KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/29/2017 Time: 07:39 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. CATHERINE HOSPITAL (15-0008) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

CEO
Title

Date

ECR Encryption: 11/29/2017 07:39
geXlionwjbRi0DXzvFQMICDKZ.FQk0
eSt:p09MD19p5opNICofA3dNFqf4g8
JS1T1cdfJu0SvsaK

PI Encryption: 11/29/2017 07:39
Q82LtnjMclTriknkYl:6wmw04rBVO0
r3dl80viw2xMTCLZK4V4Ul7WXLnzk.
HoS50WIPyG0firlO

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		411,072	-97,740			1
2	SUBPROVIDER - IPF		16,721				2
3	SUBPROVIDER - IRF		109,996	-120			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		537,789	-97,860			200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 4321 FIR STREET	P.O. Box:		1
2	City: EAST CHICAGO	State: IN	ZIP Code: 46312	County: LAKE 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. CATHERINE HOSPITAL	15-0008	23844	1	07 / 01 / 1966	N	P	P	3
4	Subprovider - IPF	ST. CATHERINE HOSPITAL OA BHS	15-S008	23844	4	07 / 01 / 2015	N	P	P	4
5	Subprovider - IRF	ST. CATHERINE HOSPITAL - REHAB	15-T008	23844	5	01 / 01 / 2002	N	P	P	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	ST. CATHERINE HHA	15-7453	23844		01 / 01 / 1996	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017	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.	3	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.	1,276	111	156	721	9,725		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.	22	289		11	710		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	Y	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N			76

Long Term Care Hospital PPS

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

TEFRA Providers

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	15H054	140

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

141	Name: NAME: COMMUNITY FOUNDATION OF	Contractor's Name: WPS	Contractor's Number: 08001	141
142	Street: STREET: 10010 DONALD S POWERS	P.O. Box: STE 201		142
143	City: CITY: MUNSTER	State: IN	ZIP Code: 46321	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.	Y	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	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.	N		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)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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	10/05/2017	Y	10/05/2017	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: JANE	Last name: BACHMANN	Title: CONSULTANT	41
42	Employer: BACHMANN ASSOCIATES			42
43	Phone number: 3122852828	E-mail Address: JBOPIL@ATT.NET		43

						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	149	54,385			9,069	963	26,772	1
2	HMO and other (see instructions)						3,967	10,489		2
3	HMO IPF Subprovider						428	124		3
4	HMO IRF Subprovider						663	1,010		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)		149	54,385			9,069	963	26,772	7
8	Intensive Care Unit	31	16	5,840			1,044	93	2,698	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						220	1,192	13
14	Total (see instructions)		165	60,225			10,113	1,276	30,662	14
15	CAH Visits									15
16	Subprovider - IPF	40	16	5,840			2,093	133	3,065	16
17	Subprovider - IRF	41	30	10,950			5,304	22	7,496	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					11,680		22,161	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)		211							27
28	Observation Bed Days								6,776	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							224	261	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,118	243	6,307	1
2	HMO and other (see instructions)					640	2,162		2
3	HMO IPF Subprovider						19		3
4	HMO IRF Subprovider						94		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)		867.61			2,118	243	6,307	14
15	CAH Visits								15
16	Subprovider - IPF		22.23			197	13	290	16
17	Subprovider - IRF		38.71			515	3	725	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		15.91						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)		944.46						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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	57,875,752		57,875,752	1,808,930.00	31.99	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B		720,527		720,527	6,627.00	108.73	3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		2,294,825		2,294,825	16,839.00	136.28	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)		4,755,924		4,755,924	118,463.00	40.15	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		558,643		558,643	3,423.00	163.20	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)		12,609,093		12,609,093			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		911,797		911,797			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		141,910		141,910			21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		307,092		307,092			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							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		526,151		526,151	12,881.00	40.85	26
27	Administrative & General		5,485,681		5,485,681	176,024.00	31.16	27
28	Administrative & General under contract (see instructions)		1,782,061		1,782,061	12,506.00	142.50	28
29	Maintenance & Repairs		1,169,715		1,169,715	41,662.00	28.08	29
30	Operation of Plant		849,027		849,027	16,712.00	50.80	30
31	Laundry & Linen Service		95,558		95,558	6,382.00	14.97	31
32	Housekeeping		1,766,907		1,766,907	107,350.00	16.46	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		1,634,095	-937,971	696,124	39,873.00	17.46	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			937,971	937,971	53,748.00	17.45	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,099,143		1,099,143	28,138.00	39.06	38
39	Central Services and Supply							39
40	Pharmacy		1,633,856		1,633,856	37,006.00	44.15	40
41	Medical Records & Medical Records Library		107,162		107,162	3,687.00	29.06	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	56,642,461		56,642,461	1,797,970.00	31.50	1
2	Excluded area salaries (see instructions)	4,755,924		4,755,924	118,463.00	40.15	2
3	Subtotal salarles (line 1 minus line 2)	51,886,537		51,886,537	1,679,507.00	30.89	3
4	Subtotal other wages & related costs (see instructions)	558,643		558,643	3,423.00	163.20	4
5	Subtotal wage-related costs (see instructions)	12,609,093		12,609,093		24.30%	5
6	Total (sum of lines 3 through 5)	65,054,273		65,054,273	1,682,930.00	38.66	6
7	Total overhead cost (see instructions)	16,149,356		16,149,356	535,969.00	30.13	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	972,062	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	1,462,574	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)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	53,231	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	113,063	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	633,654	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	2,789,402	17
18	Medicare Taxes - Employers Portion Only	686,775	18
19	Unemployment Insurance	43,770	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	41,007	23
24	Total Wage Related cost (Sum of lines 1-23)	6,795,538	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

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	856,771		1
2	Hospital	856,771		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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 15-7453** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County: LAKE

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours		2,371		1,595	3,966	1
2	Unduplicated Census Count (see instructions)		271.00		220.00	579.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)	1.04		1.04	4
5	Other Administrative Personnel	5.40	0.02	5.42	5
6	Direct Nursing Service	6.24		6.24	6
7	Nursing Supervisor	1.02		1.02	7
8	Physical Therapy Service	0.08	2.08	2.16	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service		0.78	0.78	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service		0.09	0.09	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.01		0.01	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	2.19		2.19	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	23844	20

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	5,358	841	70	80	6,349	21
22	Skilled Nursing Visit Charges	902,702	140,413	11,742	13,496	1,068,353	22
23	Physical Therapy Visits	1,832	212	7	22	2,073	23
24	Physical Therapy Visit Charges	360,300	41,316	1,361	4,426	407,403	24
25	Occupational Therapy Visits	663	84		5	752	25
26	Occupational Therapy Visit Charges	129,618	16,442		975	147,035	26
27	Speech Pathology Visits	117	10			127	27
28	Speech Pathology Visit Charges	22,959	1,962			24,921	28
29	Medical Social Service Visits	8				8	29
30	Medical Social Service Visit Charges	1,774				1,774	30
31	Home Health Aide Visits	1,765	569	2	35	2,371	31
32	Home Health Aide Visit Charges	222,009	70,605	258	4,401	297,273	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	9,743	1,716	79	142	11,680	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	1,639,362	270,738	13,361	23,298	1,946,759	35
36	Total Number of Episodes (standard/non-outlier)	399		28	10	437	36
37	Total Number of Ourlier Episodes		40		1	41	37
38	Total Non-Routine Medical Supply Charges	144,247	44,549	3,714	14,516	207,026	38

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)	0.259815	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	31,748,644	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	13,231,469	5
6	Medicaid charges	176,188,070	6
7	Medicaid cost (line 1 times line 6)	45,776,303	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.	796,190	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)	6,129	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)	38,915	14
15	State or local indigent care program cost (line 1 times line 14)	10,111	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.	3,982	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)	800,172	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	14,674,262	7,122,537	21,796,799	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,812,593	7,122,537	10,935,130	21
22	Payments received from patients for amounts previously written off as charity care	44,961	682,633	727,594	22
23	Cost of charity care (line 21 minus line 22)	3,767,632	6,439,904	10,207,536	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)	5,437,656	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	722,728	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,111,890	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	4,325,766	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,513,061	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	11,720,597	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,520,769	31

		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				2,646,696	2,646,696	681,327	3,328,023	1
2	00200	Cap Rel Costs-Mvble Equip				3,710,739	3,710,739	998,689	4,709,428	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	86,960	-1,324,998	-1,238,038	9,488,538	8,250,500	-133,683	8,116,817	4
4.01	00401	MAINTENANCE OF PERSONNEL	439,191	437,600	876,791	-195,659	681,132	-215	680,917	4.01
5.01	00540	NONPATIENT TELEPHONES						603,410	603,410	5.01
5.02	00560	PURCHASING RECEIVING & STORES	305,697	233,060	538,757	-55,561	483,196	-5,669	477,527	5.02
5.03	00570	ADMITTING	974,867	363,191	1,338,058	-208,708	1,129,350		1,129,350	5.03
5.04	00580	CASHIERING ACCOUNTS RECEIVABLE						2,436,771	2,436,771	5.04
5.05	00590	OTHER ADMIN & GENERAL	4,205,117	98,828,431	103,033,548	-1,689,884	101,343,664	-79,914,873	21,428,791	5.05
6	00600	Maintenance & Repairs	1,169,715	7,937,018	9,106,733	-3,234,914	5,871,819	-6,008	5,865,811	6
7	00700	Operation of Plant	849,027	2,378,102	3,227,129	-141,442	3,085,687	-24,110	3,061,577	7
8	00800	Laundry & Linen Service	95,558	559,132	654,690	-39,022	615,668	-39,804	575,864	8
9	00900	Housekeeping	1,766,907	1,057,749	2,824,656	-506,819	2,317,837		2,317,837	9
10	01000	Dietary	1,634,095	1,860,688	3,494,783	-2,352,701	1,142,082		1,142,082	10
11	01100	Cafeteria				2,006,005	2,006,005	-835,473	1,170,532	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,099,143	552,956	1,652,099	-266,634	1,385,465	-5,175	1,380,290	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	1,633,856	6,324,241	7,958,097	-5,102,792	2,855,305		2,855,305	15
16	01600	Medical Records & Library	107,162	123,199	230,361	-15,294	215,067	2,599,709	2,814,776	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	13,323,868	6,640,228	19,964,096	-4,610,489	15,353,607	-29,364	15,324,243	30
31	03100	Intensive Care Unit	2,277,410	1,172,478	3,449,888	-508,115	2,941,773	-42,512	2,899,261	31
40	04000	Subprovider - IPF	1,169,151	859,479	2,028,630	-412,694	1,615,936	-275	1,615,661	40
41	04100	Subprovider - IRF	1,988,481	1,625,649	3,614,130	-454,635	3,159,495	-6,604	3,152,891	41
43	04300	Nursery				466,674	466,674		466,674	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	3,392,685	8,521,190	11,913,875	-4,410,447	7,503,428	-725,557	6,777,871	50
51	05100	Recovery Room	349,630	101,151	450,781	-38,090	412,691		412,691	51
52	05200	Delivery Room & Labor Room				1,386,163	1,386,163		1,386,163	52
53	05300	Anesthesiology	2,318,565	829,091	3,147,656	-256,148	2,891,508	-2,676,572	214,936	53
54	05400	Radiology-Diagnostic	1,763,167	1,539,353	3,302,520	-866,806	2,435,714	-28,785	2,406,929	54
54.01	05401	ULTRASOUND	394,193	159,493	553,686	-42,336	511,350		511,350	54.01
54.02	03040	AUDIOLOGY								54.02
56	05600	Radioisotope	542,290	544,862	1,087,152	-143,920	943,232		943,232	56
57	05700	CT Scan	466,592	656,015	1,122,607	-393,232	729,375		729,375	57
59	05900	Cardiac Catheterization	1,149,007	4,924,275	6,073,282	-3,976,423	2,096,859	-9,978	2,086,881	59
60	06000	Laboratory	2,476,730	3,312,167	5,788,897	-610,250	5,178,647	-9,964	5,168,683	60
62	06200	Whole Blood & Packed Red Blood Cells	166,794	700,163	866,957	39,895	906,852		906,852	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	06301	NONINVASIVE LAB	676,774	451,798	1,128,572	-158,624	969,948	-99,617	870,331	63.02
65	06500	Respiratory Therapy	1,128,585	579,661	1,708,246	-280,516	1,427,730	-29,916	1,397,814	65
66	06600	Physical Therapy	1,410,047	1,389,500	2,799,547	-208,839	2,590,708	-7,914	2,582,794	66
67	06700	Occupational Therapy	494,622	930,918	1,425,540	-59,291	1,366,249		1,366,249	67
68	06800	Speech Pathology	238,273	266,099	504,372	-29,379	474,993	-53,432	421,561	68
70	07000	Electroencephalography	182,842	148,327	331,169	-51,687	279,482		279,482	70
71	07100	Medical Supplies Charged to Patients				3,711,228	3,711,228		3,711,228	71
72	07200	Impl. Dev. Charged to Patients				4,329,590	4,329,590		4,329,590	72
73	07300	Drugs Charged to Patients		1,371	1,371	4,968,150	4,969,521		4,969,521	73
74	07400	Renal Dialysis		1,215,714	1,215,714	220	1,215,934		1,215,934	74
75.01	03480	ONCOLOGY	313,502	585,225	898,727	-51,955	846,772	-444,673	402,099	75.01
76.97	07697	CARDIAC REHABILITATION	441,005	202,935	643,940	-99,393	544,547	-55,968	488,579	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,251,785	869,503	3,121,288	-388,968	2,732,320	-2,143,792	588,528	90
90.01	09001	OP PSYCH		159,919	159,919		159,919		159,919	90.01
91	09100	Emergency	2,994,167	1,881,625	4,875,792	-659,180	4,216,612	-120,184	4,096,428	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	1,242,266	937,823	2,180,089	-168,723	2,011,366	-1,135	2,010,231	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	57,519,726	160,536,381	218,056,107	64,328	218,120,435	-80,131,346	137,989,089	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices		303,329	303,329	-3,936	299,393		299,393	192
194	07950	OTHER NON REIM COST CENTER								194
194.01	07954	RETAIL PHARMACY	323,667	1,522,846	1,846,513	-58,901	1,787,612		1,787,612	194.01

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194.03	07951	ADVERTISING EXPENSE	32,359	341,182	373,541	-826	372,715		372,715	194.03
194.04	07952	REGENCY HOSPITAL		121,998	121,998	-665	121,333		121,333	194.04
194.05	07953	UNUSED SPACE								194.05
200		TOTAL (sum of lines 118-199)	57,875,752	162,825,736	220,701,488		220,701,488	-80,131,346	140,570,142	200

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	MEDICAL SUPPLIES CHARGED TO PATIENT	A	Medical Supplies Charged to P	71		279,014	1
2							2
3							3
4							4
5			Medical Supplies Charged to P	71		3,438,192	5
6			Impl. Dev. Charged to Patient	72		4,329,590	6
7							7
500	Total reclassifications					8,046,796	500
	Code Letter - A						
1	DRUGS CHARGED TO PATIENTS	B	Drugs Charged to Patients	73		4,968,150	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
500	Total reclassifications					4,968,150	500
	Code Letter - B						
1	CAFETERIA RECLASS	C	Cafeteria	11	937,971	1,068,034	1
500	Total reclassifications				937,971	1,068,034	500
	Code Letter - C						
1	BUILDING DEPR RECLASS	D	Cap Rel Costs-Bldg & Fixt	1		2,467,744	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
500	Total reclassifications					2,467,744	500
	Code Letter - D						
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Nursery	43	305,671	161,003	1
2			Delivery Room & Labor Room	52	907,936	478,227	2
500	Total reclassifications				1,213,607	639,230	500
	Code Letter - F						
1	RECLASS RENTAL EQUIPMENT	G	Cap Rel Costs-Mvble Equip	2		692,587	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
500	Total reclassifications					692,587	500
	Code Letter - G						
1	RECLASS EQUIPMENT DEPR	H	Cap Rel Costs-Mvble Equip	2		3,018,152	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
500	Total reclassifications					3,018,152	500
	Code Letter - H						
1	RECLASS PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		178,952	1
500	Total reclassifications					178,952	500
	Code Letter - J						
1	RECLASS FRINGE BENEFITS	L	Employee Benefits Department	4		8,117,128	1
2	257	L	Employee Benefits Department	4		1,387,052	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
40							40
500	Total reclassifications					9,504,180	500
	Code Letter - L						
1	RECLASS SERVICE CONTRACT COSTS	M	Operation of Plant	7		47,841	1
2			Operating Room	50		332,791	2
3			Radiology-Diagnostic	54		149,111	3
4			ULTRASOUND	54.01		12,742	4
5			CT Scan	57		79,224	5
6			Cardiac Catheterization	59		214,907	6
500	Total reclassifications					836,616	500
	Code Letter - M						
1	RECLASS REPAIRS/MAINTENCE COSTS	N	MAINTENANCE OF PERSONNEL	4.01		450	1
2			OTHER ADMIN & GENERAL	5.05		14,201	2
3			Operation of Plant	7		54,889	3
4			Housekeeping	9		5,391	4
5			Dietary	10		142,905	5
6			Nursing Administration	13		7,945	6
7			Pharmacy	15		1,115	7
8			Adults & Pediatrics	30		73,912	8
9			Intensive Care Unit	31		28,334	9
10			Subprovider - IPF	40		2,974	10
11			Subprovider - IRF	41		9,420	11
12			Operating Room	50		354,649	12
13			Anesthesiology	53		4,420	13
14			Radiology-Diagnostic	54		120,912	14
15			ULTRASOUND	54.01		38,397	15
16			Radioisotope	56		4,525	16
17			CT Scan	57		11,093	17
18			Cardiac Catheterization	59		9,694	18
19			Laboratory	60		22,755	19
20			Whole Blood & Packed Red Bloo	62		94,092	20
21			NONINVASIVE LAB	63.02		75,453	21
22			Respiratory Therapy	65		29,714	22
23			Physical Therapy	66		1,768	23
24			Speech Pathology	68		1,964	24
25			Electroencephalography	70		7,382	25
26			Renal Dialysis	74		220	26
27			ONCOLOGY	75.01		1,407	27
28			CARDIAC REHABILITATION	76.97		6,583	28
29			Clinic	90		4,320	29
30			Emergency	91		19,346	30
500	Total reclassifications					1,150,230	500
	Code Letter - N						
	GRAND TOTAL (Increases)				2,151,578	32,570,671	

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	

(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	MEDICAL SUPPLIES CHARGED TO PATIENT	A	Adults & Pediatrics	30		154,649		1
2			Intensive Care Unit	31		58,071		2
3			Subprovider - IRF	41		15,806		3
4			Emergency	91		50,488		4
5			Operating Room	50		3,945,493		5
6			Cardiac Catheterization	59		3,776,076		6
7			Anesthesiology	53		46,213		7
500	Total reclassifications					8,046,796		500
	Code letter - A							
1	DRUGS CHARGED TO PATIENTS	B	Pharmacy	15		4,742,630		1
2			Employee Benefits Department	4		15,283		2
3			Dietary	10		405		3
4			Adults & Pediatrics	30		310		4
5			Subprovider - IPF	40		570		5
6			Operating Room	50		8,995		6
7			Anesthesiology	53		29,980		7
8			Radioisotope	56		58,656		8
9			Respiratory Therapy	65		83,646		9
10			Physical Therapy	66		2,438		10
11			Clinic	90		25,237		11
500	Total reclassifications					4,968,150		500
	Code letter - B							
1	CAFETERIA RECLASS	C	Dietary	10	937,971	1,068,034		1
500	Total reclassifications				937,971	1,068,034		500
	Code letter - C							
1	BUILDING DEPR RECLASS	D	OTHER ADMIN & GENERAL	5.05		827,073	9	1
2			Maintenance & Repairs	6		752,977		2
3			Operation of Plant	7		49,835		3
4			Housekeeping	9		379		4
5			Dietary	10		18,619		5
6			Nursing Administration	13		12,788		6
7			PURCHASING RECEIVING & STORES	5.02		256		7
8			Pharmacy	15		4,905		8
9			Adults & Pediatrics	30		209,691		9
10			Intensive Care Unit	31		10,830		10
11			Subprovider - IPF	40		202,143		11
12			Subprovider - IRF	41		94,630		12
13			Operating Room	50		13,094		13
14			Radiology-Diagnostic	54		78,332		14
15			ULTRASOUND	54.01		1,856		15
16			Radioisotope	56		9,445		16
17			CT Scan	57		31,884		17
18			Cardiac Catheterization	59		74,539		18
19			Laboratory	60		25,471		19
20			NONINVASIVE LAB	63.02		347		20
21			Physical Therapy	66		688		21
22			Electroencephalography	70		2,899		22
23			CARDIAC REHABILITATION	76.97		5,715		23
24			Clinic	90		7,864		24
25			Emergency	91		21,322		25
26			Physicians' Private Offices	192		2,821		26
27			RETAIL PHARMACY	194.01		6,676		27
28			REGENCY HOSPITAL	194.04		665		28
500	Total reclassifications					2,467,744		500
	Code letter - D							
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Adults & Pediatrics	30	305,671	161,003		1
2			Adults & Pediatrics	30	907,936	478,227		2
500	Total reclassifications				1,213,607	639,230		500
	Code letter - F							
1	RECLASS RENTAL EQUIPMENT	G	MAINTENANCE OF PERSONNEL	4.01		138	10	1
2			ADMITTING	5.03		81		2
3			OTHER ADMIN & GENERAL	5.05		15,503		3
4			Maintenance & Repairs	6		33,322		4
5			Operation of Plant	7		24,374		5
6			Laundry & Linen Service	8		17,395		6
7			Dietary	10		26,036		7
8			Nursing Administration	13		5,523		8
9			Medical Supplies Charged to P	71		5,978		9
10			Adults & Pediatrics	30		1,357		10
11			Intensive Care Unit	31		2,995		11

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
12			Subprovider - IPF	40		30		12
13			Subprovider - IRF	41		1,609		13
14			Operating Room	50		225,731		14
15			Radiology-Diagnostic	54		166,306		15
16			ULTRASOUND	54.01		26,913		16
17			Radioisotope	56		2,782		17
18			CT Scan	57		42,072		18
19			Cardiac Catheterization	59		51,304		19
20			Laboratory	60		3,948		20
21			NONINVASIVE LAB	63.02		18,024		21
22			Respiratory Therapy	65		4,288		22
23			Physical Therapy	66		11,823		23
24			Occupational Therapy	67		287		24
25			Speech Pathology	68		14		25
26			Electroencephalography	70		3,350		26
27			Clinic	90		1,210		27
28			Physicians' Private Offices	192		194		28
500	Total reclassifications					692,587		500
	Code letter - G							
1	RECLASS EQUIPMENT DEPR	H	Employee Benefits Department	4		359	9	1
2			ADMITTING	5.03		571		2
3			OTHER ADMIN & GENERAL	5.05		166,694		3
4			Maintenance & Repairs	6		240,489		4
5			Operation of Plant	7		24,131		5
6			Laundry & Linen Service	8		1,069		6
7			Housekeeping	9		16,348		7
8			Dietary	10		37,052		8
9			Nursing Administration	13		84,788		9
10			PURCHASING RECEIVING & STORES	5.02		6,150		10
11			Pharmacy	15		173,988		11
12			Medical Records & Library	16		1,135		12
13			Adults & Pediatrics	30		145,422		13
14			Intensive Care Unit	31		101,350		14
15			Subprovider - IPF	40		28,734		15
16			Subprovider - IRF	41		50,541		16
17			Operating Room	50		359,717		17
18			Recovery Room	51		926		18
19			Anesthesiology	53		50,700		19
20			Radiology-Diagnostic	54		555,010		20
21			ULTRASOUND	54.01		46,418		21
22			Radioisotope	56		37,424		22
23			CT Scan	57		338,262		23
24			Cardiac Catheterization	59		115,586		24
25			Laboratory	60		122,057		25
26			Whole Blood & Packed Red Bloo	62		18,098		26
27			NONINVASIVE LAB	63.02		68,883		27
28			Respiratory Therapy	65		34,612		28
29			Physical Therapy	66		20,028		29
30			Occupational Therapy	67		2,768		30
31			Speech Pathology	68		9,944		31
32			Electroencephalography	70		23,706		32
33			ONCOLOGY	75.01		1,174		33
34			CARDIAC REHABILITATION	76.97		22,226		34
35			Clinic	90		3,321		35
36			Emergency	91		103,336		36
37			Physicians' Private Offices	192		921		37
38			RETAIL PHARMACY	194.01		3,415		38
39			ADVERTISING EXPENSE	194.03		799		39
500	Total reclassifications					3,018,152		500
	Code letter - H							
1	RECLASS PROPERTY INSURANCE	J	OTHER ADMIN & GENERAL	5.05		178,952	12	1
500	Total reclassifications					178,952		500
	Code letter - J							
1	RECLASS FRINGE BENEFITS	L						1
2	257	L	MAINTENANCE OF PERSONNEL	4.01		195,971		2
3			PURCHASING RECEIVING & STORES	5.02		49,155		3
4			ADMITTING	5.03		208,056		4
5			OTHER ADMIN & GENERAL	5.05		515,863		5
6			Maintenance & Repairs	6		221,280		6
7			Operation of Plant	7		145,832		7
8			Laundry & Linen Service	8		20,558		8
9			Housekeeping	9		495,483		9

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
10			Dietary	10		407,489		10
11			Nursing Administration	13		171,480		11
12			Pharmacy	15		182,384		12
13			Medical Records & Library	16		14,159		13
14			Adults & Pediatrics	30		2,320,135		14
15			Intensive Care Unit	31		363,203		15
16			Subprovider - IPF	40		184,191		16
17			Subprovider - IRF	41		301,469		17
18			Operating Room	50		544,857		18
19			Recovery Room	51		37,164		19
20			Anesthesiology	53		133,675		20
21			Radiology-Diagnostic	54		337,181		21
22			ULTRASOUND	54.01		18,288		22
23			Radioisotope	56		40,138		23
24			CT Scan	57		71,331		24
25			Cardiac Catheterization	59		183,519		25
26			Laboratory	60		481,529		26
27			Whole Blood & Packed Red Bloo	62		36,099		27
28			NONINVASIVE LAB	63.02		146,823		28
29			Respiratory Therapy	65		187,684		29
30			Physical Therapy	66		175,630		30
31			Occupational Therapy	67		56,236		31
32			Speech Pathology	68		21,385		32
33			Electroencephalography	70		29,114		33
34			ONCOLOGY	75.01		52,188		34
35			CARDIAC REHABILITATION	76.97		78,035		35
36			Clinic	90		355,656		36
37			Emergency	91		503,380		37
38			Home Health Agency	101		168,723		38
39			RETAIL PHARMACY	194.01		48,810		39
40			ADVERTISING EXPENSE	194.03		27		40
500	Total reclassifications					9,504,180		500
	Code letter - L							
1	RECLASS SERVICE CONTRACT COSTS	M	Maintenance & Repairs	6		836,616		1
2								2
3								3
4								4
5								5
6								6
500	Total reclassifications					836,616		500
	Code letter - M							
1	RECLASS REPAIRS/MAINTENCE COSTS	N	Maintenance & Repairs	6		1,150,230		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
500	Total reclassifications					1,150,230		500
	Code letter - N							

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
	GRAND TOTAL (Decreases)				2,151,578	32,570,671		

(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								1
2	Land Improvements	2,638,270					2,638,270		2
3	Buildings and Fixtures	70,285,982	4,107,414		4,107,414	363,370	74,030,026		3
4	Building Improvements	45,370					45,370		4
5	Fixed Equipment								5
6	Movable Equipment	109,205,493	2,512,965		2,512,965	2,078,632	109,639,826		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	182,175,115	6,620,379		6,620,379	2,442,002	186,353,492		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	182,175,115	6,620,379		6,620,379	2,442,002	186,353,492		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								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								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	76,713,666		76,713,666	0.411657					1
2	Cap Rel Costs-Mvble Equ	109,639,826		109,639,826	0.588343					2
3	Total (sum of lines 1-2)	186,353,492		186,353,492	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	3,149,071			178,952			3,328,023	1
2	Cap Rel Costs-Mvble Equip	4,016,841	692,587					4,709,428	2
3	Total (sum of lines 1-2)	7,165,912	692,587		178,952			8,037,451	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)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-44,130	NONPATIENT TELEPHONES	5.01		7
8	Television and radio service (chapter 21)	A	-448	Cap Rel Costs-Mvble Equip	2	9	8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,422,653				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-450,040				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures	A	564,462	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	76,673	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	OTHER OPERATING REVENUE	B	-39,183	CARDIAC REHABILITATION	76.97		33
33.07	LAB REVENUE	B	-2,480	Laboratory	60		33.07
33.08	OFFSET OTHER INCOME	B	-1,700	Speech Pathology	68		33.08
33.11	OFFSET OTHER INCOME	B	-7,914	Physical Therapy	66		33.11
33.12	OTHER RELEASED TEMP REST OP	B	-2,038	Emergency	91		33.12
33.13	OTHER OPERATING REVENUE	B	-215	MAINTENANCE OF PERSONNEL	4.01		33.13
33.14	OTHER INCOME	B	-4,445	Clinic	90		33.14
33.15	OFFSET OCC HEALTH COSTS FOR BP/US	A	-1,602,701	Clinic	90		33.15
33.16	OFFSET INTERCO REVENUE	B	-99,617	NONINVASIVE LAB	63.02		33.16
33.19	OTHER OPERATING REVENUE	B	-88,806	OTHER ADMIN & GENERAL	5.05		33.19
33.23	OTHER OPER REV	B	-5,669	PURCHASING RECEIVING & STORES	5.02		33.23
33.26	CAFETERIA REVENUE	B	-835,473	Cafeteria	11		33.26
33.28	OTHER OPER REVENUE	B	-24,110	Operation of Plant	7		33.28
33.29	OTHER OPERATING REVENUE	B	-6,008	Maintenance & Repairs	6		33.29
33.30	OTHER OPERATING REVENUE	B	-39,804	Laundry & Linen Service	8		33.30
33.31	OFFSET OTHER REVENUE	B	-6,604	Subprovider - IRF	41		33.31
33.32	OFFSET OTHER REVENUE	B	-34	Intensive Care Unit	31		33.32
33.33	OFFSET OTHER REVENUE	B	-380	Adults & Pediatrics	30		33.33
33.34	RELEASED TEMP REST OP	B	-3,030	Medical Records & Library	16		33.34
33.35	RELEASED TEMP REST OP	B	-7,790	CARDIAC REHABILITATION	76.97		33.35
33.36	OFFSET OTHER INCOME	B	-53,600	OTHER ADMIN & GENERAL	5.05		33.36
33.37	RELEASED TEMP REST INCOME	B	-25,563	OTHER ADMIN & GENERAL	5.05		33.37
34	OFFSET TELEPHONE DEPRECIATION	A	-324	Cap Rel Costs-Mvble Equip	2	9	34
34.01	OFFSET CONTRIBUTIONS	A	-43,117	OTHER ADMIN & GENERAL	5.05		34.01
34.03	OFFSET CAPITATION EXPENSE	A	-68,919,003	OTHER ADMIN & GENERAL	5.05		34.03
35	CRNA SALARIES	A	-720,527	Anesthesiology	53		35
35.01	OFFSET BENEFITS FOR CRNA	A	-133,675	Employee Benefits Department	4		35.01
35.02	OFFSET BENEFITS FOR ANESTHESIOLOGI	A	-151,962	Anesthesiology	53		35.02
36	OFFSET CONTRIBUTIONS	A	-275	Subprovider - IPF	40		36
37	OFFSET CONTRIBUTIONS	A	-31	Clinic	90		37
38							38
38.01	OFFSET OTHER ANEST PHYS COSTS	A	-238,787	Anesthesiology	53		38.01
39	OFFSET FEES FOR ON CALL SURGEONS	A	-708,900	Operating Room	50		39

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
40	MDWISE ADD BACK	A	7,824,715	OTHER ADMIN & GENERAL	5.05		40
41	OFFSET MEDICAID ASSESSMENT	A	-4,453,430	OTHER ADMIN & GENERAL	5.05		41
42	OFFSET OTHER PHYSICIAN EXPENSES	A	-3,675	Adults & Pediatrics	30		42
43							43
43.01	OFFSET OTHER PHYSICIAN EXPENSES	A	-6,192	Clinic	90		43.01
43.02	OFFSET OTHER PHYSICIAN EXPENSES	A	-1,500	OTHER ADMIN & GENERAL	5.05		43.02
44	OFFSET OTHER INCOME	B	-17,511	Radiology-Diagnostic	54		44
45	OFFSET OTHER INCOME	B	-8	Employee Benefits Department	4		45
46	ELIMINATE PHYSICIAN COSTS	A	-6,977,826	OTHER ADMIN & GENERAL	5.05		46
46.02	OFFSET OCC HEALTH PHYS PART B	A	-210	Clinic	90		46.02
46.04	OFFSET ONCOLOGY PHYSICIAN COSTS	A	-444,673	ONCOLOGY	75.01		46.04
47	HHA MARKETING EXPENSE	A	-1,135	Home Health Agency	101		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-80,131,346				50

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

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

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	Cap Rel Costs-Bldg & Fixt	DEPRECIATION BLDG	116,865		116,865	9	1
2	2	Cap Rel Costs-Mvble Equip	DEPRECIATION EQUIP	922,788		922,788	9	2
3	5.05	OTHER ADMIN & GENERAL	A&G OTHER	12,889,915	20,066,658	-7,176,743		3
3.01	5.01	NONPATIENT TELEPHONES	TELECOMMUNICATIONS	647,540		647,540		3.01
3.02	16	Medical Records & Library	MEDICAL RECORDS	2,602,739		2,602,739		3.02
3.03	5.04	CASHIERING ACCOUNTS RECEIVABLE	PATIENT ACCOUNTING	2,436,771		2,436,771		3.03
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			19,616,618	20,066,658	-450,040		5

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

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

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

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

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

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

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

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	5.05	OTHER ADMIN & GENERA	36,049		36,049	211,500	360	36,606	1,830	1
2	13	Nursing Administrati AGGREGATE	43,509	4,068	39,441	211,500	377	38,334	1,917	2
3	16	Medical Records & Li	10,317		10,317	211,500	104	10,575	529	3
4	30	Adults & Pediatrics AGGREGATE	39,850	24,400	15,450	211,500	143	14,541	727	4
5	31	Intensive Care Unit AGGREGATE	42,478	42,478						5
6	50	Operating Room	35,256		35,256	246,400	157	18,599	930	6
7	54	Radiology-Diagnostic	25,000		25,000	271,900	105	13,726	686	7
8	59	Cardiac Catheterizat	20,350		20,350	211,500	102	10,372	519	8
9	60	Laboratory	40,272		40,272	260,300	262	32,788	1,639	9
10	65	Respiratory Therapy AGGREGATE	29,916	29,916						10
11	90	Clinic AGGREGATE	36,248	36,248						11
12										12
13	76.97	CARDIAC REHABILITATI	18,350		18,350	211,500	92	9,355	468	13
14	90	Clinic AGGREGATE	222,171	202,330	19,841	211,500	198	20,133	1,007	14
15	53	Anesthesiology AGGREGATE	1,539,988	1,539,988						15
16	91	Emergency	240,267		240,267	211,500	1,201	122,121	6,106	16
17	90	Clinic OCC HEALTH SALA	291,635	291,635						17
18										18
19	68	Speech Pathology AGGREGATE	51,732	51,732						19
20	53	Anesthesiology	58,050		58,050	211,500	322	32,742	1,637	20
200		TOTAL	2,781,438	2,222,795	558,643		3,423	359,892	17,995	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	5.05	OTHER ADMIN & GENERA					36,606			1
2	13	Nursing Administrati AGGREGATE					38,334	1,107	5,175	2
3	16	Medical Records & Li					10,575			3
4	30	Adults & Pediatrics AGGREGATE					14,541	909	25,309	4
5	31	Intensive Care Unit AGGREGATE							42,478	5
6	50	Operating Room					18,599	16,657	16,657	6
7	54	Radiology-Diagnostic					13,726	11,274	11,274	7
8	59	Cardiac Catheterizat					10,372	9,978	9,978	8
9	60	Laboratory					32,788	7,484	7,484	9
10	65	Respiratory Therapy AGGREGATE							29,916	10
11	90	Clinic AGGREGATE							36,248	11
12										12
13	76.97	CARDIAC REHABILITATI					9,355	8,995	8,995	13
14	90	Clinic AGGREGATE					20,133		202,330	14
15	53	Anesthesiology AGGREGATE							1,539,988	15
16	91	Emergency					122,121	118,146	118,146	16
17	90	Clinic OCC HEALTH SALA							291,635	17
18										18
19	68	Speech Pathology AGGREGATE							51,732	19
20	53	Anesthesiology					32,742	25,308	25,308	20
200		TOTAL					359,892	199,858	2,422,653	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,328,023	3,328,023					1
2	Cap Rel Costs-Mvble Equip	4,709,428		4,709,428				2
4	Employee Benefits Department	8,116,817	1,344	564	8,118,725			4
4.01	MAINTENANCE OF PERSONNEL	680,917	16,100		64,214	761,231		4.01
5.01	NONPATIENT TELEPHONES	603,410	6,368				609,778	5.01
5.02	PURCHASING RECEIVING & STORES	477,527	60,318	9,654	44,696	7,362	3,851	5.02
5.03	ADMITTING	1,129,350	27,199	896	142,534	23,655	13,479	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE	2,436,771						5.04
5.05	OTHER ADMIN & GENERAL	21,428,791	328,076	261,665	614,826	38,386	133,512	5.05
6	Maintenance & Repairs	5,865,811	461,063	377,503	171,023	14,519	4,493	6
7	Operation of Plant	3,061,577	137,994	37,879	124,135	12,899	13,479	7
8	Laundry & Linen Service	575,864	12,845	1,678	13,971	2,110	1,284	8
9	Housekeeping	2,317,837	52,685	25,662	258,338	45,641	7,702	9
10	Dietary	1,142,082	88,406	26,754	101,780	16,187	13,479	10
11	Cafeteria	1,170,532	28,591	3,152	137,140	21,806		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,380,290	19,024	133,094	160,705	10,445	2,567	13
14	Central Services & Supply							14
15	Pharmacy	2,855,305	33,237	273,114	238,884	14,854	21,182	15
16	Medical Records & Library	2,814,776	27,931	1,782	15,668	1,350	12,196	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,324,243	493,239	228,273	1,770,621	184,898	64,829	30
31	Intensive Care Unit	2,899,261	57,481	159,092	332,978	26,706	8,344	31
40	Subprovider - IPF	1,615,661	59,029	45,105	170,940	18,183	8,986	40
41	Subprovider - IRF	3,152,891	113,813	79,336	290,734	31,663	17,331	41
43	Nursery	466,674	13,222		44,692	3,574		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,777,871	247,916	564,659	496,041	40,227	44,931	50
51	Recovery Room	412,691	9,543	1,454	51,119	3,542	2,567	51
52	Delivery Room & Labor Room	1,386,163	39,282		132,748	10,609		52
53	Anesthesiology	214,936	2,516	79,585	8,487		3,851	53
54	Radiology-Diagnostic	2,406,929	70,907	871,212	257,791	26,362	17,972	54
54.01	ULTRASOUND	511,350	8,545	72,864	57,635	3,206	5,135	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	943,232	14,362	58,746	79,288	4,057	5,777	56
57	CT Scan	729,375	9,536	530,980	68,220	4,728	2,567	57
59	Cardiac Catheterization	2,086,881	50,610	181,439	167,995	12,711	29,526	59
60	Laboratory	5,168,683	92,533	191,597	362,120	37,560	37,229	60
62	Whole Blood & Packed Red Blood Cells	906,852	5,786	28,409	24,387	2,487	4,493	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	870,331	16,626	108,128	98,950	9,300	5,135	63.02
65	Respiratory Therapy	1,397,814	19,283	54,331	165,009	15,557	6,419	65
66	Physical Therapy	2,582,794	69,815	31,439	206,162	15,230	23,107	66
67	Occupational Therapy	1,366,249	19,205	4,345	72,318	6,028		67
68	Speech Pathology	421,561	6,132	15,609	34,838	1,996	1,284	68
70	Electroencephalography	279,482	32,459	37,212	26,733	2,626	4,493	70
71	Medical Supplies Charged to Patients	3,711,228						71
72	Impl. Dev. Charged to Patients	4,329,590						72
73	Drugs Charged to Patients	4,969,521						73
74	Renal Dialysis	1,215,934	2,358					74
75.01	ONCOLOGY	402,099	7,838	1,843	45,837	4,351	1,284	75.01
76.97	CARDIAC REHABILITATION	488,579	43,629	34,889	64,479	5,079	3,851	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	588,528	36,507	5,213	329,231	26,256	5,135	90
90.01	OP PSYCH	159,919	4,701					90.01
91	Emergency	4,096,428	79,083	162,210	437,774	38,558	26,959	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,010,231	21,241		181,630	13,014	8,344	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	137,989,089	2,948,378	4,701,367	8,066,671	757,722	566,773	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,781					190
192	Physicians' Private Offices	299,393	223,995	1,446			642	192
194	OTHER NON REIM COST CENTER			5,361				194
194.01	RETAIL PHARMACY	1,787,612	9,292		47,323	3,157		194.01
194.03	ADVERTISING EXPENSE	372,715	7,507	1,254	4,731	352	3,209	194.03
194.04	REGENCY HOSPITAL	121,333	130,070				39,154	194.04

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	140,570,142	3,328,023	4,709,428	8,118,725	761,231	609,778	202

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	
		5.02	5.03	5.04	4A	5.05	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES	603,408						5.02
5.03	ADMITTING	9,802	1,346,915					5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE			2,436,771				5.04
5.05	OTHER ADMIN & GENERAL	19,631			22,824,887	22,824,887		5.05
6	Maintenance & Repairs	114,314			7,008,726	1,358,642	8,367,368	6
7	Operation of Plant	90,628			3,478,591	674,325	475,642	7
8	Laundry & Linen Service	55,055			662,807	128,485	44,275	8
9	Housekeeping	79,979			2,787,844	540,424	181,597	9
10	Dietary	62,912			1,451,600	281,393	304,721	10
11	Cafeteria				1,361,221	263,873	98,548	11
12	Maintenance of Personnel							12
13	Nursing Administration	7,065			1,713,190	332,102	65,572	13
14	Central Services & Supply							14
15	Pharmacy	4,853			3,441,429	667,121	114,562	15
16	Medical Records & Library	759			2,874,462	557,214	96,272	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	36,037	159,682	288,850	18,550,672	3,596,017	1,700,110	30
31	Intensive Care Unit	5,997	15,000	27,134	3,531,993	684,677	198,126	31
40	Subprovider - IPF	2,814	24,601	44,501	1,989,820	385,727	203,464	40
41	Subprovider - IRF	8,498	19,646	35,538	3,749,450	726,831	392,295	41
43	Nursery		3,454	6,248	537,864	104,265	45,575	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,039	121,263	219,352	8,537,299	1,654,955	854,525	50
51	Recovery Room	389	7,723	13,969	502,997	97,506	32,894	51
52	Delivery Room & Labor Room		10,259	18,557	1,597,618	309,698	135,399	52
53	Anesthesiology	1,388	15,724	28,444	354,931	68,803	8,671	53
54	Radiology-Diagnostic	4,686	67,000	121,197	3,844,056	745,170	244,406	54
54.01	ULTRASOUND	335	16,745	30,290	706,105	136,878	29,453	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	777	28,174	50,963	1,185,376	229,785	49,504	56
57	CT Scan	887	88,991	160,977	1,596,261	309,435	32,867	57
59	Cardiac Catheterization	12,140	58,509	105,838	2,705,649	524,490	174,444	59
60	Laboratory	10,316	185,483	335,853	6,421,374	1,244,783	318,947	60
62	Whole Blood & Packed Red Blood Cells	423	7,260	13,133	993,230	192,538	19,943	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,563	37,715	68,222	1,216,970	235,910	57,308	63.02
65	Respiratory Therapy	2,932	29,534	53,424	1,744,303	338,133	66,466	65
66	Physical Therapy	4,733	26,973	48,792	3,009,045	583,303	240,639	66
67	Occupational Therapy	851	15,163	27,429	1,511,588	293,021	66,195	67
68	Speech Pathology	922	3,726	6,739	492,807	95,531	21,135	68
70	Electroencephalography	180	11,942	21,602	416,729	80,783	111,879	70
71	Medical Supplies Charged to Patients	228	28,573	51,686	3,791,715	735,024		71
72	Impl. Dev. Charged to Patients		25,732	46,547	4,401,869	853,302		72
73	Drugs Charged to Patients		143,980	260,446	5,373,947	1,041,740		73
74	Renal Dialysis		11,478	20,763	1,250,533	242,416	8,129	74
75.01	ONCOLOGY	1,922	5,253	9,502	479,929	93,034	27,015	75.01
76.97	CARDIAC REHABILITATION	3,305	1,710	3,092	648,613	125,734	150,383	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	9,836	3,838	6,942	1,011,486	196,077	125,834	90
90.01	OP PSYCH	9	2,078	3,759	170,466	33,045	16,203	90.01
91	Emergency	10,596	163,196	295,205	5,310,009	1,029,345	272,585	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	5,040	6,510	11,777	2,257,787	437,672	73,213	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	597,841	1,346,915	2,436,771	137,497,248	22,229,207	7,058,796	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				8,781	1,702	30,266	190
192	Physicians' Private Offices	224			525,700	101,907	772,072	192
194	OTHER NON REIM COST CENTER				5,361	1,039		194
194.01	RETAIL PHARMACY	273			1,847,657	358,168	32,027	194.01
194.03	ADVERTISING EXPENSE	4,055			393,823	76,343	25,877	194.03
194.04	REGENCY HOSPITAL	1,015			291,572	56,521	448,330	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	
		5.02	5.03	5.04	4A	5.05	6	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	603,408	1,346,915	2,436,771	140,570,142	22,824,887	8,367,368	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
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant	4,628,558						7
8	Laundry & Linen Service	25,968	861,535					8
9	Housekeeping	106,508		3,616,373				9
10	Dietary	178,721		159,686	2,376,121			10
11	Cafeteria	57,799		50,923		1,832,364		11
12	Maintenance of Personnel							12
13	Nursing Administration	38,459		37,692		33,836	2,220,851	13
14	Central Services & Supply							14
15	Pharmacy	67,191		57,462		48,118		15
16	Medical Records & Library	56,464		49,775		4,372		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	997,127	242,676	904,394	1,628,400	598,953	1,021,447	30
31	Intensive Care Unit	116,202	24,733	126,307	78,816	86,511	147,544	31
40	Subprovider - IPF	119,333	44,248	105,949	144,288	58,902	100,449	40
41	Subprovider - IRF	230,084	63,330	200,472	342,453	102,568	174,938	41
43	Nursery	26,730	7,749	25,623		11,579	19,748	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	501,186	114,425	441,563		130,310	222,227	50
51	Recovery Room	19,293	18,766	16,998		11,473	19,581	51
52	Delivery Room & Labor Room	79,412	23,013	68,985		34,366	58,607	52
53	Anesthesiology	5,085		4,480				53
54	Radiology-Diagnostic	143,346	24,724	124,473		85,398		54
54.01	ULTRASOUND	17,275	28,271	15,220		10,387		54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	29,035	8,332	27,163		13,142		56
57	CT Scan	19,277		16,984		15,315		57
59	Cardiac Catheterization	102,313	16,640	90,155		41,176	70,201	59
60	Laboratory	187,065		164,587		121,672		60
62	Whole Blood & Packed Red Blood Cells	11,697		10,305		8,055		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	33,612	14,835	32,413		30,126		63.02
65	Respiratory Therapy	38,983		32,763		50,396		65
66	Physical Therapy	141,137	23,532	123,563		49,336		66
67	Occupational Therapy	38,824		34,205		19,528		67
68	Speech Pathology	12,396		10,739		6,465		68
70	Electroencephalography	65,618	16,839	57,812		8,505		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	4,768		5,279				74
75.01	ONCOLOGY	15,844		13,959		14,096		75.01
76.97	CARDIAC REHABILITATION	88,201	12,181	77,708		16,454	28,044	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	73,802	15,061	66,717		85,054	145,071	90
90.01	OP PSYCH	9,503		5,461				90.01
91	Emergency	159,873	112,394	140,854		124,904	212,994	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	42,940		37,832				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,861,071	811,749	3,338,501	2,193,957	1,820,997	2,220,851	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	17,751		15,640				190
192	Physicians' Private Offices	452,826						192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY	18,784		14,603		10,228		194.01
194.03	ADVERTISING EXPENSE	15,177		13,371		1,139		194.03
194.04	REGENCY HOSPITAL	262,949	49,786	234,258	182,164			194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,628,558	861,535	3,616,373	2,376,121	1,832,364	2,220,851	202

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		15	16	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
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	4,395,883						15
16	Medical Records & Library		3,638,559					16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		431,314	29,671,110		29,671,110		30
31	Intensive Care Unit		40,517	5,035,426		5,035,426		31
40	Subprovider - IPF		66,450	3,218,630		3,218,630		40
41	Subprovider - IRF		53,066	6,035,487		6,035,487		41
43	Nursery		9,329	788,462		788,462		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		327,539	12,784,029		12,784,029		50
51	Recovery Room		20,859	740,367		740,367		51
52	Delivery Room & Labor Room		27,710	2,334,808		2,334,808		52
53	Anesthesiology		42,473	484,443		484,443		53
54	Radiology-Diagnostic		180,972	5,392,545		5,392,545		54
54.01	ULTRASOUND		45,230	988,819		988,819		54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		76,099	1,618,436		1,618,436		56
57	CT Scan		240,372	2,230,511		2,230,511		57
59	Cardiac Catheterization		158,038	3,883,106		3,883,106		59
60	Laboratory		501,443	8,959,871		8,959,871		60
62	Whole Blood & Packed Red Blood Cells		19,610	1,255,378		1,255,378		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		101,870	1,723,044		1,723,044		63.02
65	Respiratory Therapy		79,774	2,350,818		2,350,818		65
66	Physical Therapy		72,857	4,243,412		4,243,412		66
67	Occupational Therapy		40,957	2,004,318		2,004,318		67
68	Speech Pathology		10,063	649,136		649,136		68
70	Electroencephalography		32,256	790,421		790,421		70
71	Medical Supplies Charged to Patients		77,177	4,603,916		4,603,916		71
72	Impl. Dev. Charged to Patients		69,505	5,324,676		5,324,676		72
73	Drugs Charged to Patients	4,395,883	388,900	11,200,470		11,200,470		73
74	Renal Dialysis		31,004	1,542,129		1,542,129		74
75.01	ONCOLOGY		14,189	658,066		658,066		75.01
76.97	CARDIAC REHABILITATION		4,618	1,151,936		1,151,936		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		10,366	1,729,468		1,729,468		90
90.01	OP PSYCH		5,613	240,291		240,291		90.01
91	Emergency		440,804	7,803,762		7,803,762		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		17,585	2,867,029		2,867,029		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,395,883	3,638,559	134,304,320		134,304,320		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			74,140		74,140		190
192	Physicians' Private Offices			1,852,505		1,852,505		192
194	OTHER NON REIM COST CENTER			6,400		6,400		194
194.01	RETAIL PHARMACY			2,281,467		2,281,467		194.01
194.03	ADVERTISING EXPENSE			525,730		525,730		194.03
194.04	REGENCY HOSPITAL			1,525,580		1,525,580		194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		15	16	24	25	26		
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,395,883	3,638,559	140,570,142		140,570,142		202

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	
		0	1	2	2A	4	4.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		1,344	564	1,908	1,908		4
4.01	MAINTENANCE OF PERSONNEL		16,100		16,100	15	16,115	4.01
5.01	NONPATIENT TELEPHONES		6,368		6,368			5.01
5.02	PURCHASING RECEIVING & STORES		60,318	9,654	69,972	10	156	5.02
5.03	ADMITTING		27,199	896	28,095	33	501	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL		328,076	261,665	589,741	143	813	5.05
6	Maintenance & Repairs		461,063	377,503	838,566	40	307	6
7	Operation of Plant		137,994	37,879	175,873	29	273	7
8	Laundry & Linen Service		12,845	1,678	14,523	3	45	8
9	Housekeeping		52,685	25,662	78,347	60	966	9
10	Dietary		88,406	26,754	115,160	24	343	10
11	Cafeteria		28,591	3,152	31,743	32	462	11
12	Maintenance of Personnel							12
13	Nursing Administration		19,024	133,094	152,118	37	221	13
14	Central Services & Supply							14
15	Pharmacy		33,237	273,114	306,351	56	314	15
16	Medical Records & Library		27,931	1,782	29,713	4	29	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		493,239	228,273	721,512	432	3,913	30
31	Intensive Care Unit		57,481	159,092	216,573	77	565	31
40	Subprovider - IPF		59,029	45,105	104,134	40	385	40
41	Subprovider - IRF		113,813	79,336	193,149	68	670	41
43	Nursery		13,222		13,222	10	76	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		247,916	564,659	812,575	115	852	50
51	Recovery Room		9,543	1,454	10,997	12	75	51
52	Delivery Room & Labor Room		39,282		39,282	31	225	52
53	Anesthesiology		2,516	79,585	82,101	2		53
54	Radiology-Diagnostic		70,907	871,212	942,119	60	558	54
54.01	ULTRASOUND		8,545	72,864	81,409	13	68	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		14,362	58,746	73,108	18	86	56
57	CT Scan		9,536	530,980	540,516	16	100	57
59	Cardiac Catheterization		50,610	181,439	232,049	39	269	59
60	Laboratory		92,533	191,597	284,130	84	795	60
62	Whole Blood & Packed Red Blood Cells		5,786	28,409	34,195	6	53	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		16,626	108,128	124,754	23	197	63.02
65	Respiratory Therapy		19,283	54,331	73,614	38	329	65
66	Physical Therapy		69,815	31,439	101,254	48	322	66
67	Occupational Therapy		19,205	4,345	23,550	17	128	67
68	Speech Pathology		6,132	15,609	21,741	8	42	68
70	Electroencephalography		32,459	37,212	69,671	6	56	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis		2,358		2,358			74
75.01	ONCOLOGY		7,838	1,843	9,681	11	92	75.01
76.97	CARDIAC REHABILITATION		43,629	34,889	78,518	15	108	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		36,507	5,213	41,720	77	556	90
90.01	OP PSYCH		4,701		4,701			90.01
91	Emergency		79,083	162,210	241,293	102	816	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		21,241		21,241	42	275	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,948,378	4,701,367	7,649,745	1,896	16,041	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,781		8,781			190
192	Physicians' Private Offices		223,995	1,446	225,441			192
194	OTHER NON REIM COST CENTER			5,361	5,361			194
194.01	RETAIL PHARMACY		9,292		9,292	11	67	194.01
194.03	ADVERTISING EXPENSE		7,507	1,254	8,761	1	7	194.03
194.04	REGENCY HOSPITAL		130,070		130,070			194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	
		0	1	2	2A	4	4.01	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,328,023	4,709,428	8,037,451	1,908	16,115	202

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES	6,368						5.01
5.02	PURCHASING RECEIVING & STORES	40	70,178					5.02
5.03	ADMITTING	141	1,140	29,910				5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	1,394	2,283		594,374			5.05
6	Maintenance & Repairs	47	13,298		35,380	887,638		6
7	Operation of Plant	141	10,540		17,560	50,458	254,874	7
8	Laundry & Linen Service	13	6,403		3,346	4,697	1,430	8
9	Housekeeping	80	9,302		14,073	19,264	5,865	9
10	Dietary	141	7,317		7,328	32,326	9,841	10
11	Cafeteria				6,871	10,454	3,183	11
12	Maintenance of Personnel							12
13	Nursing Administration	27	822		8,648	6,956	2,118	13
14	Central Services & Supply							14
15	Pharmacy	221	564		17,372	12,153	3,700	15
16	Medical Records & Library	127	88		14,510	10,213	3,109	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	677	4,191	3,554	93,638	180,349	54,907	30
31	Intensive Care Unit	87	697	334	17,830	21,018	6,399	31
40	Subprovider - IPF	94	327	548	10,045	21,584	6,571	40
41	Subprovider - IRF	181	988	437	18,927	41,616	12,670	41
43	Nursery			77	2,715	4,835	1,472	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	469	2,912	2,699	43,096	90,651	27,598	50
51	Recovery Room	27	45	172	2,539	3,490	1,062	51
52	Delivery Room & Labor Room			228	8,065	14,364	4,373	52
53	Anesthesiology	40	161	350	1,792	920	280	53
54	Radiology-Diagnostic	188	545	1,491	19,405	25,927	7,893	54
54.01	ULTRASOUND	54	39	373	3,564	3,125	951	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	60	90	627	5,984	5,252	1,599	56
57	CT Scan	27	103	1,981	8,058	3,487	1,061	57
59	Cardiac Catheterization	308	1,412	1,302	13,658	18,506	5,634	59
60	Laboratory	389	1,200	4,062	32,415	33,835	10,301	60
62	Whole Blood & Packed Red Blood Cells	47	49	162	5,014	2,116	644	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	54	298	839	6,143	6,079	1,851	63.02
65	Respiratory Therapy	67	341	657	8,805	7,051	2,147	65
66	Physical Therapy	241	550	600	15,190	25,528	7,772	66
67	Occupational Therapy		99	337	7,630	7,022	2,138	67
68	Speech Pathology	13	107	83	2,488	2,242	683	68
70	Electroencephalography	47	21	266	2,104	11,869	3,613	70
71	Medical Supplies Charged to Patients		27	636	19,141			71
72	Impl. Dev. Charged to Patients			573	22,221			72
73	Drugs Charged to Patients			3,204	27,128			73
74	Renal Dialysis			255	6,313	862	263	74
75.01	ONCOLOGY	13	224	117	2,423	2,866	872	75.01
76.97	CARDIAC REHABILITATION	40	384	38	3,274	15,953	4,857	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	54	1,144	85	5,106	13,349	4,064	90
90.01	OP PSYCH		1	46	861	1,719	523	90.01
91	Emergency	282	1,232	3,632	26,805	28,917	8,804	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	87	586	145	11,397	7,767	2,365	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,918	69,530	29,910	578,862	748,820	212,613	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				44	3,211	977	190
192	Physicians' Private Offices	7	26		2,654	81,904	24,935	192
194	OTHER NON REIM COST CENTER				27			194
194.01	RETAIL PHARMACY		32		9,327	3,398	1,034	194.01
194.03	ADVERTISING EXPENSE	34	472		1,988	2,745	836	194.03
194.04	REGENCY HOSPITAL	409	118		1,472	47,560	14,479	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	6,368	70,178	29,910	594,374	887,638	254,874	202

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	30,460						8
9	Housekeeping		127,957					9
10	Dietary		5,650	178,130				10
11	Cafeteria		1,802		54,547			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,334		1,007	173,288		13
14	Central Services & Supply							14
15	Pharmacy		2,033		1,432		344,196	15
16	Medical Records & Library		1,761		130			16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,580	31,996	122,075	17,832	79,701		30
31	Intensive Care Unit	874	4,469	5,909	2,575	11,512		31
40	Subprovider - IPF	1,564	3,749	10,817	1,753	7,838		40
41	Subprovider - IRF	2,239	7,093	25,673	3,053	13,650		41
43	Nursery	274	907		345	1,541		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,046	15,624		3,879	17,340		50
51	Recovery Room	663	601		342	1,528		51
52	Delivery Room & Labor Room	814	2,441		1,023	4,573		52
53	Anesthesiology		159					53
54	Radiology-Diagnostic	874	4,404		2,542			54
54.01	ULTRASOUND	1,000	539		309			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	295	961		391			56
57	CT Scan		601		456			57
59	Cardiac Catheterization	588	3,190		1,226	5,478		59
60	Laboratory		5,824		3,622			60
62	Whole Blood & Packed Red Blood Cells		365		240			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	525	1,147		897			63.02
65	Respiratory Therapy		1,159		1,500			65
66	Physical Therapy	832	4,372		1,469			66
67	Occupational Therapy		1,210		581			67
68	Speech Pathology		380		192			68
70	Electroencephalography	595	2,046		253			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						344,196	73
74	Renal Dialysis		187					74
75.01	ONCOLOGY		494		420			75.01
76.97	CARDIAC REHABILITATION	431	2,750		490	2,188		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	532	2,361		2,532	11,320		90
90.01	OP PSYCH		193					90.01
91	Emergency	3,974	4,984		3,718	16,619		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,339					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	28,700	118,125	164,474	54,209	173,288	344,196	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		553					190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		517		304			194.01
194.03	ADVERTISING EXPENSE		473		34			194.03
194.04	REGENCY HOSPITAL	1,760	8,289	13,656				194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	30,460	127,957	178,130	54,547	173,288	344,196	202

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	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
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
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	59,684						16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,047	1,330,404		1,330,404			30
31	Intensive Care Unit	662	289,581		289,581			31
40	Subprovider - IPF	1,086	170,535		170,535			40
41	Subprovider - IRF	867	321,281		321,281			41
43	Nursery	152	25,626		25,626			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,351	1,027,207		1,027,207			50
51	Recovery Room	341	21,894		21,894			51
52	Delivery Room & Labor Room	453	75,872		75,872			52
53	Anesthesiology	694	86,499		86,499			53
54	Radiology-Diagnostic	2,957	1,008,963		1,008,963			54
54.01	ULTRASOUND	739	92,183		92,183			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,243	89,714		89,714			56
57	CT Scan	3,927	560,333		560,333			57
59	Cardiac Catheterization	2,582	286,241		286,241			59
60	Laboratory	8,431	385,088		385,088			60
62	Whole Blood & Packed Red Blood Cells	320	43,211		43,211			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	1,664	144,471		144,471			63.02
65	Respiratory Therapy	1,303	97,011		97,011			65
66	Physical Therapy	1,190	159,368		159,368			66
67	Occupational Therapy	669	43,381		43,381			67
68	Speech Pathology	164	28,143		28,143			68
70	Electroencephalography	527	91,074		91,074			70
71	Medical Supplies Charged to Patients	1,261	21,065		21,065			71
72	Impl. Dev. Charged to Patients	1,136	23,930		23,930			72
73	Drugs Charged to Patients	6,354	380,882		380,882			73
74	Renal Dialysis	507	10,745		10,745			74
75.01	ONCOLOGY	232	17,445		17,445			75.01
76.97	CARDIAC REHABILITATION	75	109,121		109,121			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	169	83,069		83,069			90
90.01	OP PSYCH	92	8,136		8,136			90.01
91	Emergency	7,202	348,380		348,380			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	287	45,531		45,531			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	59,684	7,426,384		7,426,384			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		13,566		13,566			190
192	Physicians' Private Offices		334,967		334,967			192
194	OTHER NON REIM COST CENTER		5,388		5,388			194
194.01	RETAIL PHARMACY		23,982		23,982			194.01
194.03	ADVERTISING EXPENSE		15,351		15,351			194.03
194.04	REGENCY HOSPITAL		217,813		217,813			194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	59,684	8,037,451		8,037,451			202

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DEPRECIATI EXPENSE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINT OF PERSONNEL FTE'S	NONPATIENT TELEPHONES NUMBER OF TELEPHONES	PURCHASING RECEIVING & STORES COSTED REQ	
		1	2	4	4.01	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	423,352						1
2	Cap Rel Costs-Mvble Equip		3,000,152					2
4	Employee Benefits Department	171	359	55,528,277				4
4.01	MAINTENANCE OF PERSONNEL	2,048		439,191	93,066			4.01
5.01	NONPATIENT TELEPHONES	810				950		5.01
5.02	PURCHASING RECEIVING & STORES	7,673	6,150	305,697	900	6	1,538,581	5.02
5.03	ADMITTING	3,460	571	974,867	2,892	21	24,994	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	41,734	166,694	4,205,117	4,693	208	50,055	5.05
6	Maintenance & Repairs	58,651	240,489	1,169,715	1,775	7	291,479	6
7	Operation of Plant	17,554	24,131	849,027	1,577	21	231,085	7
8	Laundry & Linen Service	1,634	1,069	95,558	258	2	140,380	8
9	Housekeeping	6,702	16,348	1,766,907	5,580	12	203,931	9
10	Dietary	11,246	17,044	696,124	1,979	21	160,415	10
11	Cafeteria	3,637	2,008	937,971	2,666			11
12	Maintenance of Personnel							12
13	Nursing Administration	2,420	84,788	1,099,143	1,277	4	18,014	13
14	Central Services & Supply							14
15	Pharmacy	4,228	173,988	1,633,856	1,816	33	12,375	15
16	Medical Records & Library	3,553	1,135	107,162	165	19	1,935	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	62,744	145,422	12,110,261	22,605	101	91,888	30
31	Intensive Care Unit	7,312	101,350	2,277,410	3,265	13	15,290	31
40	Subprovider - IPF	7,509	28,734	1,169,151	2,223	14	7,175	40
41	Subprovider - IRF	14,478	50,541	1,988,481	3,871	27	21,669	41
43	Nursery	1,682		305,671	437			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,537	359,717	3,392,685	4,918	70	63,846	50
51	Recovery Room	1,214	926	349,630	433	4	991	51
52	Delivery Room & Labor Room	4,997		907,936	1,297			52
53	Anesthesiology	320	50,700	58,050		6	3,538	53
54	Radiology-Diagnostic	9,020	555,010	1,763,167	3,223	28	11,948	54
54.01	ULTRASOUND	1,087	46,418	394,193	392	8	855	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,827	37,424	542,290	496	9	1,980	56
57	CT Scan	1,213	338,262	466,592	578	4	2,261	57
59	Cardiac Catheterization	6,438	115,586	1,149,007	1,554	46	30,956	59
60	Laboratory	11,771	122,057	2,476,730	4,592	58	26,304	60
62	Whole Blood & Packed Red Blood Cells	736	18,098	166,794	304	7	1,079	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,115	68,883	676,774	1,137	8	6,535	63.02
65	Respiratory Therapy	2,453	34,612	1,128,585	1,902	10	7,476	65
66	Physical Therapy	8,881	20,028	1,410,047	1,862	36	12,069	66
67	Occupational Therapy	2,443	2,768	494,622	737		2,170	67
68	Speech Pathology	780	9,944	238,273	244	2	2,350	68
70	Electroencephalography	4,129	23,706	182,842	321	7	459	70
71	Medical Supplies Charged to Patients						581	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	300						74
75.01	ONCOLOGY	997	1,174	313,502	532	2	4,901	75.01
76.97	CARDIAC REHABILITATION	5,550	22,226	441,005	621	6	8,426	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,644	3,321	2,251,785	3,210	8	25,080	90
90.01	OP PSYCH	598					24	90.01
91	Emergency	10,060	103,336	2,994,167	4,714	42	27,019	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,702		1,242,266	1,591	13	12,852	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	375,058	2,995,017	55,172,251	92,637	883	1,524,385	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,117						190
192	Physicians' Private Offices	28,494	921			1	572	192
194	OTHER NON REIM COST CENTER		3,415					194
194.01	RETAIL PHARMACY	1,182		323,667	386		697	194.01
194.03	ADVERTISING EXPENSE	955	799	32,359	43	5	10,339	194.03
194.04	REGENCY HOSPITAL	16,546				61	2,588	194.04
194.05	UNUSED SPACE							194.05

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DEPRECIATI EXPENSE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINT OF PERSONNEL FTE'S	NONPATIENT TELEPHONES NUMBER OF TELEPHONES	PURCHASING RECEIVING & STORES COSTED REQ	
		1	2	4	4.01	5.01	5.02	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,328,023	4,709,428	8,118,725	761,231	609,778	603,408	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.861125	1.569730	0.146209	8.179475	641.871579	0.392185	203
204	Cost to be allocated (Per Wkst. B, Part II)			1,908	16,115	6,368	70,178	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000034	0.173157	6.703158	0.045612	205

	COST CENTER DESCRIPTIONS	ADMITTING GROSS REVENUE	CASHIERING ACCOUNTS RECEIVABLE GROSS REVENUE	RECON-CILIATION	OTHER ADMIN GENERAL ACCUM COST	MAIN-TENANCE + REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	5A.05	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING	516,923,804						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE		516,923,804					5.04
5.05	OTHER ADMIN & GENERAL			-22,824,887	117,745,255			5.05
6	Maintenance & Repairs				7,008,726	308,805		6
7	Operation of Plant				3,478,591	17,554	291,251	7
8	Laundry & Linen Service				662,807	1,634	1,634	8
9	Housekeeping				2,787,844	6,702	6,702	9
10	Dietary				1,451,600	11,246	11,246	10
11	Cafeteria				1,361,221	3,637	3,637	11
12	Maintenance of Personnel							12
13	Nursing Administration				1,713,190	2,420	2,420	13
14	Central Services & Supply							14
15	Pharmacy				3,441,429	4,228	4,228	15
16	Medical Records & Library				2,874,462	3,553	3,553	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	61,274,861	61,274,861		18,550,672	62,744	62,744	30
31	Intensive Care Unit	5,756,023	5,756,023		3,531,993	7,312	7,312	31
40	Subprovider - IPF	9,440,267	9,440,267		1,989,820	7,509	7,509	40
41	Subprovider - IRF	7,538,901	7,538,901		3,749,450	14,478	14,478	41
43	Nursery	1,325,318	1,325,318		537,864	1,682	1,682	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	46,532,066	46,532,066		8,537,299	31,537	31,537	50
51	Recovery Room	2,963,375	2,963,375		502,997	1,214	1,214	51
52	Delivery Room & Labor Room	3,936,602	3,936,602		1,597,618	4,997	4,997	52
53	Anesthesiology	6,033,948	6,033,948		354,931	320	320	53
54	Radiology-Diagnostic	25,709,927	25,709,927		3,844,056	9,020	9,020	54
54.01	ULTRASOUND	6,425,611	6,425,611		706,105	1,087	1,087	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	10,811,036	10,811,036		1,185,376	1,827	1,827	56
57	CT Scan	34,148,638	34,148,638		1,596,261	1,213	1,213	57
59	Cardiac Catheterization	22,451,775	22,451,775		2,705,649	6,438	6,438	59
60	Laboratory	71,247,362	71,247,362		6,421,374	11,771	11,771	60
62	Whole Blood & Packed Red Blood Cells	2,785,970	2,785,970		993,230	736	736	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	14,472,292	14,472,292		1,216,970	2,115	2,115	63.02
65	Respiratory Therapy	11,333,150	11,333,150		1,744,303	2,453	2,453	65
66	Physical Therapy	10,350,425	10,350,425		3,009,045	8,881	8,881	66
67	Occupational Therapy	5,818,580	5,818,580		1,511,588	2,443	2,443	67
68	Speech Pathology	1,429,601	1,429,601		492,807	780	780	68
70	Electroencephalography	4,582,453	4,582,453		416,729	4,129	4,129	70
71	Medical Supplies Charged to Patients	10,964,261	10,964,261		3,791,715			71
72	Impl. Dev. Charged to Patients	9,874,234	9,874,234		4,401,869			72
73	Drugs Charged to Patients	55,249,391	55,249,391		5,373,947			73
74	Renal Dialysis	4,404,629	4,404,629		1,250,533	300	300	74
75.01	ONCOLOGY	2,015,722	2,015,722		479,929	997	997	75.01
76.97	CARDIAC REHABILITATION	656,022	656,022		648,613	5,550	5,550	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,472,610	1,472,610		1,011,486	4,644	4,644	90
90.01	OP PSYCH	797,417	797,417		170,466	598	598	90.01
91	Emergency	62,623,064	62,623,064		5,310,009	10,060	10,060	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,498,273	2,498,273		2,257,787	2,702	2,702	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	516,923,804	516,923,804	-22,824,887	114,672,361	260,511	242,957	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				8,781	1,117	1,117	190
192	Physicians' Private Offices				525,700	28,494	28,494	192
194	OTHER NON REIM COST CENTER				5,361			194
194.01	RETAIL PHARMACY				1,847,657	1,182	1,182	194.01
194.03	ADVERTISING EXPENSE				393,823	955	955	194.03
194.04	REGENCY HOSPITAL				291,572	16,546	16,546	194.04
194.05	UNUSED SPACE							194.05

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

	COST CENTER DESCRIPTIONS	ADMITTING GROSS REVENUE	CASHIERING ACCOUNTS RECEIVABLE GROSS REVENUE	RECON-CILIATION	OTHER ADMIN GENERAL ACCUM COST	MAIN-TENANCE + REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	5A.05	5.05	6	7	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,346,915	2,436,771		22,824,887	8,367,368	4,628,558	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.002606	0.004714		0.193850	27.095960	15.891990	203
204	Cost to be allocated (Per Wkst. B, Part II)	29,910			594,374	887,638	254,874	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000058			0.005048	2.874429	0.875101	205

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PHARMACY COSTED REQUIS.	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	190,889						8
9	Housekeeping		258,286					9
10	Dietary		11,405	152,065				10
11	Cafeteria		3,637		69,155			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,692		1,277	1,022,268		13
14	Central Services & Supply							14
15	Pharmacy		4,104		1,816		10,000	15
16	Medical Records & Library		3,555		165			16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	53,769	64,593	104,213	22,605	470,177		30
31	Intensive Care Unit	5,480	9,021	5,044	3,265	67,915		31
40	Subprovider - IPF	9,804	7,567	9,234	2,223	46,237		40
41	Subprovider - IRF	14,032	14,318	21,916	3,871	80,525		41
43	Nursery	1,717	1,830		437	9,090		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,353	31,537		4,918	102,292		50
51	Recovery Room	4,158	1,214		433	9,013		51
52	Delivery Room & Labor Room	5,099	4,927		1,297	26,977		52
53	Anesthesiology		320					53
54	Radiology-Diagnostic	5,478	8,890		3,223			54
54.01	ULTRASOUND	6,264	1,087		392			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,846	1,940		496			56
57	CT Scan		1,213		578			57
59	Cardiac Catheterization	3,687	6,439		1,554	32,314		59
60	Laboratory		11,755		4,592			60
62	Whole Blood & Packed Red Blood Cells		736		304			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	3,287	2,315		1,137			63.02
65	Respiratory Therapy		2,340		1,902			65
66	Physical Therapy	5,214	8,825		1,862			66
67	Occupational Therapy		2,443		737			67
68	Speech Pathology		767		244			68
70	Electroencephalography	3,731	4,129		321			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						10,000	73
74	Renal Dialysis		377					74
75.01	ONCOLOGY		997		532			75.01
76.97	CARDIAC REHABILITATION	2,699	5,550		621	12,909		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,337	4,765		3,210	66,777		90
90.01	OP PSYCH		390					90.01
91	Emergency	24,903	10,060		4,714	98,042		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,702					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	179,858	238,440	140,407	68,726	1,022,268	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,117					190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		1,043		386			194.01
194.03	ADVERTISING EXPENSE		955		43			194.03
194.04	REGENCY HOSPITAL	11,031	16,731	11,658				194.04
194.05	UNUSED SPACE							194.05

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PHARMACY COSTED REQUIS.	
		8	9	10	11	13	15	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	861,535	3,616,373	2,376,121	1,832,364	2,220,851	4,395,883	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.513277	14.001429	15.625693	26.496479	2.172474	439.588300	203
204	Cost to be allocated (Per Wkst. B, Part II)	30,460	127,957	178,130	54,547	173,288	344,196	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.159569	0.495408	1.171407	0.788764	0.169513	34.419600	205

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE						
		16						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
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	516,923,804						16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	61,274,861						30
31	Intensive Care Unit	5,756,023						31
40	Subprovider - IPF	9,440,267						40
41	Subprovider - IRF	7,538,901						41
43	Nursery	1,325,318						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	46,532,066						50
51	Recovery Room	2,963,375						51
52	Delivery Room & Labor Room	3,936,602						52
53	Anesthesiology	6,033,948						53
54	Radiology-Diagnostic	25,709,927						54
54.01	ULTRASOUND	6,425,611						54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	10,811,036						56
57	CT Scan	34,148,638						57
59	Cardiac Catheterization	22,451,775						59
60	Laboratory	71,247,362						60
62	Whole Blood & Packed Red Blood Cells	2,785,970						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	14,472,292						63.02
65	Respiratory Therapy	11,333,150						65
66	Physical Therapy	10,350,425						66
67	Occupational Therapy	5,818,580						67
68	Speech Pathology	1,429,601						68
70	Electroencephalography	4,582,453						70
71	Medical Supplies Charged to Patients	10,964,261						71
72	Impl. Dev. Charged to Patients	9,874,234						72
73	Drugs Charged to Patients	55,249,391						73
74	Renal Dialysis	4,404,629						74
75.01	ONCOLOGY	2,015,722						75.01
76.97	CARDIAC REHABILITATION	656,022						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,472,610						90
90.01	OP PSYCH	797,417						90.01
91	Emergency	62,623,064						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,498,273						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	516,923,804						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY							194.01
194.03	ADVERTISING EXPENSE							194.03

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE						
		16						
194.04	REGENCY HOSPITAL							194.04
194.05	UNUSED SPACE							194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,638,559						202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.007039						203
204	Cost to be allocated (Per Wkst. B, Part II)	59,684						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000115						205

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	29,671,110		29,671,110	909	29,672,019	30
31	Intensive Care Unit	5,035,426		5,035,426		5,035,426	31
40	Subprovider - IPF	3,218,630		3,218,630		3,218,630	40
41	Subprovider - IRF	6,035,487		6,035,487		6,035,487	41
43	Nursery	788,462		788,462		788,462	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	12,784,029		12,784,029	16,657	12,800,686	50
51	Recovery Room	740,367		740,367		740,367	51
52	Delivery Room & Labor Room	2,334,808		2,334,808		2,334,808	52
53	Anesthesiology	484,443		484,443	25,308	509,751	53
54	Radiology-Diagnostic	5,392,545		5,392,545	11,274	5,403,819	54
54.01	ULTRASOUND	988,819		988,819		988,819	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,618,436		1,618,436		1,618,436	56
57	CT Scan	2,230,511		2,230,511		2,230,511	57
59	Cardiac Catheterization	3,883,106		3,883,106	9,978	3,893,084	59
60	Laboratory	8,959,871		8,959,871	7,484	8,967,355	60
62	Whole Blood & Packed Red Blood Cells	1,255,378		1,255,378		1,255,378	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,723,044		1,723,044		1,723,044	63.02
65	Respiratory Therapy	2,350,818		2,350,818		2,350,818	65
66	Physical Therapy	4,243,412		4,243,412		4,243,412	66
67	Occupational Therapy	2,004,318		2,004,318		2,004,318	67
68	Speech Pathology	649,136		649,136		649,136	68
70	Electroencephalography	790,421		790,421		790,421	70
71	Medical Supplies Charged to Patients	4,603,916		4,603,916		4,603,916	71
72	Impl. Dev. Charged to Patients	5,324,676		5,324,676		5,324,676	72
73	Drugs Charged to Patients	11,200,470		11,200,470		11,200,470	73
74	Renal Dialysis	1,542,129		1,542,129		1,542,129	74
75.01	ONCOLOGY	658,066		658,066		658,066	75.01
76.97	CARDIAC REHABILITATION	1,151,936		1,151,936	8,995	1,160,931	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,729,468		1,729,468		1,729,468	90
90.01	OP PSYCH	240,291		240,291		240,291	90.01
91	Emergency	7,803,762		7,803,762	118,146	7,921,908	91
92	Observation Beds (Non-Distinct Part)	5,993,101		5,993,101		5,993,101	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,867,029		2,867,029		2,867,029	101
200	Subtotal (sum of lines 30 thru 199)	140,297,421		140,297,421	198,751	140,496,172	200
201	Less Observation Beds	5,993,101		5,993,101		5,993,101	201
202	Total (line 200 minus line 201)	134,304,320		134,304,320		134,503,071	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	47,470,604		47,470,604				30
31	Intensive Care Unit	5,756,023		5,756,023				31
40	Subprovider - IPF	9,440,267		9,440,267				40
41	Subprovider - IRF	7,538,901		7,538,901				41
43	Nursery	1,325,318		1,325,318				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,912,855	33,619,211	46,532,066	0.274736	0.274736	0.275094	50
51	Recovery Room	939,817	2,023,558	2,963,375	0.249839	0.249839	0.249839	51
52	Delivery Room & Labor Room	2,636,483	1,300,119	3,936,602	0.593102	0.593102	0.593102	52
53	Anesthesiology	1,974,943	4,059,005	6,033,948	0.080286	0.080286	0.084481	53
54	Radiology-Diagnostic	6,290,860	19,419,067	25,709,927	0.209746	0.209746	0.210184	54
54.01	ULTRASOUND	995,893	5,429,718	6,425,611	0.153887	0.153887	0.153887	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	2,115,067	8,695,969	10,811,036	0.149702	0.149702	0.149702	56
57	CT Scan	9,520,742	24,627,896	34,148,638	0.065318	0.065318	0.065318	57
59	Cardiac Catheterization	10,350,862	12,100,913	22,451,775	0.172953	0.172953	0.173398	59
60	Laboratory	23,898,107	47,349,255	71,247,362	0.125757	0.125757	0.125862	60
62	Whole Blood & Packed Red Blood Cells	1,954,188	831,782	2,785,970	0.450607	0.450607	0.450607	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	5,004,400	9,467,892	14,472,292	0.119058	0.119058	0.119058	63.02
65	Respiratory Therapy	9,036,145	2,297,005	11,333,150	0.207428	0.207428	0.207428	65
66	Physical Therapy	5,805,385	4,545,040	10,350,425	0.409975	0.409975	0.409975	66
67	Occupational Therapy	4,693,476	1,125,104	5,818,580	0.344469	0.344469	0.344469	67
68	Speech Pathology	766,617	662,984	1,429,601	0.454068	0.454068	0.454068	68
70	Electroencephalography	904,544	3,677,909	4,582,453	0.172489	0.172489	0.172489	70
71	Medical Supplies Charged to Patients	5,295,030	5,669,231	10,964,261	0.419902	0.419902	0.419902	71
72	Impl. Dev. Charged to Patients	5,610,887	4,263,347	9,874,234	0.539250	0.539250	0.539250	72
73	Drugs Charged to Patients	28,489,521	26,759,870	55,249,391	0.202726	0.202726	0.202726	73
74	Renal Dialysis	3,668,429	736,200	4,404,629	0.350116	0.350116	0.350116	74
75.01	ONCOLOGY	2,909	2,012,813	2,015,722	0.326467	0.326467	0.326467	75.01
76.97	CARDIAC REHABILITATION	129,581	526,441	656,022	1.755941	1.755941	1.769653	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	54,262	1,418,348	1,472,610	1.174424	1.174424	1.174424	90
90.01	OP PSYCH	4,572	792,845	797,417	0.301337	0.301337	0.301337	90.01
91	Emergency	13,224,213	49,398,851	62,623,064	0.124615	0.124615	0.126501	91
92	Observation Beds (Non-Distinct Part)	1,711,269	12,092,988	13,804,257	0.434149	0.434149	0.434149	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,498,273	2,498,273				101
200	Subtotal (sum of lines 30 thru 199)	229,522,170	287,401,634	516,923,804				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	229,522,170	287,401,634	516,923,804				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,330,404		1,330,404	33,548	39.66	9,069	359,677	30
31	Intensive Care Unit	289,581		289,581	2,698	107.33	1,044	112,053	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	170,535		170,535	3,065	55.64	2,093	116,455	40
41	Subprovider - IRF	321,281		321,281	7,496	42.86	5,304	227,329	41
42	Subprovider I								42
43	Nursery	25,626		25,626	1,192	21.50			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,137,427		2,137,427	47,999		17,510	815,514	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-0008** **WORKSHEET D PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,027,207	46,532,066	0.022075	4,105,867	90,637	50
51	Recovery Room	21,894	2,963,375	0.007388	321,488	2,375	51
52	Delivery Room & Labor Room	75,872	3,936,602	0.019273	7,911	152	52
53	Anesthesiology	86,499	6,033,948	0.014335	727,004	10,422	53
54	Radiology-Diagnostic	1,008,963	25,709,927	0.039244	2,265,918	88,924	54
54.01	ULTRASOUND	92,183	6,425,611	0.014346	265,983	3,816	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,714	10,811,036	0.008298	928,231	7,702	56
57	CT Scan	560,333	34,148,638	0.016409	3,685,639	60,478	57
59	Cardiac Catheterization	286,241	22,451,775	0.012749	4,663,581	59,456	59
60	Laboratory	385,088	71,247,362	0.005405	8,316,355	44,950	60
62	Whole Blood & Packed Red Blood	43,211	2,785,970	0.015510	604,037	9,369	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	144,471	14,472,292	0.009983	2,088,831	20,853	63.02
65	Respiratory Therapy	97,011	11,333,150	0.008560	4,550,609	38,953	65
66	Physical Therapy	159,368	10,350,425	0.015397	873,108	13,443	66
67	Occupational Therapy	43,381	5,818,580	0.007456	507,194	3,782	67
68	Speech Pathology	28,143	1,429,601	0.019686	166,104	3,270	68
70	Electroencephalography	91,074	4,582,453	0.019875	294,968	5,862	70
71	Medical Supplies Charged to Pat	21,065	10,964,261	0.001921	1,135,715	2,182	71
72	Impl. Dev. Charged to Patients	23,930	9,874,234	0.002423	2,340,965	5,672	72
73	Drugs Charged to Patients	380,882	55,249,391	0.006894	8,909,681	61,423	73
74	Renal Dialysis	10,745	4,404,629	0.002439	1,429,580	3,487	74
75.01	ONCOLOGY	17,445	2,015,722	0.008654			75.01
76.97	CARDIAC REHABILITATION	109,121	656,022	0.166337	51,040	8,490	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	83,069	1,472,610	0.056409	6,749	381	90
90.01	OP PSYCH	8,136	797,417	0.010203			90.01
91	Emergency	348,380	62,623,064	0.005563	4,930,814	27,430	91
92	Observation Beds (Non-Distinct	268,713	13,804,257	0.019466	835,073	16,256	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,512,139	442,894,418		54,012,445	589,765	200

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

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	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V [XX] 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)	33,548		9,069		30
31	Intensive Care Unit	2,698		1,044		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	3,065		2,093		40
41	Subprovider - IRF	7,496		5,304		41
42	Subprovider I					42
43	Nursery	1,192				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	47,999		17,510		200

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0008** | **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	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
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	OP PSYCH							90.01
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: 15-0008** | **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	46,532,066			4,105,867		8,673,990		50
51	Recovery Room	2,963,375			321,488		321,531		51
52	Delivery Room & Labor Room	3,936,602			7,911				52
53	Anesthesiology	6,033,948			727,004		908,093		53
54	Radiology-Diagnostic	25,709,927			2,265,918		3,430,216		54
54.01	ULTRASOUND	6,425,611			265,983		610,223		54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	10,811,036			928,231		3,061,528		56
57	CT Scan	34,148,638			3,685,639		4,875,305		57
59	Cardiac Catheterization	22,451,775			4,663,581		4,490,280		59
60	Laboratory	71,247,362			8,316,355		3,872,623		60
62	Whole Blood & Packed Red Blood	2,785,970			604,037		84,019		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	14,472,292			2,088,831		2,766,202		63.02
65	Respiratory Therapy	11,333,150			4,550,609		488,755		65
66	Physical Therapy	10,350,425			873,108		165,219		66
67	Occupational Therapy	5,818,580			507,194		33,814		67
68	Speech Pathology	1,429,601			166,104		42,518		68
70	Electroencephalography	4,582,453			294,968		690,831		70
71	Medical Supplies Charged to Pat	10,964,261			1,135,715		2,463,401		71
72	Impl. Dev. Charged to Patients	9,874,234			2,340,965		1,413,379		72
73	Drugs Charged to Patients	55,249,391			8,909,681		7,810,579		73
74	Renal Dialysis	4,404,629			1,429,580		136,800		74
75.01	ONCOLOGY	2,015,722					762,063		75.01
76.97	CARDIAC REHABILITATION	656,022			51,040		143,231		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,472,610			6,749		212,520		90
90.01	OP PSYCH	797,417					216,494		90.01
91	Emergency	62,623,064			4,930,814		6,260,166		91
92	Observation Beds (Non-Distinct	13,804,257			835,073		1,769,881		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	442,894,418			54,012,445		55,703,661		200

(A) Worksheet A line numbers

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	0.274736	8,673,990		126,420	2,383,057		34,732	50
51	Recovery Room	0.249839	321,531			80,331			51
52	Delivery Room & Labor Room	0.593102							52
53	Anesthesiology	0.080286	908,093			72,907			53
54	Radiology-Diagnostic	0.209746	3,430,216			719,474			54
54.01	ULTRASOUND	0.153887	610,223			93,905			54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.149702	3,061,528			458,317			56
57	CT Scan	0.065318	4,875,305			318,445			57
59	Cardiac Catheterization	0.172953	4,490,280			776,607			59
60	Laboratory	0.125757	3,872,623			487,009			60
62	Whole Blood & Packed Red Blood	0.450607	84,019			37,860			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.119058	2,766,202			329,338			63.02
65	Respiratory Therapy	0.207428	488,755			101,381			65
66	Physical Therapy	0.409975	165,219			67,736			66
67	Occupational Therapy	0.344469	33,814			11,648			67
68	Speech Pathology	0.454068	42,518			19,306			68
70	Electroencephalography	0.172489	690,831			119,161			70
71	Medical Supplies Charged to Pat	0.419902	2,463,401			1,034,387			71
72	Impl. Dev. Charged to Patients	0.539250	1,413,379			762,165			72
73	Drugs Charged to Patients	0.202726	7,810,579		32,223	1,583,407		6,532	73
74	Renal Dialysis	0.350116	136,800			47,896			74
75.01	ONCOLOGY	0.326467	762,063			248,788			75.01
76.97	CARDIAC REHABILITATION	1.755941	143,231			251,505			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.174424	212,520			249,589			90
90.01	OP PSYCH	0.301337	216,494			65,238			90.01
91	Emergency	0.124615	6,260,166			780,111			91
92	Observation Beds (Non-Distinct	0.434149	1,769,881			768,392			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		55,703,661		158,643	11,867,960		41,264	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		55,703,661		158,643	11,867,960		41,264	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-S008** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,027,207	46,532,066	0.022075	6,611	146	50
51	Recovery Room	21,894	2,963,375	0.007388	9,627	71	51
52	Delivery Room & Labor Room	75,872	3,936,602	0.019273			52
53	Anesthesiology	86,499	6,033,948	0.014335	11,768	169	53
54	Radiology-Diagnostic	1,008,963	25,709,927	0.039244	74,890	2,939	54
54.01	ULTRASOUND	92,183	6,425,611	0.014346	3,064	44	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,714	10,811,036	0.008298	11,451	95	56
57	CT Scan	560,333	34,148,638	0.016409	133,799	2,196	57
59	Cardiac Catheterization	286,241	22,451,775	0.012749	8,290	106	59
60	Laboratory	385,088	71,247,362	0.005405	600,827	3,247	60
62	Whole Blood & Packed Red Blood	43,211	2,785,970	0.015510			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	144,471	14,472,292	0.009983	76,490	764	63.02
65	Respiratory Therapy	97,011	11,333,150	0.008560	81,242	695	65
66	Physical Therapy	159,368	10,350,425	0.015397	100,235	1,543	66
67	Occupational Therapy	43,381	5,818,580	0.007456	73,397	547	67
68	Speech Pathology	28,143	1,429,601	0.019686	14,390	283	68
70	Electroencephalography	91,074	4,582,453	0.019875	8,240	164	70
71	Medical Supplies Charged to Pat	21,065	10,964,261	0.001921	62,072	119	71
72	Impl. Dev. Charged to Patients	23,930	9,874,234	0.002423			72
73	Drugs Charged to Patients	380,882	55,249,391	0.006894	887,771	6,120	73
74	Renal Dialysis	10,745	4,404,629	0.002439	99,000	241	74
75.01	ONCOLOGY	17,445	2,015,722	0.008654			75.01
76.97	CARDIAC REHABILITATION	109,121	656,022	0.166337			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	83,069	1,472,610	0.056409			90
90.01	OP PSYCH	8,136	797,417	0.010203			90.01
91	Emergency	348,380	62,623,064	0.005563	229,758	1,278	91
92	Observation Beds (Non-Distinct		13,804,257				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,243,426	442,894,418		2,492,922	20,767	200

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-S008** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
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	OP PSYCH							90.01
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: 15-S008** | **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

(A)	Cost Center Description	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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	46,532,066			6,611				50
51	Recovery Room	2,963,375			9,627				51
52	Delivery Room & Labor Room	3,936,602							52
53	Anesthesiology	6,033,948			11,768				53
54	Radiology-Diagnostic	25,709,927			74,890				54
54.01	ULTRASOUND	6,425,611			3,064				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	10,811,036			11,451				56
57	CT Scan	34,148,638			133,799				57
59	Cardiac Catheterization	22,451,775			8,290				59
60	Laboratory	71,247,362			600,827				60
62	Whole Blood & Packed Red Blood	2,785,970							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	14,472,292			76,490				63.02
65	Respiratory Therapy	11,333,150			81,242				65
66	Physical Therapy	10,350,425			100,235				66
67	Occupational Therapy	5,818,580			73,397				67
68	Speech Pathology	1,429,601			14,390				68
70	Electroencephalography	4,582,453			8,240				70
71	Medical Supplies Charged to Pat	10,964,261			62,072				71
72	Impl. Dev. Charged to Patients	9,874,234							72
73	Drugs Charged to Patients	55,249,391			887,771				73
74	Renal Dialysis	4,404,629			99,000				74
75.01	ONCOLOGY	2,015,722							75.01
76.97	CARDIAC REHABILITATION	656,022							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,472,610							90
90.01	OP PSYCH	797,417							90.01
91	Emergency	62,623,064			229,758				91
92	Observation Beds (Non-Distinct	13,804,257							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	442,894,418			2,492,922				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-S008** **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	0.274736							50
51	Recovery Room	0.249839							51
52	Delivery Room & Labor Room	0.593102							52
53	Anesthesiology	0.080286							53
54	Radiology-Diagnostic	0.209746							54
54.01	ULTRASOUND	0.153887							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.149702							56
57	CT Scan	0.065318							57
59	Cardiac Catheterization	0.172953							59
60	Laboratory	0.125757							60
62	Whole Blood & Packed Red Blood	0.450607							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.119058							63.02
65	Respiratory Therapy	0.207428							65
66	Physical Therapy	0.409975							66
67	Occupational Therapy	0.344469							67
68	Speech Pathology	0.454068							68
70	Electroencephalography	0.172489							70
71	Medical Supplies Charged to Pat	0.419902							71
72	Impl. Dev. Charged to Patients	0.539250							72
73	Drugs Charged to Patients	0.202726							73
74	Renal Dialysis	0.350116							74
75.01	ONCOLOGY	0.326467							75.01
76.97	CARDIAC REHABILITATION	1.755941							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.174424							90
90.01	OP PSYCH	0.301337							90.01
91	Emergency	0.124615							91
92	Observation Beds (Non-Distinct	0.434149							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: 15-T008** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,027,207	46,532,066	0.022075	48,708	1,075	50
51	Recovery Room	21,894	2,963,375	0.007388	9,943	73	51
52	Delivery Room & Labor Room	75,872	3,936,602	0.019273			52
53	Anesthesiology	86,499	6,033,948	0.014335	17,858	256	53
54	Radiology-Diagnostic	1,008,963	25,709,927	0.039244	198,225	7,779	54
54.01	ULTRASOUND	92,183	6,425,611	0.014346	20,689	297	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,714	10,811,036	0.008298	55,650	462	56
57	CT Scan	560,333	34,148,638	0.016409	163,184	2,678	57
59	Cardiac Catheterization	286,241	22,451,775	0.012749	89,955	1,147	59
60	Laboratory	385,088	71,247,362	0.005405	1,345,246	7,271	60
62	Whole Blood & Packed Red Blood	43,211	2,785,970	0.015510	50,145	778	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	144,471	14,472,292	0.009983	328,011	3,275	63.02
65	Respiratory Therapy	97,011	11,333,150	0.008560	594,303	5,087	65
66	Physical Therapy	159,368	10,350,425	0.015397	2,642,534	40,687	66
67	Occupational Therapy	43,381	5,818,580	0.007456	2,483,267	18,515	67
68	Speech Pathology	28,143	1,429,601	0.019686	284,737	5,605	68
70	Electroencephalography	91,074	4,582,453	0.019875	110,432	2,195	70
71	Medical Supplies Charged to Pat	21,065	10,964,261	0.001921	461,273	886	71
72	Impl. Dev. Charged to Patients	23,930	9,874,234	0.002423	31,317	76	72
73	Drugs Charged to Patients	380,882	55,249,391	0.006894	2,957,534	20,389	73
74	Renal Dialysis	10,745	4,404,629	0.002439	582,398	1,420	74
75.01	ONCOLOGY	17,445	2,015,722	0.008654			75.01
76.97	CARDIAC REHABILITATION	109,121	656,022	0.166337	283	47	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	83,069	1,472,610	0.056409	808	46	90
90.01	OP PSYCH	8,136	797,417	0.010203			90.01
91	Emergency	348,380	62,623,064	0.005563	6,477	36	91
92	Observation Beds (Non-Distinct		13,804,257				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,243,426	442,894,418		12,482,977	120,080	200

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-T008** | **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	
	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
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
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	OP PSYCH							90.01
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: 15-T008** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	46,532,066			48,708				50
51	Recovery Room	2,963,375			9,943				51
52	Delivery Room & Labor Room	3,936,602							52
53	Anesthesiology	6,033,948			17,858				53
54	Radiology-Diagnostic	25,709,927			198,225				54
54.01	ULTRASOUND	6,425,611			20,689				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	10,811,036			55,650				56
57	CT Scan	34,148,638			163,184				57
59	Cardiac Catheterization	22,451,775			89,955				59
60	Laboratory	71,247,362			1,345,246				60
62	Whole Blood & Packed Red Blood	2,785,970			50,145				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	14,472,292			328,011		858		63.02
65	Respiratory Therapy	11,333,150			594,303				65
66	Physical Therapy	10,350,425			2,642,534				66
67	Occupational Therapy	5,818,580			2,483,267				67
68	Speech Pathology	1,429,601			284,737				68
70	Electroencephalography	4,582,453			110,432				70
71	Medical Supplies Charged to Pat	10,964,261			461,273		1,182		71
72	Impl. Dev. Charged to Patients	9,874,234			31,317				72
73	Drugs Charged to Patients	55,249,391			2,957,534		3,954		73
74	Renal Dialysis	4,404,629			582,398				74
75.01	ONCOLOGY	2,015,722							75.01
76.97	CARDIAC REHABILITATION	656,022			283				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,472,610			808				90
90.01	OP PSYCH	797,417							90.01
91	Emergency	62,623,064			6,477				91
92	Observation Beds (Non-Distinct	13,804,257							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	442,894,418			12,482,977		5,994		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-T008** **WORKSHEET D PART V**

Check Applicable Boxes:

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS 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	0.274736							50
51	Recovery Room	0.249839							51
52	Delivery Room & Labor Room	0.593102							52
53	Anesthesiology	0.080286							53
54	Radiology-Diagnostic	0.209746							54
54.01	ULTRASOUND	0.153887							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.149702							56
57	CT Scan	0.065318							57
59	Cardiac Catheterization	0.172953							59
60	Laboratory	0.125757							60
62	Whole Blood & Packed Red Blood	0.450607							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.119058	858			102			63.02
65	Respiratory Therapy	0.207428							65
66	Physical Therapy	0.409975							66
67	Occupational Therapy	0.344469							67
68	Speech Pathology	0.454068							68
70	Electroencephalography	0.172489							70
71	Medical Supplies Charged to Pat	0.419902	1,182			496			71
72	Impl. Dev. Charged to Patients	0.539250							72
73	Drugs Charged to Patients	0.202726	3,954		1,859	802		377	73
74	Renal Dialysis	0.350116							74
75.01	ONCOLOGY	0.326467							75.01
76.97	CARDIAC REHABILITATION	1.755941							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.174424							90
90.01	OP PSYCH	0.301337							90.01
91	Emergency	0.124615							91
92	Observation Beds (Non-Distinct	0.434149							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		5,994		1,859	1,400		377	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		5,994		1,859	1,400		377	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes: **[ ] Title V** **[XX] PPS** **[ ] Title XVIII, Part A** **[ ] TEFRA** **[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)	1,330,404		1,330,404	33,548	39.66	963	38,193	30
31	Intensive Care Unit	289,581		289,581	2,698	107.33	93	9,982	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	170,535		170,535	3,065	55.64	133	7,400	40
41	Subprovider - IRF	321,281		321,281	7,496	42.86	22	943	41
42	Subprovider I								42
43	Nursery	25,626		25,626	1,192	21.50	220	4,730	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,137,427		2,137,427	47,999		1,431	61,248	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-0008** **WORKSHEET D PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,027,207	46,532,066	0.022075	327,823	7,237	50
51	Recovery Room	21,894	2,963,375	0.007388	37,723	279	51
52	Delivery Room & Labor Room	75,872	3,936,602	0.019273	264,729	5,102	52
53	Anesthesiology	86,499	6,033,948	0.014335	79,165	1,135	53
54	Radiology-Diagnostic	1,008,963	25,709,927	0.039244	161,856	6,352	54
54.01	ULTRASOUND	92,183	6,425,611	0.014346	58,131	834	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,714	10,811,036	0.008298	54,286	450	56
57	CT Scan	560,333	34,148,638	0.016409	214,281	3,516	57
59	Cardiac Catheterization	286,241	22,451,775	0.012749	311,884	3,976	59
60	Laboratory	385,088	71,247,362	0.005405	864,055	4,670	60
62	Whole Blood & Packed Red Blood	43,211	2,785,970	0.015510	42,919	666	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	144,471	14,472,292	0.009983	151,320	1,511	63.02
65	Respiratory Therapy	97,011	11,333,150	0.008560	155,658	1,332	65
66	Physical Therapy	159,368	10,350,425	0.015397	53,320	821	66
67	Occupational Therapy	43,381	5,818,580	0.007456	24,778	185	67
68	Speech Pathology	28,143	1,429,601	0.019686	35,980	708	68
70	Electroencephalography	91,074	4,582,453	0.019875	8,120	161	70
71	Medical Supplies Charged to Pat	21,065	10,964,261	0.001921	169,116	325	71
72	Impl. Dev. Charged to Patients	23,930	9,874,234	0.002423	160,731	389	72
73	Drugs Charged to Patients	380,882	55,249,391	0.006894	948,999	6,542	73
74	Renal Dialysis	10,745	4,404,629	0.002439	152,170	371	74
75.01	ONCOLOGY	17,445	2,015,722	0.008654			75.01
76.97	CARDIAC REHABILITATION	109,121	656,022	0.166337	1,367	227	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	83,069	1,472,610	0.056409	141	8	90
90.01	OP PSYCH	8,136	797,417	0.010203			90.01
91	Emergency	348,380	62,623,064	0.005563	303,747	1,690	91
92	Observation Beds (Non-Distinct	268,713	13,804,257	0.019466	31,450	612	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,512,139	442,894,418		4,613,749	49,099	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] 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)	33,548		963		30
31	Intensive Care Unit	2,698		93		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	3,065		133		40
41	Subprovider - IRF	7,496		22		41
42	Subprovider I					42
43	Nursery	1,192		220		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	47,999		1,431		200

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0008** | **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; [XX] PPS; [ ] TEFRA; [ ] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost (1)	Nursing School (2)	Allied Health (3)	All Other Medical Education Cost (4)	Total Cost (sum of col. 1 through col. 4) (5)	Total Outpatient Cost (sum of col. 2, 3, and 4) (6)	
	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
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
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	OP PSYCH							90.01
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: 15-0008** | **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; [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	46,532,066			327,823				50
51	Recovery Room	2,963,375			37,723				51
52	Delivery Room & Labor Room	3,936,602			264,729				52
53	Anesthesiology	6,033,948			79,165				53
54	Radiology-Diagnostic	25,709,927			161,856				54
54.01	ULTRASOUND	6,425,611			58,131				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	10,811,036			54,286				56
57	CT Scan	34,148,638			214,281				57
59	Cardiac Catheterization	22,451,775			311,884				59
60	Laboratory	71,247,362			864,055				60
62	Whole Blood & Packed Red Blood	2,785,970			42,919				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	14,472,292			151,320				63.02
65	Respiratory Therapy	11,333,150			155,658				65
66	Physical Therapy	10,350,425			53,320				66
67	Occupational Therapy	5,818,580			24,778				67
68	Speech Pathology	1,429,601			35,980				68
70	Electroencephalography	4,582,453			8,120				70
71	Medical Supplies Charged to Pat	10,964,261			169,116				71
72	Impl. Dev. Charged to Patients	9,874,234			160,731				72
73	Drugs Charged to Patients	55,249,391			948,999				73
74	Renal Dialysis	4,404,629			152,170				74
75.01	ONCOLOGY	2,015,722							75.01
76.97	CARDIAC REHABILITATION	656,022			1,367				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,472,610			141				90
90.01	OP PSYCH	797,417							90.01
91	Emergency	62,623,064			303,747				91
92	Observation Beds (Non-Distinct	13,804,257			31,450				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	442,894,418			4,613,749				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-0008** **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	0.274736							50
51	Recovery Room	0.249839							51
52	Delivery Room & Labor Room	0.593102							52
53	Anesthesiology	0.080286							53
54	Radiology-Diagnostic	0.209746							54
54.01	ULTRASOUND	0.153887							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.149702							56
57	CT Scan	0.065318							57
59	Cardiac Catheterization	0.172953							59
60	Laboratory	0.125757							60
62	Whole Blood & Packed Red Blood	0.450607							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.119058							63.02
65	Respiratory Therapy	0.207428							65
66	Physical Therapy	0.409975							66
67	Occupational Therapy	0.344469							67
68	Speech Pathology	0.454068							68
70	Electroencephalography	0.172489							70
71	Medical Supplies Charged to Pat	0.419902							71
72	Impl. Dev. Charged to Patients	0.539250							72
73	Drugs Charged to Patients	0.202726							73
74	Renal Dialysis	0.350116							74
75.01	ONCOLOGY	0.326467							75.01
76.97	CARDIAC REHABILITATION	1.755941							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.174424							90
90.01	OP PSYCH	0.301337							90.01
91	Emergency	0.124615							91
92	Observation Beds (Non-Distinct	0.434149							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: 15-S008** **WORKSHEET D PART II**

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

		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	1,027,207	46,532,066	0.022075			50
51	Recovery Room	21,894	2,963,375	0.007388			51
52	Delivery Room & Labor Room	75,872	3,936,602	0.019273			52
53	Anesthesiology	86,499	6,033,948	0.014335			53
54	Radiology-Diagnostic	1,008,963	25,709,927	0.039244	9,108	357	54
54.01	ULTRASOUND	92,183	6,425,611	0.014346			54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,714	10,811,036	0.008298			56
57	CT Scan	560,333	34,148,638	0.016409	7,944	130	57
59	Cardiac Catheterization	286,241	22,451,775	0.012749			59
60	Laboratory	385,088	71,247,362	0.005405	42,330	229	60
62	Whole Blood & Packed Red Blood	43,211	2,785,970	0.015510			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	144,471	14,472,292	0.009983	3,825	38	63.02
65	Respiratory Therapy	97,011	11,333,150	0.008560	1,794	15	65
66	Physical Therapy	159,368	10,350,425	0.015397	6,348	98	66
67	Occupational Therapy	43,381	5,818,580	0.007456	4,682	35	67
68	Speech Pathology	28,143	1,429,601	0.019686	586	12	68
70	Electroencephalography	91,074	4,582,453	0.019875	800	16	70
71	Medical Supplies Charged to Pat	21,065	10,964,261	0.001921	1,716	3	71
72	Impl. Dev. Charged to Patients	23,930	9,874,234	0.002423			72
73	Drugs Charged to Patients	380,882	55,249,391	0.006894	62,122	428	73
74	Renal Dialysis	10,745	4,404,629	0.002439	1,155	3	74
75.01	ONCOLOGY	17,445	2,015,722	0.008654			75.01
76.97	CARDIAC REHABILITATION	109,121	656,022	0.166337			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	83,069	1,472,610	0.056409			90
90.01	OP PSYCH	8,136	797,417	0.010203			90.01
91	Emergency	348,380	62,623,064	0.005563	22,953	128	91
92	Observation Beds (Non-Distinct		13,804,257				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,243,426	442,894,418		165,363	1,492	200

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-S008** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
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	OP PSYCH							90.01
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: 15-S008** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[ ] Title XVIII, Part A [XX] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [ ] 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	46,532,066							50
51	Recovery Room	2,963,375							51
52	Delivery Room & Labor Room	3,936,602							52
53	Anesthesiology	6,033,948							53
54	Radiology-Diagnostic	25,709,927			9,108				54
54.01	ULTRASOUND	6,425,611							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	10,811,036							56
57	CT Scan	34,148,638			7,944				57
59	Cardiac Catheterization	22,451,775							59
60	Laboratory	71,247,362			42,330				60
62	Whole Blood & Packed Red Blood	2,785,970							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	14,472,292			3,825				63.02
65	Respiratory Therapy	11,333,150			1,794				65
66	Physical Therapy	10,350,425			6,348				66
67	Occupational Therapy	5,818,580			4,682				67
68	Speech Pathology	1,429,601			586				68
70	Electroencephalography	4,582,453			800				70
71	Medical Supplies Charged to Pat	10,964,261			1,716				71
72	Impl. Dev. Charged to Patients	9,874,234							72
73	Drugs Charged to Patients	55,249,391			62,122				73
74	Renal Dialysis	4,404,629			1,155				74
75.01	ONCOLOGY	2,015,722							75.01
76.97	CARDIAC REHABILITATION	656,022							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,472,610							90
90.01	OP PSYCH	797,417							90.01
91	Emergency	62,623,064			22,953				91
92	Observation Beds (Non-Distinct	13,804,257							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	442,894,418			165,363				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-S008** **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	0.274736							50
51	Recovery Room	0.249839							51
52	Delivery Room & Labor Room	0.593102							52
53	Anesthesiology	0.080286							53
54	Radiology-Diagnostic	0.209746							54
54.01	ULTRASOUND	0.153887							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.149702							56
57	CT Scan	0.065318							57
59	Cardiac Catheterization	0.172953							59
60	Laboratory	0.125757							60
62	Whole Blood & Packed Red Blood	0.450607							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.119058							63.02
65	Respiratory Therapy	0.207428							65
66	Physical Therapy	0.409975							66
67	Occupational Therapy	0.344469							67
68	Speech Pathology	0.454068							68
70	Electroencephalography	0.172489							70
71	Medical Supplies Charged to Pat	0.419902							71
72	Impl. Dev. Charged to Patients	0.539250							72
73	Drugs Charged to Patients	0.202726							73
74	Renal Dialysis	0.350116							74
75.01	ONCOLOGY	0.326467							75.01
76.97	CARDIAC REHABILITATION	1.755941							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.174424							90
90.01	OP PSYCH	0.301337							90.01
91	Emergency	0.124615							91
92	Observation Beds (Non-Distinct	0.434149							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: 15-T008** **WORKSHEET D PART II**

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

		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	1,027,207	46,532,066	0.022075			50
51	Recovery Room	21,894	2,963,375	0.007388			51
52	Delivery Room & Labor Room	75,872	3,936,602	0.019273			52
53	Anesthesiology	86,499	6,033,948	0.014335			53
54	Radiology-Diagnostic	1,008,963	25,709,927	0.039244	1,530	60	54
54.01	ULTRASOUND	92,183	6,425,611	0.014346			54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,714	10,811,036	0.008298			56
57	CT Scan	560,333	34,148,638	0.016409	3,169	52	57
59	Cardiac Catheterization	286,241	22,451,775	0.012749			59
60	Laboratory	385,088	71,247,362	0.005405	12,321	67	60
62	Whole Blood & Packed Red Blood	43,211	2,785,970	0.015510			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	144,471	14,472,292	0.009983	554	6	63.02
65	Respiratory Therapy	97,011	11,333,150	0.008560	4,995	43	65
66	Physical Therapy	159,368	10,350,425	0.015397	7,656	118	66
67	Occupational Therapy	43,381	5,818,580	0.007456	8,149	61	67
68	Speech Pathology	28,143	1,429,601	0.019686			68
70	Electroencephalography	91,074	4,582,453	0.019875			70
71	Medical Supplies Charged to Pat	21,065	10,964,261	0.001921	5,400	10	71
72	Impl. Dev. Charged to Patients	23,930	9,874,234	0.002423			72
73	Drugs Charged to Patients	380,882	55,249,391	0.006894	12,853	89	73
74	Renal Dialysis	10,745	4,404,629	0.002439			74
75.01	ONCOLOGY	17,445	2,015,722	0.008654			75.01
76.97	CARDIAC REHABILITATION	109,121	656,022	0.166337			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	83,069	1,472,610	0.056409			90
90.01	OP PSYCH	8,136	797,417	0.010203			90.01
91	Emergency	348,380	62,623,064	0.005563			91
92	Observation Beds (Non-Distinct		13,804,257				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,243,426	442,894,418		56,627	506	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-T008** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
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	OP PSYCH							90.01
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: 15-T008** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [XX] IRF [ ] NF [ ] 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	46,532,066							50
51	Recovery Room	2,963,375							51
52	Delivery Room & Labor Room	3,936,602							52
53	Anesthesiology	6,033,948							53
54	Radiology-Diagnostic	25,709,927			1,530				54
54.01	ULTRASOUND	6,425,611							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	10,811,036							56
57	CT Scan	34,148,638			3,169				57
59	Cardiac Catheterization	22,451,775							59
60	Laboratory	71,247,362			12,321				60
62	Whole Blood & Packed Red Blood	2,785,970							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	14,472,292			554				63.02
65	Respiratory Therapy	11,333,150			4,995				65
66	Physical Therapy	10,350,425			7,656				66
67	Occupational Therapy	5,818,580			8,149				67
68	Speech Pathology	1,429,601							68
70	Electroencephalography	4,582,453							70
71	Medical Supplies Charged to Pat	10,964,261			5,400				71
72	Impl. Dev. Charged to Patients	9,874,234							72
73	Drugs Charged to Patients	55,249,391			12,853				73
74	Renal Dialysis	4,404,629							74
75.01	ONCOLOGY	2,015,722							75.01
76.97	CARDIAC REHABILITATION	656,022							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,472,610							90
90.01	OP PSYCH	797,417							90.01
91	Emergency	62,623,064							91
92	Observation Beds (Non-Distinct	13,804,257							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	442,894,418			56,627				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-T008** **WORKSHEET D PART V**

Check Applicable Boxes:

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.274736							50
51	Recovery Room	0.249839							51
52	Delivery Room & Labor Room	0.593102							52
53	Anesthesiology	0.080286							53
54	Radiology-Diagnostic	0.209746							54
54.01	ULTRASOUND	0.153887							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.149702							56
57	CT Scan	0.065318							57
59	Cardiac Catheterization	0.172953							59
60	Laboratory	0.125757							60
62	Whole Blood & Packed Red Blood	0.450607							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.119058							63.02
65	Respiratory Therapy	0.207428							65
66	Physical Therapy	0.409975							66
67	Occupational Therapy	0.344469							67
68	Speech Pathology	0.454068							68
70	Electroencephalography	0.172489							70
71	Medical Supplies Charged to Pat	0.419902							71
72	Impl. Dev. Charged to Patients	0.539250							72
73	Drugs Charged to Patients	0.202726							73
74	Renal Dialysis	0.350116							74
75.01	ONCOLOGY	0.326467							75.01
76.97	CARDIAC REHABILITATION	1.755941							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.174424							90
90.01	OP PSYCH	0.301337							90.01
91	Emergency	0.124615							91
92	Observation Beds (Non-Distinct	0.434149							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0008** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	33,548	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,548	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)	26,772	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	9,069	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)	29,672,019	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)	29,672,019	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)	29,672,019	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0008** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					884.46	38
39	Program general inpatient routine service cost (line 9 x line 38)					8,021,168	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)					8,021,168	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	5,035,426	2,698	1,866.36	1,044	1,948,480	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)					11,282,497	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					21,252,145	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	471,730	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	589,765	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,061,495	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	20,190,650	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 [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] NF [ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					6,776	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					884.46	88
89	Observation bed cost (line 87 x line 88) (see instructions)					5,993,101	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	1,330,404	29,672,019	0.044837	5,993,101	268,713	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-S008** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,065	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,065	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,065	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)	2,093	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)	3,218,630	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)	3,218,630	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)	3,218,630	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-S008** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,050.12	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,197,901	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)	2,197,901	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	478,997	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,676,898	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	116,455	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	20,767	51
52	Total Program excludable cost (sum of lines 50 and 51)	137,222	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,539,676	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T008** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,496	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,496	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)	7,496	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)	5,304	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)	6,035,487	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)	6,035,487	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)	6,035,487	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T008** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	805.16	38
39	Program general inpatient routine service cost (line 9 x line 38)	4,270,569	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)	4,270,569	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,554,508	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	7,825,077	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	227,329	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	120,080	51
52	Total Program excludable cost (sum of lines 50 and 51)	347,409	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	7,477,668	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0008** **WORKSHEET D-1**
PART I

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[XX] 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)	33,548	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,548	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)	26,772	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)	963	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)	1,192	15
16	Nursery days (title V or XIX only)	220	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)	29,672,019	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)	29,672,019	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)	29,672,019	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0008** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] 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)					884.46	38
39	Program general inpatient routine service cost (line 9 x line 38)					851,735	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)					851,735	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)	788,462	1,192	661.46	220	145,521	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	5,035,426	2,698	1,866.36	93	173,571	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)					1,067,017	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,237,844	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					52,905	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					49,099	51
52	Total Program excludable cost (sum of lines 50 and 51)					102,004	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,135,840	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**	**[XX] PPS**	
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					6,776	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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-S008** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] 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)	3,065	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,065	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,065	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)	133	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)	3,218,630	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)	3,218,630	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)	3,218,630	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-S008** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[XX] IPF**		**[ ] TEFRA**
	[XX] 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)	1,050.12	38
39	Program general inpatient routine service cost (line 9 x line 38)	139,666	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)	139,666	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	29,831	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	169,497	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	7,400	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,492	51
52	Total Program excludable cost (sum of lines 50 and 51)	8,892	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	160,605	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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T008** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,496	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,496	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)	7,496	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)	22	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)	6,035,487	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)	6,035,487	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)	6,035,487	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-T008** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	805.16	38
39	Program general inpatient routine service cost (line 9 x line 38)	17,714	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)	17,714	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	14,001	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	31,715	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	943	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	506	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,449	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	30,266	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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-0008** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		14,612,772		30
31	Intensive Care Unit		2,162,395		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.275094	4,105,867	1,129,499	50
51	Recovery Room	0.249839	321,488	80,320	51
52	Delivery Room & Labor Room	0.593102	7,911	4,692	52
53	Anesthesiology	0.084481	727,004	61,418	53
54	Radiology-Diagnostic	0.210184	2,265,918	476,260	54
54.01	ULTRASOUND	0.153887	265,983	40,931	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.149702	928,231	138,958	56
57	CT Scan	0.065318	3,685,639	240,739	57
59	Cardiac Catheterization	0.173398	4,663,581	808,656	59
60	Laboratory	0.125862	8,316,355	1,046,713	60
62	Whole Blood & Packed Red Blood Cells	0.450607	604,037	272,183	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.119058	2,088,831	248,692	63.02
65	Respiratory Therapy	0.207428	4,550,609	943,924	65
66	Physical Therapy	0.409975	873,108	357,952	66
67	Occupational Therapy	0.344469	507,194	174,713	67
68	Speech Pathology	0.454068	166,104	75,423	68
70	Electroencephalography	0.172489	294,968	50,879	70
71	Medical Supplies Charged to Patients	0.419902	1,135,715	476,889	71
72	Impl. Dev. Charged to Patients	0.539250	2,340,965	1,262,365	72
73	Drugs Charged to Patients	0.202726	8,909,681	1,806,224	73
74	Renal Dialysis	0.350116	1,429,580	500,519	74
75.01	ONCOLOGY	0.326467			75.01
76.97	CARDIAC REHABILITATION	1.769653	51,040	90,323	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.174424	6,749	7,926	90
90.01	OP PSYCH	0.301337			90.01
91	Emergency	0.126501	4,930,814	623,753	91
92	Observation Beds (Non-Distinct Part)	0.434149	835,073	362,546	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		54,012,445	11,282,497	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		54,012,445		202

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-S008** **WORKSHEET D-3**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [XX] 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				30
31	Intensive Care Unit				31
40	Subprovider - IPF		6,424,855		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.275094	6,611	1,819	50
51	Recovery Room	0.249839	9,627	2,405	51
52	Delivery Room & Labor Room	0.593102			52
53	Anesthesiology	0.084481	11,768	994	53
54	Radiology-Diagnostic	0.210184	74,890	15,741	54
54.01	ULTRASOUND	0.153887	3,064	472	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.149702	11,451	1,714	56
57	CT Scan	0.065318	133,799	8,739	57
59	Cardiac Catheterization	0.173398	8,290	1,437	59
60	Laboratory	0.125862	600,827	75,621	60
62	Whole Blood & Packed Red Blood Cells	0.450607			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.119058	76,490	9,107	63.02
65	Respiratory Therapy	0.207428	81,242	16,852	65
66	Physical Therapy	0.409975	100,235	41,094	66
67	Occupational Therapy	0.344469	73,397	25,283	67
68	Speech Pathology	0.454068	14,390	6,534	68
70	Electroencephalography	0.172489	8,240	1,421	70
71	Medical Supplies Charged to Patients	0.419902	62,072	26,064	71
72	Impl. Dev. Charged to Patients	0.539250			72
73	Drugs Charged to Patients	0.202726	887,771	179,974	73
74	Renal Dialysis	0.350116	99,000	34,661	74
75.01	ONCOLOGY	0.326467			75.01
76.97	CARDIAC REHABILITATION	1.769653			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.174424			90
90.01	OP PSYCH	0.301337			90.01
91	Emergency	0.126501	229,758	29,065	91
92	Observation Beds (Non-Distinct Part)	0.434149			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,492,922	478,997	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,492,922		202

(A) Worksheet A line numbers

(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
41	Subprovider - IRF		5,331,114		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.275094	48,708	13,399	50
51	Recovery Room	0.249839	9,943	2,484	51
52	Delivery Room & Labor Room	0.593102			52
53	Anesthesiology	0.084481	17,858	1,509	53
54	Radiology-Diagnostic	0.210184	198,225	41,664	54
54.01	ULTRASOUND	0.153887	20,689	3,184	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.149702	55,650	8,331	56
57	CT Scan	0.065318	163,184	10,659	57
59	Cardiac Catheterization	0.173398	89,955	15,598	59
60	Laboratory	0.125862	1,345,246	169,315	60
62	Whole Blood & Packed Red Blood Cells	0.450607	50,145	22,596	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.119058	328,011	39,052	63.02
65	Respiratory Therapy	0.207428	594,303	123,275	65
66	Physical Therapy	0.409975	2,642,534	1,083,373	66
67	Occupational Therapy	0.344469	2,483,267	855,409	67
68	Speech Pathology	0.454068	284,737	129,290	68
70	Electroencephalography	0.172489	110,432	19,048	70
71	Medical Supplies Charged to Patients	0.419902	461,273	193,689	71
72	Impl. Dev. Charged to Patients	0.539250	31,317	16,888	72
73	Drugs Charged to Patients	0.202726	2,957,534	599,569	73
74	Renal Dialysis	0.350116	582,398	203,907	74
75.01	ONCOLOGY	0.326467			75.01
76.97	CARDIAC REHABILITATION	1.769653	283	501	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.174424	808	949	90
90.01	OP PSYCH	0.301337			90.01
91	Emergency	0.126501	6,477	819	91
92	Observation Beds (Non-Distinct Part)	0.434149			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		12,482,977	3,554,508	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		12,482,977		202

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-0008** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V [XX] Title XVIII, Part A [XX] Title XIX
[XX] Hospital [ ] IPF [ ] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] Swing Bed SNF [ ] Swing Bed NF [ ] ICF/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		1,781,058		30
31	Intensive Care Unit		204,180		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery		297,950		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.275094	327,823	90,182	50
51	Recovery Room	0.249839	37,723	9,425	51
52	Delivery Room & Labor Room	0.593102	264,729	157,011	52
53	Anesthesiology	0.084481	79,165	6,688	53
54	Radiology-Diagnostic	0.210184	161,856	34,020	54
54.01	ULTRASOUND	0.153887	58,131	8,946	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.149702	54,286	8,127	56
57	CT Scan	0.065318	214,281	13,996	57
59	Cardiac Catheterization	0.173398	311,884	54,080	59
60	Laboratory	0.125862	864,055	108,752	60
62	Whole Blood & Packed Red Blood Cells	0.450607	42,919	19,340	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.119058	151,320	18,016	63.02
65	Respiratory Therapy	0.207428	155,658	32,288	65
66	Physical Therapy	0.409975	53,320	21,860	66
67	Occupational Therapy	0.344469	24,778	8,535	67
68	Speech Pathology	0.454068	35,980	16,337	68
70	Electroencephalography	0.172489	8,120	1,401	70
71	Medical Supplies Charged to Patients	0.419902	169,116	71,012	71
72	Impl. Dev. Charged to Patients	0.539250	160,731	86,674	72
73	Drugs Charged to Patients	0.202726	948,999	192,387	73
74	Renal Dialysis	0.350116	152,170	53,277	74
75.01	ONCOLOGY	0.326467			75.01
76.97	CARDIAC REHABILITATION	1.769653	1,367	2,419	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.174424	141	166	90
90.01	OP PSYCH	0.301337			90.01
91	Emergency	0.126501	303,747	38,424	91
92	Observation Beds (Non-Distinct Part)	0.434149	31,450	13,654	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,613,749	1,067,017	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,613,749		202

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-S008** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS	
[ ] Title XVIII, Part A	[XX] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA	
[XX] 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		434,197		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.275094			50
51	Recovery Room	0.249839			51
52	Delivery Room & Labor Room	0.593102			52
53	Anesthesiology	0.084481			53
54	Radiology-Diagnostic	0.210184	9,108	1,914	54
54.01	ULTRASOUND	0.153887			54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.149702			56
57	CT Scan	0.065318	7,944	519	57
59	Cardiac Catheterization	0.173398			59
60	Laboratory	0.125862	42,330	5,328	60
62	Whole Blood & Packed Red Blood Cells	0.450607			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.119058	3,825	455	63.02
65	Respiratory Therapy	0.207428	1,794	372	65
66	Physical Therapy	0.409975	6,348	2,603	66
67	Occupational Therapy	0.344469	4,682	1,613	67
68	Speech Pathology	0.454068	586	266	68
70	Electroencephalography	0.172489	800	138	70
71	Medical Supplies Charged to Patients	0.419902	1,716	721	71
72	Impl. Dev. Charged to Patients	0.539250			72
73	Drugs Charged to Patients	0.202726	62,122	12,594	73
74	Renal Dialysis	0.350116	1,155	404	74
75.01	ONCOLOGY	0.326467			75.01
76.97	CARDIAC REHABILITATION	1.769653			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.174424			90
90.01	OP PSYCH	0.301337			90.01
91	Emergency	0.126501	22,953	2,904	91
92	Observation Beds (Non-Distinct Part)	0.434149			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		165,363	29,831	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		165,363		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-T008** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF		21,816		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.275094			50
51	Recovery Room	0.249839			51
52	Delivery Room & Labor Room	0.593102			52
53	Anesthesiology	0.084481			53
54	Radiology-Diagnostic	0.210184	1,530	322	54
54.01	ULTRASOUND	0.153887			54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.149702			56
57	CT Scan	0.065318	3,169	207	57
59	Cardiac Catheterization	0.173398			59
60	Laboratory	0.125862	12,321	1,551	60
62	Whole Blood & Packed Red Blood Cells	0.450607			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.119058	554	66	63.02
65	Respiratory Therapy	0.207428	4,995	1,036	65
66	Physical Therapy	0.409975	7,656	3,139	66
67	Occupational Therapy	0.344469	8,149	2,807	67
68	Speech Pathology	0.454068			68
70	Electroencephalography	0.172489			70
71	Medical Supplies Charged to Patients	0.419902	5,400	2,267	71
72	Impl. Dev. Charged to Patients	0.539250			72
73	Drugs Charged to Patients	0.202726	12,853	2,606	73
74	Renal Dialysis	0.350116			74
75.01	ONCOLOGY	0.326467			75.01
76.97	CARDIAC REHABILITATION	1.769653			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.174424			90
90.01	OP PSYCH	0.301337			90.01
91	Emergency	0.126501			91
92	Observation Beds (Non-Distinct Part)	0.434149			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		56,627	14,001	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		56,627		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)	4,109,304			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	13,767,622			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)	195,615			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)	146.44			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 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)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
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)				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)				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)	0.1291			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3877			31
32	Sum of lines 30 and 31	0.5168			32
33	Allowable disproportionate share percentage (see instructions)	0.3185			33
34	Disproportionate share adjustment (see instructions)	1,423,450			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,094,784		1,740,252	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	526,557		1,301,613	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,828,170			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)	21,324,161			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)	21,324,161			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,613,812			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)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	14,500			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)	22,952,473			59
60	Primary payer payments	11,212			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	22,941,261			61
62	Deductibles billed to program beneficiaries	1,679,748			62
63	Coinsurance billed to program beneficiaries	182,658			63
64	Allowable bad debts (see instructions)	504,712			64
65	Adjusted reimbursable bad debts (see instructions)	328,063			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	292,980			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	21,406,918			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 (ER ADJUSTMENT PER PSR)				70
70.93	HVBP payment adjustment amount (see instructions)	112,701			70.93
70.94	HRR adjustment amount (see instructions)	-23,259			70.94
71	Amount due provider (see instructions)	21,496,360			71
71.01	Sequestration adjustment (see instructions)	429,927			71.01
72	Interim payments	20,655,361			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	411,072			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	642,722			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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	41,264			1
2	Medical and other services reimbursed under OPPS (see instructions)	11,867,960			2
3	PPS payments	9,717,724			3
4	Outlier payment (see instructions)	59,222			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	41,264			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	158,643			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)	158,643			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)	158,643			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	117,379			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	41,264			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	9,776,946			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	25,284			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,829,830			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)	7,963,096			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)	7,963,096			30
31	Primary payer payments	693			31
32	Subtotal (line 30 minus line 31)	7,962,403			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)	512,216			34
35	Adjusted reimbursable bad debts (see instructions)	332,940			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	339,224			36
37	Subtotal (see instructions)	8,295,343			37
38	MSP-LCC reconciliation amount from PS&R	4			38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	8,295,339			40
40.01	Sequestration adjustment (see instructions)	165,907			40.01
41	Interim payments	8,227,172			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-97,740			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

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-S008** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	377			1
2	Medical and other services reimbursed under OPPS (see instructions)	1,400			2
3	PPS payments	476			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	377			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,859			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)	1,859			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)	1,859			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	1,482			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	377			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	476			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	22			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)	831			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)	831			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	831			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)	831			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	831			40
40.01	Sequestration adjustment (see instructions)	17			40.01
41	Interim payments	934			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-120			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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-0008** **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				20,247,284		7,799,631	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				408,077		427,541	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)				20,655,361		8,227,172	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							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.

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-S008** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [XX] 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				2,000,501			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)				2,000,501			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							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.

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-T008** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [XX] 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				9,351,487		934	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)				9,351,487		934	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							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.

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	6,307	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	10,113	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	3,967	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	29,470	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	516,923,804	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	21,796,799	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-S008** **WORKSHEET E-3 PART II**

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

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,941,437	1
2	Net IPF PPS Outlier payment	269,860	2
3	Net IPF PPS ECT payment	2,526	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)	8.397260	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)	2,213,823	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)	2,213,823	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,213,823	18
19	Deductibles	109,312	19
20	Subtotal (line 18 minus line 19)	2,104,511	20
21	Coinsurance	63,175	21
22	Subtotal (line 20 minus line 21)	2,041,336	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	26,237	23
24	Adjusted reimbursable bad debts (see instructions)	17,054	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,437	25
26	Subtotal (sum of lines 22 and 24)	2,058,390	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)	2,058,390	31
31.01	Sequestration adjustment (see instructions)	41,168	31.01
32	Interim payments	2,000,501	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	16,721	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

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	9,165,344		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.079400		2
3	Inpatient Rehabilitation LIP payments (see instructions)	590,248		3
4	Outlier payments	65,614		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	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)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	20.536986		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	9,821,206		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	9,821,206		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	9,821,206		19
20	Deductibles	77,644		20
21	Subtotal (line 19 minus line 20)	9,743,562		21
22	Coinsurance	133,658		22
23	Subtotal (line 21 minus line 22)	9,609,904		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	68,725		24
25	Adjusted reimbursable bad debts (see instructions)	44,671		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,147		26
27	Subtotal (sum of lines 23 and 25)	9,654,575		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	9,654,575		32
32.01	Sequestration adjustment (see instructions)	193,092		32.01
33	Interim payments	9,351,487		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	109,996		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	216,081		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-0008** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	2,283,188		8
9	Ancillary service charges	4,613,749		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)	6,896,937		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)	6,896,937		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,896,937		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-S008** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	434,197		8
9	Ancillary service charges	165,363		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)	599,560		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)	599,560		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	599,560		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	21,816		8
9	Ancillary service charges	56,627		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)	78,443		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)	78,443		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	78,443		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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	79,377				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	17,387,232				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	6,415,200				7
8	Prepaid expenses	6,637,235				8
9	Other current assets	4,437,133				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	34,956,177				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	31,685,178				15
16	Accumulated depreciation					16
17	Leasehold improvements					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					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	31,685,178				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,436,319				34
35	Total other assets (sum of lines 31-34)	5,436,319				35
36	Total assets (sum of lines 11, 30 and 35)	72,077,674				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,177,049				37
38	Salaries, wages and fees payable	5,582,354				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	766,121				43
44	Other current liabilities	19,224,970				44
45	Total current liabilities (sum of lines 37 thru 44)	26,750,494				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	3,378,057				49
50	Total long term liabilities (sum of lines 46 thru 49)	3,378,057				50
51	Total liabilities (sum of lines 45 and 50)	30,128,551				51
	CAPITAL ACCOUNTS					
52	General fund balance	41,949,123				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)	41,949,123				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	72,077,674				60

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		49,392,080			1
2	Net income (loss) (from Worksheet G-3, line 29)		-7,479,012			2
3	Total (sum of line 1 and line 2)		41,913,068			3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS RELEASED FROM RESTRICTIO	135,000				5
6	NET ASSETS TRANSFERRED					6
7	CONTRIBUTIONS	180,055				7
8						8
9						9
10	Total additions (sum of lines 4-9)		315,055			10
11	Subtotal (line 3 plus line 10)		42,228,123			11
12	Deductions (debit adjustments) (specify)	9,000				12
13	TRANSFERS	270,000				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		279,000			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		41,949,123			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	NET ASSETS RELEASED FROM RESTRICTIO					5
6	NET ASSETS TRANSFERRED					6
7	CONTRIBUTIONS					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	TRANSFERS					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	47,852,572		47,852,572	1
2	Subprovider IPF	13,259,334		13,259,334	2
3	Subprovider IRF	25,327,363		25,327,363	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)	86,439,269		86,439,269	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,006,197		6,006,197	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)	6,006,197		6,006,197	16
17	Total inpatient routine care services (sum of lines 10 and 16)	92,445,466		92,445,466	17
18	Ancillary services	137,076,704		137,076,704	18
19	Outpatient services		279,434,194	279,434,194	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		2,498,273	2,498,273	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	ANESTHESIOLOGISTS REVENUE	2,579,758	4,288,411	6,868,169	27
27.01	PHYSICIAN REVENUE	88,661	9,710	98,371	27.01
27.02	CAPITATION		-7,824,715	-7,824,715	27.02
27.03	OCCUPATIONAL HEALTH		1,136,090	1,136,090	27.03
27.04	REGENCY REVENUE		4,333,076	4,333,076	27.04
27.05	DIETARY INCOME		4,257	4,257	27.05
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	232,190,589	283,879,296	516,069,885	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		220,701,488	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)		220,701,488	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	516,069,885	1
2	Less contractual allowances and discounts on patients' accounts	376,885,449	2
3	Net patient revenues (line 1 minus line 2)	139,184,436	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	220,701,488	4
5	Net income from service to patients (line 3 minus line 4)	-81,517,052	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	2,800	6
7	Income from investments	87,780	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	3,262	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	750,053	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	453,238	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	3,025	21
22	Rental of hosptial space	818,406	22
23	Governmental appropriations		23
24	Other (specify)		24
24.01	Other (CAPITATION REVENUE)	66,083,006	24.01
24.02	Other (GRANT INCOME)	-52,315	24.02
24.03	Other (OTHER INCOME)	2,965,189	24.03
24.04	Other (PHARMACY INCOME)	2,749,473	24.04
24.05	Other (CLASSES)	40,117	24.05
24.06	Other (TEMP RESTRICTED)	134,006	24.06
25	Total other income (sum of lines 6-24)	74,038,040	25
26	Total (line 5 plus line 25)	-7,479,012	26
29	Net income (or loss) for the period (line 26 minus line 28)	-7,479,012	29

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7453** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	431,385	299,622	50,238		36,199	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	714,300					6
7	Physical Therapy	9,490			321,870		7
8	Occupational Therapy				117,534		8
9	Speech Pathology				14,640		9
10	Medical Social Services	1,086					10
11	Home Health Aide	86,005					11
12	Supplies (see instructions)					97,720	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	1,242,266	299,622	50,238	454,044	133,919	24

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7453** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	817,444	-168,723	648,721	-1,135	647,586	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	714,300		714,300		714,300	6
7	Physical Therapy	331,360		331,360		331,360	7
8	Occupational Therapy	117,534		117,534		117,534	8
9	Speech Pathology	14,640		14,640		14,640	9
10	Medical Social Services	1,086		1,086		1,086	10
11	Home Health Aide	86,005		86,005		86,005	11
12	Supplies (see instructions)	97,720		97,720		97,720	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	2,180,089	-168,723	2,011,366	-1,135	2,010,231	24

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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7453** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	647,586				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	714,300				6
7	Physical Therapy	331,360				7
8	Occupational Therapy	117,534				8
9	Speech Pathology	14,640				9
10	Medical Social Services	1,086				10
11	Home Health Aide	86,005				11
12	Supplies (see instructions)	97,720				12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	2,010,231				24

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 15-7453** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		647,586	647,586		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		714,300	339,465	1,053,765	6
7	Physical Therapy		331,360	157,476	488,836	7
8	Occupational Therapy		117,534	55,857	173,391	8
9	Speech Pathology		14,640	6,958	21,598	9
10	Medical Social Services		1,086	516	1,602	10
11	Home Health Aide		86,005	40,873	126,878	11
12	Supplies (see instructions)		97,720	46,441	144,161	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		2,010,231		2,010,231	24

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-647,586	1,362,645	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						714,300	6
7	Physical Therapy						331,360	7
8	Occupational Therapy						117,534	8
9	Speech Pathology						14,640	9
10	Medical Social Services						1,086	10
11	Home Health Aide						86,005	11
12	Supplies (see instructions)						97,720	12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-647,586	1,362,645	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						647,586	25
26	Unit Cost Multiplier						0.475242	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7453** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
1	Administrative and General		21,241		181,630	13,014	8,344	1
2	Skilled Nursing Care	1,053,765						2
3	Physical Therapy	488,836						3
4	Occupational Therapy	173,391						4
5	Speech Pathology	21,598						5
6	Medical Social Services	1,602						6
7	Home Health Aide	126,878						7
8	Supplies	144,161						8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	2,010,231	21,241		181,630	13,014	8,344	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7453** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	
		5.02	5.03	5.04	4A	5.05	6	
1	Administrative and General	5,040	6,510	11,777	247,556	47,989	73,213	1
2	Skilled Nursing Care				1,053,765	204,271		2
3	Physical Therapy				488,836	94,761		3
4	Occupational Therapy				173,391	33,612		4
5	Speech Pathology				21,598	4,187		5
6	Medical Social Services				1,602	311		6
7	Home Health Aide				126,878	24,595		7
8	Supplies				144,161	27,946		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	5,040	6,510	11,777	2,257,787	437,672	73,213	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7453** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General	42,940		37,832				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	42,940		37,832				20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7453** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	Administrative and General				17,585			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)				17,585			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 15-7453** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS		
		24	25	26	27	28		
1	Administrative and General	467,115		467,115				1
2	Skilled Nursing Care	1,258,036		1,258,036	244,862	1,502,898		2
3	Physical Therapy	583,597		583,597	113,590	697,187		3
4	Occupational Therapy	207,003		207,003	40,291	247,294		4
5	Speech Pathology	25,785		25,785	5,019	30,804		5
6	Medical Social Services	1,913		1,913	372	2,285		6
7	Home Health Aide	151,473		151,473	29,482	180,955		7
8	Supplies	172,107		172,107	33,499	205,606		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	2,867,029		2,867,029	467,115	2,867,029		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.194638			21

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

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DEPRECIATI EXPENSE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINT OF PERSONNEL FTE'S	NONPATIENT TELEPHONES NUMBER OF TELEPHONES	PURCHASING RECEIVING & STORES COSTED REQ	
		1	2	4	4.01	5.01	5.02	
1	Administrative and General	2,702		1,242,266	1,591	13	12,852	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	2,702		1,242,266	1,591	13	12,852	20
21	Total cost to be allocated	21,241		181,630	13,014	8,344	5,040	21
22	Unit Cost Multiplier	7.861214		0.146209		641.846154		22
22	Unit Cost Multiplier				8.179761		0.392157	22

	HHA COST CENTER	ADMITTING GROSS REVENUE	CASHIERING ACCOUNTS RECEIVABLE GROSS REVENUE	RECON-CILIATION	OTHER ADMIN GENERAL ACCUM COST	MAIN-TENANCE + REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	4A.05	5.05	6	7	
1	Administrative and General	2,498,273	2,498,273		247,556	2,702	2,702	1
2	Skilled Nursing Care				1,053,765			2
3	Physical Therapy				488,836			3
4	Occupational Therapy				173,391			4
5	Speech Pathology				21,598			5
6	Medical Social Services				1,602			6
7	Home Health Aide				126,878			7
8	Supplies				144,161			8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	2,498,273	2,498,273		2,257,787	2,702	2,702	20
21	Total cost to be allocated	6,510	11,777		437,672	73,213	42,940	21
22	Unit Cost Multiplier	0.002606				27.095855		22
22	Unit Cost Multiplier		0.004714		0.193850		15.891932	22

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 15-7453** **WORKSHEET H-2 PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		8	9	10	11	12	13	
1	Administrative and General		2,702					1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		2,702					20
21	Total cost to be allocated		37,832					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		14.001480					22

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 15-7453** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME		
		14	15	16	17	19		
1	Administrative and General			2,498,273				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)			2,498,273				20
21	Total cost to be allocated			17,585				21
22	Unit Cost Multiplier			0.007039				22
22	Unit Cost Multiplier							22

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 15-7453** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation

	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,502,898		1,502,898	12,167	123.52	1
2	Physical Therapy	3	697,187		697,187	4,241	164.39	2
3	Occupational Therapy	4	247,294		247,294	1,559	158.62	3
4	Speech Pathology	5	30,804		30,804	213	144.62	4
5	Medical Social Services	6	2,285		2,285	15	152.33	5
6	Home Health Aide	7	180,955		180,955	3,966	45.63	6
7	Total (sum of lines 1-6)		2,661,423		2,661,423	22,161		7

Limitation Cost Comoputation

			Program Visits			
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	23844		6,349		8
9	Physical Therapy	23844		2,073		9
10	Occupational Therapy	23844		752		10
11	Speech Pathology	23844		127		11
12	Medical Social Services	23844		8		12
13	Home Health Aide	23844		2,371		13
14	Total (sum of lines 8-13)			11,680		14

Supplies and Drugs Cost Computations

	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	205,606		205,606	214,998	0.956316	15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.409975			col. 2, line 2	1
2	Occupational Therapy	67	0.344469			col. 2, line 3	2
3	Speech Pathology	68	0.454068			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.419902			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.202726			col. 2, line 16	5

Check applicable box: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		6,349			784,228		784,228	1
2	Physical Therapy		2,073			340,780		340,780	2
3	Occupational Therapy		752			119,282		119,282	3
4	Speech Pathology		127			18,367		18,367	4
5	Medical Social Services		8			1,219		1,219	5
6	Home Health Aide		2,371			108,189		108,189	6
7	Total (sum of lines 1-6)		11,680			1,372,065		1,372,065	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies		207,026			197,982		15
16	Cost of Drugs							16

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 15-7453** **WORKSHEET H-4**
PARTS I & II

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

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

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to excced 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts		6,151		9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)		-6,151	10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,139,518	11
12	Total PPS Reimbursement - Full Episodes with Outliers		117,383	12
13	Total PPS Reimbursement - LUPA Episodes		12,176	13
14	Total PPS Reimbursement - PEP Episodes		9,579	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		13,715	15
16	Total PPS Outlier Reimbursement - PSP Episodes		369	16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		1,286,589	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,286,589	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,286,589	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		1,286,589	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,286,589	31
31.01	Sequestration adjustment (see instructions)		25,732	31.01
32	Interim payments (see instructions)		1,260,857	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 15-7453** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						1,260,857	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						1,260,857	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	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date: Month, Day, Year		8

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

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 15-0008** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,444,155	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	10,222	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)	81.45	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1291	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.3877	8
9	Sum of lines 7 and 8	0.5168	9
10	Allowable disproportionate share percentage (see instructions)	0.1104	10
11	Disproportionate share adjustment (see instructions)	159,435	11
12	Total prospective capital payments (see instructions)	1,613,812	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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/29/2017 Run Time: 07:39 Version: 2017.10 (10/09/2017)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 15-0008** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		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)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		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
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
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
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
41	Subprovider - IRF							41
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
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
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	OP PSYCH							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY							194.01
194.03	ADVERTISING EXPENSE							194.03
194.04	REGENCY HOSPITAL							194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

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		
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202