52	Delivery Room & Labor Room	0.538671			52
53	Anesthesiology	0.219099			53
54	Radiology-Diagnostic	0.258120			54
57	CT Scan	0.060027			57
58	MRI	0.113481			58
60	Laboratory	0.199186			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.294260			63
65	Respiratory Therapy	0.103023			65
66	Physical Therapy	0.235957			66
69	Electrocardiology	0.111398			69
70	Electroencephalography	0.119761			70
71	Medical Supplies Charged to Patients	0.451331			71
72	Impl. Dev. Charged to Patients	0.621037			72
73	Drugs Charged to Patients	0.162827			73
75	ASC (Non-Distinct Part)	1.259531			75
76	HEMODIALYSIS	0.942468			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	0.931836			90
90.01	CHEMOTHERAPY	0.240035			90.01
90.02	KEDZIE CLINIC	0.339894			90.02
90.03	LITTLE VILLAGE CLINIC	0.267142			90.03
91	Emergency	0.210539			91
92	Observation Beds (Non-Distinct Part)	0.633050			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-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				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.106360			50
51	Recovery Room	0.532451			51
52	Delivery Room & Labor Room	0.538671			52
53	Anesthesiology	0.219099			53
54	Radiology-Diagnostic	0.258120			54
57	CT Scan	0.060027			57
58	MRI	0.113481			58
60	Laboratory	0.199186			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.294260			63
65	Respiratory Therapy	0.103023			65
66	Physical Therapy	0.235957			66
69	Electrocardiology	0.111398			69
70	Electroencephalography	0.119761			70
71	Medical Supplies Charged to Patients	0.451331			71
72	Impl. Dev. Charged to Patients	0.621037			72
73	Drugs Charged to Patients	0.162827			73
75	ASC (Non-Distinct Part)	1.259531			75
76	HEMODIALYSIS	0.942468			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	0.931836			90
90.01	CHEMOTHERAPY	0.240035			90.01
90.02	KEDZIE CLINIC	0.339894			90.02
90.03	LITTLE VILLAGE CLINIC	0.267142			90.03
91	Emergency	0.210539			91
92	Observation Beds (Non-Distinct Part)	0.633050			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)	1,155,923			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,467,771			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)	74,474			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)	102.73			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)	2.33			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.	1.17			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).				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)	2.09			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	3.10			10
11	FTE count for residents in dental and podiatric programs	0.98			11
12	Current year allowable FTE (see instructions)	3.07			12
13	Total allowable FTE count for the prior year	3.61			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	2.70			14
15	Sum of lines 12 through 14 divided by 3	3.13			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	3.13			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.030468			19
20	Prior year resident to bed ratio (see instructions)	0.034906			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.030468			21
22	IME payment adjustment (see instructions)	76,333			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)	1.01			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)	76,333			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)	0.1796			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5705			31
32	Sum of lines 30 and 31	0.7501			32
33	Allowable disproportionate share percentage (see instructions)	0.5109			33
34	Disproportionate share adjustment (see instructions)	590,561			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)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000346851	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,277,431		2,347,035	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	574,038		1,755,453	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,329,491			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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	7,694,553			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)	7,694,553			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	446,487			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)	45,095			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 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)	8,186,135			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	8,186,135			61
62	Deductibles billed to program beneficiaries	529,788			62
63	Coinsurance billed to program beneficiaries	16,714			63
64	Allowable bad debts (see instructions)	354,356			64
65	Adjusted reimbursable bad debts (see instructions)	230,331			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	194,063			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,869,964			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)	19,055			70.93
70.94	HRR adjustment amount (see instructions)	-46,607			70.94
71	Amount due provider (see instructions)	7,842,412			71
71.01	Sequestration adjustment (see instructions)	156,848			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	7,111,194			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	574,370			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	395,897			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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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)	9,980			1
2	Medical and other services reimbursed under OPPS (see instructions)	4,842,667			2
3	OPPS payments	4,583,762			3
4	Outlier payment (see instructions)	15,268			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	9,980			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	60,247			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)	60,247			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)	60,247			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	50,267			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 (see instructions)	9,980			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, 4.01, 8 and 9)	4,599,030			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	952,647			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)	3,656,363			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	30,597			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,686,960			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	3,686,960			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)	411,731			34
35	Adjusted reimbursable bad debts (see instructions)	267,625			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	231,629			36
37	Subtotal (see instructions)	3,954,585			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)	3,954,585			40
40.01	Sequestration adjustment (see instructions)	79,092			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	3,876,507			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-1,014			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

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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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 (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, 4.01, 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
40.02	Demonstration payment adjustment amount after sequestration				40.02
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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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				7,215,791		3,923,904	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	02/01/2018	104,597	02/01/2018	47,397	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		-104,597		-47,397	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)				7,111,194		3,876,507	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		574,370			6.01
	based on the cost report (1)		.02				-1,014	6.02
7	Total Medicare program liability (see instructions)				7,685,564		3,875,493	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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				1,005,032			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)				1,005,032			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		23,209			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,028,241			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.

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)	1,171,557	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)	22.657534	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)	1,171,557	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)	1,171,557	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,171,557	18
19	Deductibles	90,184	19
20	Subtotal (line 18 minus line 19)	1,081,373	20
21	Coinsurance	55,830	21
22	Subtotal (line 20 minus line 21)	1,025,543	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	36,435	23
24	Adjusted reimbursable bad debts (see instructions)	23,683	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,084	25
26	Subtotal (sum of lines 22 and 24)	1,049,226	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)	1,049,226	31
31.01	Sequestration adjustment (see instructions)	20,985	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	1,005,032	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	23,209	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

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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	3,839,884		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	3,839,884		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	3,839,884		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)	3,839,884		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)	3,839,884		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

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	546,149		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	546,149		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	546,149		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)	546,149		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)	546,149		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			2.33	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)			1.17	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)			2.09	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.10	6
7	Enter the lesser of line 5 or line 6			2.09	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	3.10	0.00	3.10	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	2.09	0.00	2.09	9
10	Weighted dental and podiatric resident FTE count for the current year		0.98		10
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.98		10.01
11	Total weighted FTE count	2.09	0.98		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.98	1.63		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.10	1.60		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	1.72	1.40		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	1.72	1.40		17
18	Per resident amount	148,651.43	139,934.19		18
19	Approved amount for resident costs	255,680	195,908	451,588	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)			1.01	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)			451,588	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	4,250			26
27	Total inpatient days (see instructions)	25,356			27
28	Ratio of inpatient days to total inpatient days	0.167613	0.000000		28
29	Program direct GME amount	75,692			29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount			75,692	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)			7,152,068	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)			7,152,068	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			4,852,647	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			4,852,647	44
45	Total reasonable cost (sum of lines 41 and 44)			12,004,715	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.595772	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.404228	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			75,692	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			45,095	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			30,597	50

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)	3,914	8,879		26
27	Total inpatient days (see instructions)	25,356	25,356		27
28	Ratio of inpatient days to total inpatient days	0.154362	0.350174		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

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,779,244				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	121,087,114				4
5	Other receivables	-2,412,904				5
6	Allowances for uncollectible notes and accounts receivable	-94,861,835				6
7	Inventory	1,385,072				7
8	Prepaid expenses					8
9	Other current assets	4,166,727				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	34,143,418				11
	FIXED ASSETS					
12	Land	472,850				12
13	Land improvements	518,789				13
14	Accumulated depreciation					14
15	Buildings	25,376,267				15
16	Accumulated depreciation	-16,269,000				16
17	Leasehold improvements	6,374,331				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	40,452,314				23
24	Accumulated depreciation	-39,116,466				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)	17,809,085				30
	OTHER ASSETS					
31	Investments	30,367,883				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,370,772				34
35	Total other assets (sum of lines 31-34)	35,738,655				35
36	Total assets (sum of lines 11, 30 and 35)	87,691,158				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	4,360,455				37
38	Salaries, wages and fees payable	1,968,186				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,869,564				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	7,706,152				44
45	Total current liabilities (sum of lines 37 thru 44)	15,904,357				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	626,491				47
48	Unsecured loans					48
49	Other long term liabilities	8,804,567				49
50	Total long term liabilities (sum of lines 46 thru 49)	9,431,058				50
51	Total liabilities (sum of lines 45 and 50)	25,335,415				51
	CAPITAL ACCOUNTS					
52	General fund balance	62,355,743				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)	62,355,743				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	87,691,158				60

SAINT ANTHONY HOSPITAL Provider CCN: 14-0095	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 17:42 Version: 2018.04 (09/26/2018)

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		61,285,839			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,069,904			2
3	Total (sum of line 1 and line 2)		62,355,743			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)		62,355,743			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)		62,355,743			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	23,957,346		23,957,346	1
2	Subprovider IPF	13,273,925		13,273,925	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)	37,231,271		37,231,271	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	11,106,231		11,106,231	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)	11,106,231		11,106,231	16
17	Total inpatient routine care services (sum of lines 10 and 16)	48,337,502		48,337,502	17
18	Ancillary services	103,200,639		103,200,639	18
19	Outpatient services		221,466,217	221,466,217	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)	151,538,141	221,466,217	373,004,358	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		111,053,942	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)		111,053,942	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	373,004,358	1
2	Less contractual allowances and discounts on patients' accounts	266,066,554	2
3	Net patient revenues (line 1 minus line 2)	106,937,804	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	111,053,942	4
5	Net income from service to patients (line 3 minus line 4)	-4,116,138	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	641,235	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	325	16
17	Revenue from sale of drugs to other than patients	1,501	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)	1,564,355	24
24.01	Other (CSDC MGMT FEES)	822,615	24.01
24.02	Other (EMR INCENTIVE PYMT)	250,474	24.02
24.03	Other (PHO MGMT FEES)	168,000	24.03
24.04	Other (RENTAL REV)	325,408	24.04
24.05	Other (FINANCE DEPT - OTHER OPER REV)	531,705	24.05
24.06	Other (OTHER OP REV)	880,424	24.06
25	Total other income (sum of lines 6-24)	5,186,042	25
26	Total (line 5 plus line 25)	1,069,904	26
29	Net income (or loss) for the period (line 26 minus line 28)	1,069,904	29

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	375,995	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	1,647	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)	46.81	3
4	Number of interns & residents (see instructions)	3.13	4
5	Indirect medical education percentage (see instructions)	1.91	5
6	Indirect medical education adjustment (see instructions)	7,182	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1796	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5705	8
9	Sum of lines 7 and 8	0.7501	9
10	Allowable disproportionate share percentage (see instructions)	0.1640	10
11	Disproportionate share adjustment (see instructions)	61,663	11
12	Total prospective capital payments (see instructions)	446,487	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