KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/27/2018 Time: 15:23 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. CATHERINE HOSPITAL (15-0008) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

ECR Encryption: 11/27/2018 15:23
.O1D7PksG57GXdy7SZzVa2JGB4MzA0
8bK.q06hlwahraNav6YMmWlWqKi28D
3AR21rVmoO0bsEVX

PI Encryption: 11/27/2018 15:23
q4cbuaLVlrtbOY3lTe2r9hU0qovRK0
Hti2v0hTOyzlX8VZPBE6n86U:bp6xk
Jbmp0iTsa20TjLNi

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

CEO
Title

11/27/2018 15:23
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		532,821	121,654			1
2	SUBPROVIDER - IPF		12,128				2
3	SUBPROVIDER - IRF		146,869	-50			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		691,818	121,604			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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 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:

							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	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 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	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.	1,338	206		582	9,836		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.	14	490		12	656		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

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

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	Y	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N				115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			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 care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.			N		122

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: 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	10/09/2018	Y	10/09/2018	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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	149	54,385			8,520	1,136	26,144	1
2	HMO and other (see instructions)						4,219	10,445		2
3	HMO IPF Subprovider						595	336		3
4	HMO IRF Subprovider						708	1,158		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			8,520	1,136	26,144	7
8	Intensive Care Unit	31	16	5,840			864	101	2,568	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						56	1,236	13
14	Total (see instructions)		165	60,225			9,384	1,293	29,948	14
15	CAH Visits									15
16	Subprovider - IPF	40	16	5,840			1,884	133	3,211	16
17	Subprovider - IRF	41	30	10,950			4,126	14	6,659	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					8,826		16,248	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30							67	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		211							27
28	Observation Bed Days								6,734	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							224	250	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,929	270	6,023	1
2	HMO and other (see instructions)					698	2,092		2
3	HMO IPF Subprovider						51		3
4	HMO IRF Subprovider						98		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)		896.75			1,929	270	6,023	14
15	CAH Visits								15
16	Subprovider - IPF		23.15			199	11	377	16
17	Subprovider - IRF		35.66			351	1	555	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		16.82						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)		972.38						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	57,984,886		57,984,886	2,022,556.00	28.67	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B		620,573		620,573	5,824.00	106.55	3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		2,405,430		2,405,430	21,074.00	114.14	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)		4,698,782		4,698,782	166,253.00	28.26	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,171,444		1,171,444	9,876.00	118.62	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		530,585		530,585	3,258.00	162.86	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		8,496,752		8,496,752	269,400.00	31.54	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)		13,050,848		13,050,848			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		1,210,728		1,210,728			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		90,956		90,956			21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		387,686		387,686			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		2,050,492		2,050,492			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		480,225		480,225	12,956.00	37.07	26
27	Administrative & General		5,366,157		5,366,157	183,791.00	29.20	27
28	Administrative & General under contract (see instructions)		1,289,154		1,289,154	9,612.00	134.12	28
29	Maintenance & Repairs		1,192,578		1,192,578	39,245.00	30.39	29
30	Operation of Plant		874,446		874,446	34,522.00	25.33	30
31	Laundry & Linen Service		75,036		75,036	4,630.00	16.21	31
32	Housekeeping		1,809,441		1,809,441	121,782.00	14.86	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		1,702,137	-977,027	725,110	44,823.00	16.18	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			977,027	977,027	60,394.00	16.18	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,108,203		1,108,203	27,410.00	40.43	38
39	Central Services and Supply							39
40	Pharmacy		1,694,458		1,694,458	41,020.00	41.31	40
41	Medical Records & Medical Records Library		104,885		104,885	3,647.00	28.76	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		56,248,037		56,248,037	2,005,270.00	28.05	1
2	Excluded area salaries (see instructions)		4,698,782		4,698,782	166,253.00	28.26	2
3	Subtotal salarles (line 1 minus line 2)		51,549,255		51,549,255	1,839,017.00	28.03	3
4	Subtotal other wages & related costs (see instructions)		10,198,781		10,198,781	282,534.00	36.10	4
5	Subtotal wage-related costs (see instructions)		15,101,340		15,101,340		29.29%	5
6	Total (sum of lines 3 through 5)		76,849,376		76,849,376	2,121,551.00	36.22	6
7	Total overhead cost (see instructions)		15,696,720		15,696,720	583,832.00	26.89	7

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	2,346,049	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,773,836	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	557,813	10
11	Life Insurance (If employee is owner or beneficiary)	51,636	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	53,360	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	814,484	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	3,315,671	17
18	Medicare Taxes - Employers Portion Only	806,377	18
19	Unemployment Insurance	20,992	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	14,740,218	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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	1,171,444	14,740,218	1
2	Hospital	1,171,444	14,740,218	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

HOSPITAL-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		1,545		900	2,445	1
2	Unduplicated Census Count (see instructions)		235.00		236.00	471.00	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)	0.93		0.93	4
5	Other Administrative Personnel	5.21		5.21	5
6	Direct Nursing Service	5.24		5.24	6
7	Nursing Supervisor				7
8	Physical Therapy Service	1.73	0.40	2.13	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	0.59	0.16	0.75	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	0.01	0.09	0.10	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	1.39		1.39	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	3,728	413	46	156	4,343	21
22	Skilled Nursing Visit Charges	650,714	72,014	8,058	27,593	758,379	22
23	Physical Therapy Visits	1,686	96	3	66	1,851	23
24	Physical Therapy Visit Charges	343,651	19,626	621	13,552	377,450	24
25	Occupational Therapy Visits	908	40		50	998	25
26	Occupational Therapy Visit Charges	186,502	8,168		10,354	205,024	26
27	Speech Pathology Visits	48	22		9	79	27
28	Speech Pathology Visit Charges	9,636	4,466		1,881	15,983	28
29	Medical Social Service Visits	6	1	1	2	10	29
30	Medical Social Service Visit Charges	1,401	230	237	460	2,328	30
31	Home Health Aide Visits	1,312	175	4	54	1,545	31
32	Home Health Aide Visit Charges	170,564	22,707	516	7,078	200,865	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,688	747	54	337	8,826	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	1,362,468	127,211	9,432	60,918	1,560,029	35
36	Total Number of Episodes (standard/non-outlier)	333		23	15	371	36
37	Total Number of Ourlier Episodes		19		2	21	37
38	Total Non-Routine Medical Supply Charges	120,982	13,912	2,468	5,301	142,663	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)	0.245530	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	35,482,509	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	8,787,198	5
6	Medicaid charges	186,798,146	6
7	Medicaid cost (line 1 times line 6)	45,864,549	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,594,842	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)	8,395	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)	80,100	14
15	State or local indigent care program cost (line 1 times line 14)	19,667	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.	11,272	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)	1,606,114	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)	14,088,117	1,604,063	15,692,180	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,459,055	1,604,063	5,063,118	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	3,459,055	1,604,063	5,063,118	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)	6,705,020	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	841,012	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,293,865	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,411,155	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,781,454	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	6,844,572	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,450,686	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				2,475,814	2,475,814	836,179	3,311,993	1
2	00200	Cap Rel Costs-Mvble Equip				3,103,388	3,103,388	971,221	4,074,609	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	120,305	-1,414,890	-1,294,585	10,356,828	9,062,243	-471,193	8,591,050	4
4.01	00401	MAINTENANCE OF PERSONNEL	359,920	1,063,302	1,423,222	-890,759	532,463	-175	532,288	4.01
5.01	00540	NONPATIENT TELEPHONES						519,634	519,634	5.01
5.02	00560	PURCHASING RECEIVING & STORES	272,137	124,565	396,702	-53,379	343,323	-1,904	341,419	5.02
5.03	00570	ADMITTING	923,058	344,616	1,267,674	-192,789	1,074,885		1,074,885	5.03
5.04	00580	CASHIERING ACCOUNTS RECEIVABLE						2,534,909	2,534,909	5.04
5.05	00590	OTHER ADMIN & GENERAL	4,170,962	98,324,154	102,495,116	-897,564	101,597,552	-80,952,475	20,645,077	5.05
6	00600	Maintenance & Repairs	1,192,578	5,453,290	6,645,868	-876,957	5,768,911	-7,146	5,761,765	6
7	00700	Operation of Plant	874,446	2,432,588	3,307,034	-593,502	2,713,532	-19,385	2,694,147	7
8	00800	Laundry & Linen Service	75,036	593,473	668,509	-38,174	630,335	-39,787	590,548	8
9	00900	Housekeeping	1,809,441	1,106,330	2,915,771	-534,415	2,381,356		2,381,356	9
10	01000	Dietary	1,702,137	2,166,927	3,869,064	-2,737,332	1,131,732		1,131,732	10
11	01100	Cafeteria				2,220,843	2,220,843	-869,963	1,350,880	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,108,203	599,493	1,707,696	-257,226	1,450,470	-385	1,450,085	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	1,694,458	6,469,498	8,163,956	-4,002,040	4,161,916		4,161,916	15
16	01600	Medical Records & Library	104,885	134,822	239,707	-15,798	223,909	2,345,516	2,569,425	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	13,287,605	6,586,289	19,873,894	-4,643,791	15,230,103	-30,876	15,199,227	30
31	03100	Intensive Care Unit	2,258,643	1,283,345	3,541,988	-666,327	2,875,661	-19,077	2,856,584	31
40	04000	Subprovider - IPF	1,195,993	881,700	2,077,693	-428,301	1,649,392		1,649,392	40
41	04100	Subprovider - IRF	1,833,031	1,406,163	3,239,194	-415,308	2,823,886	-37	2,823,849	41
43	04300	Nursery				571,412	571,412		571,412	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	3,470,390	8,523,983	11,994,373	-4,808,890	7,185,483	-656,714	6,528,769	50
51	05100	Recovery Room	356,491	113,109	469,600	-47,156	422,444	-2	422,442	51
52	05200	Delivery Room & Labor Room				1,255,217	1,255,217		1,255,217	52
53	05300	Anesthesiology	2,205,017	791,171	2,996,188	-231,669	2,764,519	-2,467,378	297,141	53
54	05400	Radiology-Diagnostic	1,734,320	1,666,897	3,401,217	-1,101,951	2,299,266	-37,124	2,262,142	54
54.01	05401	ULTRASOUND	424,398	240,571	664,969	-101,777	563,192		563,192	54.01
54.02	03040	AUDIOLOGY								54.02
56	05600	Radioisotope	528,708	663,025	1,191,733	-80,949	1,110,784		1,110,784	56
57	05700	CT Scan	458,501	729,607	1,188,108	-367,997	820,111		820,111	57
59	05900	Cardiac Catheterization	1,088,614	5,541,111	6,629,725	-4,198,733	2,430,992	-36,745	2,394,247	59
60	06000	Laboratory	2,590,588	3,397,312	5,987,900	-606,097	5,381,803	-16,951	5,364,852	60
62	06200	Whole Blood & Packed Red Blood Cells	146,727	638,577	785,304	-54,588	730,716		730,716	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	06301	NONINVASIVE LAB	734,270	399,661	1,133,931	-259,765	874,166	-114,747	759,419	63.02
65	06500	Respiratory Therapy	1,125,073	549,858	1,674,931	-218,637	1,456,294	-16,076	1,440,218	65
66	06600	Physical Therapy	1,535,049	1,434,737	2,969,786	-275,960	2,693,826	-116,547	2,577,279	66
67	06700	Occupational Therapy	591,576	730,280	1,321,856	-77,515	1,244,341		1,244,341	67
68	06800	Speech Pathology	258,023	238,851	496,874	-45,219	451,655	-11,719	439,936	68
70	07000	Electroencephalography	184,324	128,486	312,810	-59,384	253,426		253,426	70
71	07100	Medical Supplies Charged to Patients				3,625,203	3,625,203		3,625,203	71
72	07200	Impl. Dev. Charged to Patients				4,006,331	4,006,331		4,006,331	72
73	07300	Drugs Charged to Patients		886	886	3,625,076	3,625,962		3,625,962	73
74	07400	Renal Dialysis		978,848	978,848	-3,721	975,127		975,127	74
75.01	03480	ONCOLOGY	356,180	822,795	1,178,975	-90,093	1,088,882	-643,834	445,048	75.01
76.97	07697	CARDIAC REHABILITATION	469,728	172,960	642,688	-102,041	540,647	-35,744	504,903	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,124,609	810,055	2,934,664	-369,527	2,565,137	-2,422,000	143,137	90
90.01	09001	OP PSYCH		154,015	154,015		154,015		154,015	90.01
91	09100	Emergency	2,949,704	1,732,625	4,682,329	-612,703	4,069,626	-123,355	3,946,271	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	1,329,834	578,921	1,908,755	-195,682	1,713,073	-274	1,712,799	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	57,644,962	158,594,006	216,238,968	86,396	216,325,364	-81,904,154	134,421,210	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices		300,103	300,103	-18,210	281,893		281,893	192
194	07950	OTHER NON REIM COST CENTER								194
194.01	07954	RETAIL PHARMACY	306,135	2,170,000	2,476,135	-66,419	2,409,716		2,409,716	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	33,789	541,770	575,559	-696	574,863		574,863	194.03
194.04	07952	REGENCY HOSPITAL		148,619	148,619	-1,071	147,548		147,548	194.04
194.05	07953	UNUSED SPACE								194.05
200		TOTAL (sum of lines 118-199)	57,984,886	161,754,498	219,739,384		219,739,384	-81,904,154	137,835,230	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		264,740	1
2							2
3							3
4							4
5			Medical Supplies Charged to P	71		3,360,463	5
6			Impl. Dev. Charged to Patient	72		4,006,331	6
7							7
8							8
500	Total reclassifications					7,631,534	500
	Code Letter - A						
1	RECLASS DRUGS	B	Drugs Charged to Patients	73		3,625,160	1
500	Total reclassifications					3,625,160	500
	Code Letter - B						
1	CAFETERIA RECLASS	C	Cafeteria	11	977,027	1,243,816	1
500	Total reclassifications				977,027	1,243,816	500
	Code Letter - C						
1	BUILDING DEPR RECLASS	D	Cap Rel Costs-Bldg & Fixt	1		2,313,670	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
500	Total reclassifications					2,313,670	500
	Code Letter - D						
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Nursery	43	378,026	193,386	1
2			Delivery Room & Labor Room	52	830,408	424,809	2
500	Total reclassifications				1,208,434	618,195	500
	Code Letter - F						
1	RECLASS BLDG RENTAL	G	Cap Rel Costs-Bldg & Fixt	1		1,216	1
2	RECLASS RENTAL EQUIPMENT	G	Cap Rel Costs-Mvble Equip	2		709,844	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

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
21							21
22							22
23							23
24							24
25							25
26							26
27							27
500	Total reclassifications					711,060	500
	Code Letter - G						
1	RECLASS EQUIPMENT DEPR	H	Cap Rel Costs-Mvble Equip	2		2,393,544	1
2			Maintenance & Repairs	6		186,107	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
500	Total reclassifications					2,579,651	500
	Code Letter - H						
1	RECLASS PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		160,928	1
500	Total reclassifications					160,928	500
	Code Letter - J						
1	RECLASS FRINGE BENEFITS	L	Employee Benefits Department	4		8,328,446	1
2	257	L	Employee Benefits Department	4		2,028,741	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

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
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
41							41
500	Total reclassifications					10,357,187	500
	Code Letter - L						
	GRAND TOTAL (Increases)				2,185,461	29,241,201	

(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		162,963		1
2			Intensive Care Unit	31		54,141		2
3			Subprovider - IRF	41		13,843		3
4			Emergency	91		33,793		4
5			Operating Room	50		3,601,490		5
6			Anesthesiology	53		33,352		6
7			Cardiac Catheterization	59		3,715,645		7
8			Physical Therapy	66		16,307		8
500	Total reclassifications					7,631,534		500
	Code letter - A							
1	RECLASS DRUGS	B	Pharmacy	15		3,625,160		1
500	Total reclassifications					3,625,160		500
	Code letter - B							
1	CAFETERIA RECLASS	C	Dietary	10	977,027	1,243,816		1
500	Total reclassifications				977,027	1,243,816		500
	Code letter - C							
1	BUILDING DEPR RECLASS	D	OTHER ADMIN & GENERAL	5.05		79,532	9	1
2			Maintenance & Repairs	6		807,766		2
3			Operation of Plant	7		393,087		3
4			Housekeeping	9		650		4
5			Dietary	10		25,726		5
6			Nursing Administration	13		9,169		6
7			PURCHASING RECEIVING & STORES	5.02		256		7
8			Pharmacy	15		6,588		8
9			Adults & Pediatrics	30		235,032		9
10			Intensive Care Unit	31		144,439		10
11			Subprovider - IPF	40		192,361		11
12			Subprovider - IRF	41		61,422		12
13			Operating Room	50		14,110		13
14			Radiology-Diagnostic	54		89,216		14
15			ULTRASOUND	54.01		1,856		15
16			Radioisotope	56		8,605		16
17			CT Scan	57		35,071		17
18			Cardiac Catheterization	59		68,910		18
19			Laboratory	60		25,471		19
20			Physical Therapy	66		659		20
21			Electroencephalography	70		2,899		21
22			Renal Dialysis	74		2,995		22
23			ONCOLOGY	75.01		26,174		23
24			CARDIAC REHABILITATION	76.97		7,077		24
25			Clinic	90		26,572		25
26			Emergency	91		23,397		26
27			Physicians' Private Offices	192		17,289		27
28			RETAIL PHARMACY	194.01		6,676		28
29			REGENCY HOSPITAL	194.04		665		29
500	Total reclassifications					2,313,670		500
	Code letter - D							
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Adults & Pediatrics	30	378,026	193,386		1
2			Adults & Pediatrics	30	830,408	424,809		2
500	Total reclassifications				1,208,434	618,195		500
	Code letter - F							
1	RECLASS BLDG RENTAL	G	OTHER ADMIN & GENERAL	5.05		1,216	10	1
2	RECLASS RENTAL EQUIPMENT	G	MAINTENANCE OF PERSONNEL	4.01		1,240	10	2
3			PURCHASING RECEIVING & STORES	5.02		2,162		3
4			OTHER ADMIN & GENERAL	5.05		31,712		4
5			Maintenance & Repairs	6		18,297		5
6			Operation of Plant	7		8,001		6
7			Laundry & Linen Service	8		18,591		7
8			Housekeeping	9		137		8
9			Dietary	10		45,521		9
10			Nursing Administration	13		49		10
11			Adults & Pediatrics	30		1,313		11
12			Subprovider - IRF	41		3,679		12
13			Operating Room	50		237,874		13
14			Radiology-Diagnostic	54		199,534		14
15			ULTRASOUND	54.01		43,751		15
16			Radioisotope	56		3,036		16
17			CT Scan	57		39,357		17
18			Cardiac Catheterization	59		2,695		18
19			Laboratory	60		2,694		19

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
20			NONINVASIVE LAB	63.02		4,548		20
21			Respiratory Therapy	65		4,195		21
22			Physical Therapy	66		35,812		22
23			Occupational Therapy	67		752		23
24			Electroencephalography	70		2,573		24
25			Renal Dialysis	74		726		25
26			Clinic	90		1,189		26
27			REGENCY HOSPITAL	194.04		406		27
500	Total reclassifications					711,060		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		74,002		3
4			Operation of Plant	7		27,660		4
5			Laundry & Linen Service	8		1,069		5
6			Housekeeping	9		17,095		6
7			Dietary	10		41,399		7
8			Nursing Administration	13		88,420		8
9			PURCHASING RECEIVING & STORES	5.02		787		9
10			Pharmacy	15		168,200		10
11			Medical Records & Library	16		1,135		11
12			Adults & Pediatrics	30		142,040		12
13			Intensive Care Unit	31		64,045		13
14			Subprovider - IPF	40		29,281		14
15			Subprovider - IRF	41		42,521		15
16			Operating Room	50		386,398		16
17			Recovery Room	51		957		17
18			Anesthesiology	53		58,043		18
19			Radiology-Diagnostic	54		495,038		19
20			ULTRASOUND	54.01		32,097		20
21			Radioisotope	56		22,987		21
22			CT Scan	57		221,074		22
23			Cardiac Catheterization	59		245,645		23
24			Laboratory	60		113,202		24
25			Whole Blood & Packed Red Bloo	62		21,220		25
26			NONINVASIVE LAB	63.02		120,201		26
27			Respiratory Therapy	65		32,457		27
28			Physical Therapy	66		19,377		28
29			Occupational Therapy	67		3,497		29
30			Speech Pathology	68		9,595		30
31			Electroencephalography	70		25,473		31
32			ONCOLOGY	75.01		709		32
33			CARDIAC REHABILITATION	76.97		20,772		33
34			Clinic	90		3,941		34
35			Emergency	91		41,551		35
36			Physicians' Private Offices	192		921		36
37			RETAIL PHARMACY	194.01		5,258		37
38			ADVERTISING EXPENSE	194.03		654		38
500	Total reclassifications					2,579,651		500
	Code letter - H							
1	RECLASS PROPERTY INSURANCE	J	OTHER ADMIN & GENERAL	5.05		160,928	12	1
500	Total reclassifications					160,928		500
	Code letter - J							
1	RECLASS FRINGE BENEFITS	L						1
2	257	L	MAINTENANCE OF PERSONNEL	4.01		889,519		2
3			PURCHASING RECEIVING & STORES	5.02		50,174		3
4			ADMITTING	5.03		192,218		4
5			OTHER ADMIN & GENERAL	5.05		550,174		5
6			Maintenance & Repairs	6		237,001		6
7			Operation of Plant	7		164,754		7
8			Laundry & Linen Service	8		18,514		8
9			Housekeeping	9		516,533		9
10			Dietary	10		403,843		10
11			Nursing Administration	13		159,588		11
12			Pharmacy	15		202,092		12
13			Medical Records & Library	16		14,663		13
14			Adults & Pediatrics	30		2,275,814		14
15			Intensive Care Unit	31		403,702		15
16			Subprovider - IPF	40		206,659		16
17			Subprovider - IRF	41		293,843		17
18			Operating Room	50		569,018		18
19			Recovery Room	51		46,199		19

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
20			Anesthesiology	53		140,274		20
21			Radiology-Diagnostic	54		318,163		21
22			ULTRASOUND	54.01		24,073		22
23			Radioisotope	56		46,321		23
24			CT Scan	57		72,495		24
25			Cardiac Catheterization	59		165,838		25
26			Laboratory	60		464,730		26
27			Whole Blood & Packed Red Bloo	62		33,368		27
28			NONINVASIVE LAB	63.02		135,016		28
29			Respiratory Therapy	65		181,985		29
30			Physical Therapy	66		203,805		30
31			Occupational Therapy	67		73,266		31
32			Speech Pathology	68		35,624		32
33			Electroencephalography	70		28,439		33
34			Drugs Charged to Patients	73		84		34
35			ONCOLOGY	75.01		63,210		35
36			CARDIAC REHABILITATION	76.97		74,192		36
37			Clinic	90		337,825		37
38			Emergency	91		513,962		38
39			Home Health Agency	101		195,682		39
40			RETAIL PHARMACY	194.01		54,485		40
41			ADVERTISING EXPENSE	194.03		42		41
500	Total reclassifications					10,357,187		500
	Code letter - L							
	GRAND TOTAL (Decreases)				2,185,461	29,241,201		

(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	74,030,026	3,668,020		3,668,020	697,896	77,000,150		3
4	Building Improvements	45,370				8,944	36,426		4
5	Fixed Equipment								5
6	Movable Equipment	109,639,826	2,045,667		2,045,667	4,241,844	107,443,649		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	186,353,492	5,713,687		5,713,687	4,948,684	187,118,495		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	186,353,492	5,713,687		5,713,687	4,948,684	187,118,495		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	79,674,846		79,674,846	0.425799					1
2	Cap Rel Costs-Mvble Equ	107,443,649		107,443,649	0.574201					2
3	Total (sum of lines 1-2)	187,118,495		187,118,495	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	3,149,849	1,216		160,928			3,311,993	1
2	Cap Rel Costs-Mvble Equip	3,364,765	709,844					4,074,609	2
3	Total (sum of lines 1-2)	6,514,614	711,060		160,928			7,386,602	3

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

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-53,503	NONPATIENT TELEPHONES	5.01		7
8	Television and radio service (chapter 21)	A	-1,624	Cap Rel Costs-Mvble Equip	2	9	8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,076,270				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-2,486,616				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 and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures	A	697,028	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	14,275	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	-35,744	CARDIAC REHABILITATION	76.97		33
33.07	LAB REVENUE	B	-7,980	Laboratory	60		33.07
33.13	OTHER OPERATING REVENUE	B	-175	MAINTENANCE OF PERSONNEL	4.01		33.13
33.14	OTHER INCOME	B	-854	Clinic	90		33.14
33.15	OFFSET OCC HEALTH COSTS FOR BP/US	A	-1,587,583	Clinic	90		33.15
33.16	OFFSET INTERCO REVENUE	B	-114,747	NONINVASIVE LAB	63.02		33.16
33.17	OFFSET OCC HEALTH BP/US STEEL BENE	A	-270,320	Employee Benefits Department	4		33.17
33.19	OTHER OPERATING REVENUE	B	-61,017	OTHER ADMIN & GENERAL	5.05		33.19
33.23	OTHER OPER REV	B	-1,904	PURCHASING RECEIVING & STORES	5.02		33.23
33.26	CAFETERIA REVENUE	B	-869,963	Cafeteria	11		33.26
33.28	OTHER OPER REVENUE	B	-19,385	Operation of Plant	7		33.28
33.29	OTHER OPERATING REVENUE	B	-7,146	Maintenance & Repairs	6		33.29
33.30	OTHER OPERATING REVENUE	B	-39,787	Laundry & Linen Service	8		33.30
33.31	OFFSET OTHER REVENUE	B	-37	Subprovider - IRF	41		33.31
33.32	OFFSET OTHER REVENUE	B	-5,940	Intensive Care Unit	31		33.32
33.33	OFFSET OTHER REVENUE	B	-176	Adults & Pediatrics	30		33.33
33.34	RELEASED TEMP REST OP	B	-6,051	Medical Records & Library	16		33.34
33.36	OFFSET OTHER INCOME	B	-2,940	OTHER ADMIN & GENERAL	5.05		33.36
33.37	RELEASED TEMP REST INCOME	B	-24,589	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	-1,306,700	OTHER ADMIN & GENERAL	5.05		34.01
34.03	OFFSET CAPITATION EXPENSE	A	-68,002,807	OTHER ADMIN & GENERAL	5.05		34.03
35	CRNA SALARIES	A	-620,573	Anesthesiology	53		35
35.01	OFFSET BENEFITS CRNA/ANEST	A	-133,585	Employee Benefits Department	4		35.01
35.02	OFFSET BENEFITS FOR ANEST/CRNA	A	-159,995	Anesthesiology	53		35.02
36	OFFSET CONTRIBUTIONS	A	-300	Medical Records & Library	16		36
37	OFFSET WOUND CLINIC NP	A	-116,547	Physical Therapy	66		37
38	OFFSET OCC HEALTH 28700 TO BENEFIT	A	-67,288	Employee Benefits Department	4		38
38.01	OFFSET OTHER ANEST PHYS COSTS	A	-177,936	Anesthesiology	53		38.01
39	OFFSET FEES FOR ON CALL SURGEONS	A	-656,700	Operating Room	50		39
40	MDWISE ADD BACK	A	8,743,155	OTHER ADMIN & GENERAL	5.05		40
41	OFFSET MEDICAID ASSESSMENT	A	-5,968,264	OTHER ADMIN & GENERAL	5.05		41
42	OFFSET OCC HEALTH 28700	A	-331,088	Clinic	90		42

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
43	OFFSET OCC HEALTH 28700	A	-180,398	Clinic	90		43
44	OFFSET OTHER INCOME	B	-25,967	Radiology-Diagnostic	54		44
45	OFFSET OTHER INCOME	B	-14	Operating Room	50		45
45.01	OTHER OP REV	B	-2	Recovery Room	51		45.01
46	ELIMINATE PHYSICIAN COSTS	A	-5,284,739	OTHER ADMIN & GENERAL	5.05		46
46.02	OFFSET OCC HEALTH PHYS PART B	A	-6,926	Clinic	90		46.02
46.04	OFFSET ONCOLOGY PHYSICIAN COSTS	A	-643,834	ONCOLOGY	75.01		46.04
47	HHA MARKETING EXPENSE	A	-274	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)		-81,904,154				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	139,151		139,151	9	1
2	2	Cap Rel Costs-Mvble Equip	DEPRECIATION EQUIP	958,894		958,894	9	2
3	5.05	OTHER ADMIN & GENERAL	A&G OTHER	13,396,576	22,441,150	-9,044,574		3
3.01	5.01	NONPATIENT TELEPHONES	TELECOMMUNICATIONS	573,137		573,137		3.01
3.02	16	Medical Records & Library	MEDICAL RECORDS	2,351,867		2,351,867		3.02
3.03	5.04	CASHIERING ACCOUNTS RECEIVABLE	PATIENT ACCOUNTING	2,534,909		2,534,909		3.03
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			19,954,534	22,441,150	-2,486,616		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:

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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	25,825		25,825	211,500	258	26,234	1,312	1
2	13	Nursing Administrati	38,516		38,516	211,500	375	38,131	1,907	2
3	16	Medical Records & Li	14,650		14,650	211,500	147	14,947	747	3
4	30	Adults & Pediatrics AGGREGATE	45,750	30,700	15,050	211,500	151	15,354	768	4
5	31	Intensive Care Unit AGGREGATE	24,627	9,514	15,113	211,500	113	11,490	575	5
6	53	Anesthesiology	693		693	239,400	4	460	23	6
7	54	Radiology-Diagnostic	24,752		24,752	271,900	104	13,595	680	7
8	59	Cardiac Catheterizat	65,013		65,013	211,500	278	28,268	1,413	8
9	60	Laboratory	48,016		48,016	260,300	312	39,045	1,952	9
10	65	Respiratory Therapy AGGREGATE	16,076	16,076						10
11										11
12	68	Speech Pathology AGGREGATE	11,719	11,719						12
13	90	Clinic	23,031		23,031	211,500	172	17,489	874	13
14	90	Clinic	6,926		6,926	211,500	69	7,016	351	14
15	53	Anesthesiology AGGREGATE	1,508,641	1,508,641						15
16	91	Emergency	253,000		253,000	211,500	1,275	129,645	6,482	16
17	90	Clinic OCC HEALTH SALA	309,609	309,609						17
18										18
19										19
20										20
200		TOTAL	2,416,844	1,886,259	530,585		3,258	341,674	17,084	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					26,234			1
2	13	Nursing Administrati					38,131	385	385	2
3	16	Medical Records & Li					14,947			3
4	30	Adults & Pediatrics AGGREGATE					15,354		30,700	4
5	31	Intensive Care Unit AGGREGATE					11,490	3,623	13,137	5
6	53	Anesthesiology					460	233	233	6
7	54	Radiology-Diagnostic					13,595	11,157	11,157	7
8	59	Cardiac Catheterizat					28,268	36,745	36,745	8
9	60	Laboratory					39,045	8,971	8,971	9
10	65	Respiratory Therapy AGGREGATE							16,076	10
11										11
12	68	Speech Pathology AGGREGATE							11,719	12
13	90	Clinic					17,489	5,542	5,542	13
14	90	Clinic					7,016			14
15	53	Anesthesiology AGGREGATE							1,508,641	15
16	91	Emergency					129,645	123,355	123,355	16
17	90	Clinic OCC HEALTH SALA							309,609	17
18										18
19										19
20										20
200		TOTAL					341,674	190,011	2,076,270	200

	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	3,311,993	3,311,993					1
2	Cap Rel Costs-Mvble Equip	4,074,609		4,074,609				2
4	Employee Benefits Department	8,591,050	1,328	567	8,592,945			4
4.01	MAINTENANCE OF PERSONNEL	532,288	15,078		55,490	602,856		4.01
5.01	NONPATIENT TELEPHONES	519,634	6,289				525,923	5.01
5.02	PURCHASING RECEIVING & STORES	341,419	59,063	1,243	41,956	5,229	3,847	5.02
5.03	ADMITTING	1,074,885	26,865	902	142,312	17,721	11,541	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE	2,534,909					9,342	5.04
5.05	OTHER ADMIN & GENERAL	20,645,077	327,671	116,887	643,054	32,185	104,966	5.05
6	Maintenance & Repairs	5,761,765	462,918		183,865	11,774	3,847	6
7	Operation of Plant	2,694,147	136,280	43,689	134,817	10,358	12,640	7
8	Laundry & Linen Service	590,548	12,687	1,689	11,569	1,391	1,099	8
9	Housekeeping	2,381,356	52,037	27,002	278,969	36,534	6,595	9
10	Dietary	1,131,732	86,604	29,602	111,793	13,447	12,090	10
11	Cafeteria	1,350,880	28,239	35,789	150,632	18,120		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,450,085	16,942	139,661	170,856	8,224	2,198	13
14	Central Services & Supply							14
15	Pharmacy	4,161,916	33,309	265,675	261,241	12,305	18,135	15
16	Medical Records & Library	2,569,425	26,197	1,793	16,171	1,092	10,442	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,199,227	501,863	224,355	1,862,294	143,408	56,054	30
31	Intensive Care Unit	2,856,584	71,673	101,160	348,224	21,115	7,144	31
40	Subprovider - IPF	1,649,392	58,303	46,250	184,391	14,445	7,694	40
41	Subprovider - IRF	2,823,849	112,412	67,163	282,606	22,251	14,838	41
43	Nursery	571,412	16,305		58,282	3,501		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,528,769	243,311	610,323	535,044	33,114	38,469	50
51	Recovery Room	422,442	9,426	1,512	54,962	2,727	2,198	51
52	Delivery Room & Labor Room	1,255,217	35,817		128,027	7,681		52
53	Anesthesiology	297,141	2,485	91,680	11,687	4,886	3,297	53
54	Radiology-Diagnostic	2,262,142	70,330	781,918	267,387	19,793	15,388	54
54.01	ULTRASOUND	563,192	8,440	50,698	65,431	2,877	4,396	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,110,784	13,890	36,308	81,513	3,082	4,946	56
57	CT Scan	820,111	9,418	349,190	70,689	3,987	2,198	57
59	Cardiac Catheterization	2,394,247	49,987	388,001	167,836	9,129	25,279	59
60	Laboratory	5,364,852	84,818	178,805	399,401	29,776	31,874	60
62	Whole Blood & Packed Red Blood Cells	730,716	5,715	33,517	22,621	1,585	3,847	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	759,419	16,414	189,860	113,205	7,694	4,396	63.02
65	Respiratory Therapy	1,440,218	14,776	51,266	173,457	11,519	5,496	65
66	Physical Therapy	2,577,279	69,406	30,606	236,665	12,536	19,784	66
67	Occupational Therapy	1,244,341	18,968	5,524	91,206	5,653		67
68	Speech Pathology	439,936	6,149	15,155	39,780	1,716	1,099	68
70	Electroencephalography	253,426	29,745	40,235	28,418	2,040	3,847	70
71	Medical Supplies Charged to Patients	3,625,203						71
72	Impl. Dev. Charged to Patients	4,006,331						72
73	Drugs Charged to Patients	3,625,962						73
74	Renal Dialysis	975,127	6,367					74
75.01	ONCOLOGY	445,048	9,348	1,120	54,914	4,137	1,099	75.01
76.97	CARDIAC REHABILITATION	504,903	43,092	32,810	72,420	4,287	3,297	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	143,137	37,595	6,225	327,559	18,726	4,396	90
90.01	OP PSYCH	154,015	4,969					90.01
91	Emergency	3,946,271	77,985	65,631	454,768	29,633	23,081	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,712,799	15,948		205,026	10,495	7,144	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	134,421,210	2,936,462	4,063,811	8,540,538	600,173	488,003	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,673					190
192	Physicians' Private Offices	281,893	222,255	1,455			1,649	192
194	OTHER NON REIM COST CENTER			8,305				194
194.01	RETAIL PHARMACY	2,409,716	8,331		47,198	2,396		194.01
194.03	ADVERTISING EXPENSE	574,863	7,803	1,038	5,209	287	2,748	194.03
194.04	REGENCY HOSPITAL	147,548	128,469				33,523	194.04

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)	137,835,230	3,311,993	4,074,609	8,592,945	602,856	525,923	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	452,757						5.02
5.03	ADMITTING	785	1,275,011					5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE			2,544,251				5.04
5.05	OTHER ADMIN & GENERAL	1,137			21,870,977	21,870,977		5.05
6	Maintenance & Repairs	466			6,424,635	1,211,693	7,636,328	6
7	Operation of Plant	199			3,032,130	571,863	431,319	7
8	Laundry & Linen Service	27			619,010	116,746	40,154	8
9	Housekeeping	1,087			2,783,580	524,986	164,694	9
10	Dietary	5,584			1,390,852	262,316	274,096	10
11	Cafeteria				1,583,660	298,680	89,375	11
12	Maintenance of Personnel							12
13	Nursing Administration	510			1,788,476	337,308	53,620	13
14	Central Services & Supply							14
15	Pharmacy	4,198			4,756,779	897,133	105,422	15
16	Medical Records & Library	32			2,625,152	495,106	82,912	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	59,209	154,109	307,510	18,508,029	3,490,635	1,588,371	30
31	Intensive Care Unit	14,570	13,788	27,513	3,461,771	652,893	226,841	31
40	Subprovider - IPF	1,821	25,070	50,025	2,037,391	384,254	184,525	40
41	Subprovider - IRF	8,712	16,905	33,733	3,382,469	637,937	355,779	41
43	Nursery		4,384	8,749	662,633	124,973	51,605	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	71,935	119,452	238,355	8,418,772	1,587,789	770,069	50
51	Recovery Room	725	7,103	14,173	515,268	97,180	29,833	51
52	Delivery Room & Labor Room		9,631	19,218	1,455,591	274,526	113,359	52
53	Anesthesiology	9,936	16,208	32,342	469,662	88,579	7,864	53
54	Radiology-Diagnostic	2,883	58,694	117,117	3,595,652	678,144	222,589	54
54.01	ULTRASOUND	2,926	16,976	33,874	748,810	141,226	26,712	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	828	27,949	55,770	1,335,070	251,796	43,962	56
57	CT Scan	4,737	76,700	153,047	1,490,077	281,030	29,808	57
59	Cardiac Catheterization	125,544	66,230	132,155	3,358,408	633,399	158,206	59
60	Laboratory	78,592	167,176	333,670	6,668,964	1,257,773	268,444	60
62	Whole Blood & Packed Red Blood Cells	5,996	6,230	12,432	822,659	155,154	18,086	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	1,129	37,617	75,062	1,204,796	227,226	51,949	63.02
65	Respiratory Therapy	4,535	25,941	51,763	1,778,971	335,516	46,764	65
66	Physical Therapy	6,612	26,088	52,057	3,031,033	571,656	219,665	66
67	Occupational Therapy	843	13,256	26,452	1,406,243	265,219	60,034	67
68	Speech Pathology	147	3,562	7,108	514,652	97,064	19,462	68
70	Electroencephalography	1,138	11,463	22,873	393,185	74,155	94,142	70
71	Medical Supplies Charged to Patients		26,654	53,185	3,705,042	698,775		71
72	Impl. Dev. Charged to Patients		23,134	46,162	4,075,627	768,667		72
73	Drugs Charged to Patients	7	139,609	278,576	4,044,154	762,731		73
74	Renal Dialysis	144	9,013	17,984	1,008,635	190,230	20,151	74
75.01	ONCOLOGY	2,029	6,219	12,409	536,323	101,151	29,587	75.01
76.97	CARDIAC REHABILITATION	401	1,816	3,624	666,650	125,731	136,385	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,088	1,056	2,107	542,889	102,389	118,986	90
90.01	OP PSYCH		1,868	3,727	164,579	31,040	15,727	90.01
91	Emergency	26,333	156,075	311,432	5,091,209	960,207	246,819	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,971	5,035	10,047	1,970,465	371,632	50,475	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	451,816	1,275,011	2,544,251	133,940,930	21,136,508	6,447,791	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				8,673	1,636	27,449	190
192	Physicians' Private Offices				507,252	95,668	703,425	192
194	OTHER NON REIM COST CENTER				8,305	1,566		194
194.01	RETAIL PHARMACY	880			2,468,521	465,566	26,368	194.01
194.03	ADVERTISING EXPENSE	5			591,953	111,643	24,697	194.03
194.04	REGENCY HOSPITAL	56			309,596	58,390	406,598	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)	452,757	1,275,011	2,544,251	137,835,230	21,870,977	7,636,328	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	4,035,312						7
8	Laundry & Linen Service	22,489	798,399					8
9	Housekeeping	92,240		3,565,500				9
10	Dietary	153,513		155,206	2,235,983			10
11	Cafeteria	50,056		50,608		2,072,379		11
12	Maintenance of Personnel							12
13	Nursing Administration	30,031		30,362		38,248	2,278,045	13
14	Central Services & Supply							14
15	Pharmacy	59,043		59,694		57,227		15
16	Medical Records & Library	46,437		46,949		5,078		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	889,602	244,874	899,412	1,542,759	666,960	1,053,753	30
31	Intensive Care Unit	127,047	26,266	128,448	72,708	98,202	155,155	31
40	Subprovider - IPF	103,347	30,362	104,486	147,900	67,180	106,139	40
41	Subprovider - IRF	199,261	49,102	201,458	288,215	103,484	163,512	41
43	Nursery	28,902	9,874	29,221		16,280	25,702	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	431,293	120,704	436,048		154,007	243,367	50
51	Recovery Room	16,708	20,006	16,893		12,682	20,019	51
52	Delivery Room & Labor Room	63,489	21,696	64,189		35,723	56,461	52
53	Anesthesiology	4,404		4,453		22,722		53
54	Radiology-Diagnostic	124,666	31,303	126,040		92,050		54
54.01	ULTRASOUND	14,960	32,247	15,125		13,378		54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	24,622	11,481	24,894		14,336		56
57	CT Scan	16,695		16,879		18,544		57
59	Cardiac Catheterization	88,607	25,031	89,583		42,456	67,092	59
60	Laboratory	150,348		152,005		138,482		60
62	Whole Blood & Packed Red Blood Cells	10,130		10,241		7,371		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	29,095	9,944	29,416		35,781		63.02
65	Respiratory Therapy	26,191		26,480		53,570		65
66	Physical Therapy	123,028	27,489	124,384		58,300		66
67	Occupational Therapy	33,623		33,994		26,292		67
68	Speech Pathology	10,900		11,021		7,980		68
70	Electroencephalography	52,726	14,103	53,308		9,489		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	11,286		11,410				74
75.01	ONCOLOGY	16,571		16,753		19,240		75.01
76.97	CARDIAC REHABILITATION	76,385	14,287	77,227		19,936	31,508	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	66,641	11,469	67,375		87,088	137,611	90
90.01	OP PSYCH	8,808		8,905				90.01
91	Emergency	138,236	50,223	139,760		137,814	217,726	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	28,269		28,581				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,369,649	750,461	3,290,808	2,051,582	2,059,900	2,278,045	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	15,373		15,543				190
192	Physicians' Private Offices	393,967						192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY	14,768		14,931		11,144		194.01
194.03	ADVERTISING EXPENSE	13,832		13,984		1,335		194.03
194.04	REGENCY HOSPITAL	227,723	47,938	230,234	184,401			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	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)	4,035,312	798,399	3,565,500	2,235,983	2,072,379	2,278,045	202

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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		
	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	5,935,298						15
16	Medical Records & Library		3,301,634					16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		399,022	29,283,417		29,283,417		30
31	Intensive Care Unit		35,701	4,985,032		4,985,032		31
40	Subprovider - IPF		64,912	3,230,496		3,230,496		40
41	Subprovider - IRF		43,772	5,424,989		5,424,989		41
43	Nursery		11,352	960,542		960,542		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		309,288	12,471,337		12,471,337		50
51	Recovery Room		18,391	746,980		746,980		51
52	Delivery Room & Labor Room		24,937	2,109,971		2,109,971		52
53	Anesthesiology		41,967	639,651		639,651		53
54	Radiology-Diagnostic		151,971	5,022,415		5,022,415		54
54.01	ULTRASOUND		43,955	1,036,413		1,036,413		54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		72,367	1,778,528		1,778,528		56
57	CT Scan		198,592	2,051,625		2,051,625		57
59	Cardiac Catheterization		171,483	4,634,265		4,634,265		59
60	Laboratory		433,200	9,069,216		9,069,216		60
62	Whole Blood & Packed Red Blood Cells		16,132	1,039,773		1,039,773		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		97,399	1,685,606		1,685,606		63.02
65	Respiratory Therapy		67,167	2,334,659		2,334,659		65
66	Physical Therapy		67,549	4,223,104		4,223,104		66
67	Occupational Therapy		34,324	1,859,729		1,859,729		67
68	Speech Pathology		9,224	670,303		670,303		68
70	Electroencephalography		29,680	720,788		720,788		70
71	Medical Supplies Charged to Patients		69,012	4,472,829		4,472,829		71
72	Impl. Dev. Charged to Patients		59,899	4,904,193		4,904,193		72
73	Drugs Charged to Patients	5,935,298	361,478	11,103,661		11,103,661		73
74	Renal Dialysis		23,336	1,265,048		1,265,048		74
75.01	ONCOLOGY		16,102	735,727		735,727		75.01
76.97	CARDIAC REHABILITATION		4,703	1,152,812		1,152,812		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		2,734	1,137,182		1,137,182		90
90.01	OP PSYCH		4,836	233,895		233,895		90.01
91	Emergency		404,112	7,386,106		7,386,106		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		13,037	2,462,459		2,462,459		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,935,298	3,301,634	130,832,751		130,832,751		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			68,674		68,674		190
192	Physicians' Private Offices			1,700,312		1,700,312		192
194	OTHER NON REIM COST CENTER			9,871		9,871		194
194.01	RETAIL PHARMACY			3,001,298		3,001,298		194.01
194.03	ADVERTISING EXPENSE			757,444		757,444		194.03
194.04	REGENCY HOSPITAL			1,464,880		1,464,880		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	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)	5,935,298	3,301,634	137,835,230		137,835,230		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		1,328	567	1,895	1,895		4
4.01	MAINTENANCE OF PERSONNEL		15,078		15,078	12	15,090	4.01
5.01	NONPATIENT TELEPHONES		6,289		6,289			5.01
5.02	PURCHASING RECEIVING & STORES		59,063	1,243	60,306	9	131	5.02
5.03	ADMITTING		26,865	902	27,767	31	444	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL		327,671	116,887	444,558	142	806	5.05
6	Maintenance & Repairs		462,918		462,918	41	295	6
7	Operation of Plant		136,280	43,689	179,969	30	259	7
8	Laundry & Linen Service		12,687	1,689	14,376	3	35	8
9	Housekeeping		52,037	27,002	79,039	62	914	9
10	Dietary		86,604	29,602	116,206	25	337	10
11	Cafeteria		28,239	35,789	64,028	33	454	11
12	Maintenance of Personnel							12
13	Nursing Administration		16,942	139,661	156,603	38	206	13
14	Central Services & Supply							14
15	Pharmacy		33,309	265,675	298,984	58	308	15
16	Medical Records & Library		26,197	1,793	27,990	4	27	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		501,863	224,355	726,218	410	3,586	30
31	Intensive Care Unit		71,673	101,160	172,833	77	529	31
40	Subprovider - IPF		58,303	46,250	104,553	41	362	40
41	Subprovider - IRF		112,412	67,163	179,575	62	557	41
43	Nursery		16,305		16,305	13	88	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		243,311	610,323	853,634	118	829	50
51	Recovery Room		9,426	1,512	10,938	12	68	51
52	Delivery Room & Labor Room		35,817		35,817	28	192	52
53	Anesthesiology		2,485	91,680	94,165	3	122	53
54	Radiology-Diagnostic		70,330	781,918	852,248	59	495	54
54.01	ULTRASOUND		8,440	50,698	59,138	14	72	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		13,890	36,308	50,198	18	77	56
57	CT Scan		9,418	349,190	358,608	16	100	57
59	Cardiac Catheterization		49,987	388,001	437,988	37	229	59
60	Laboratory		84,818	178,805	263,623	88	745	60
62	Whole Blood & Packed Red Blood Cells		5,715	33,517	39,232	5	40	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		16,414	189,860	206,274	25	193	63.02
65	Respiratory Therapy		14,776	51,266	66,042	38	288	65
66	Physical Therapy		69,406	30,606	100,012	52	314	66
67	Occupational Therapy		18,968	5,524	24,492	20	142	67
68	Speech Pathology		6,149	15,155	21,304	9	43	68
70	Electroencephalography		29,745	40,235	69,980	6	51	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis		6,367		6,367			74
75.01	ONCOLOGY		9,348	1,120	10,468	12	104	75.01
76.97	CARDIAC REHABILITATION		43,092	32,810	75,902	16	107	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		37,595	6,225	43,820	72	469	90
90.01	OP PSYCH		4,969		4,969			90.01
91	Emergency		77,985	65,631	143,616	100	742	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		15,948		15,948	45	263	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,936,462	4,063,811	7,000,273	1,884	15,023	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,673		8,673			190
192	Physicians' Private Offices		222,255	1,455	223,710			192
194	OTHER NON REIM COST CENTER			8,305	8,305			194
194.01	RETAIL PHARMACY		8,331		8,331	10	60	194.01
194.03	ADVERTISING EXPENSE		7,803	1,038	8,841	1	7	194.03
194.04	REGENCY HOSPITAL		128,469		128,469			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)		3,311,993	4,074,609	7,386,602	1,895	15,090	202

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	
		5.01	5.02	5.03	5.04	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	6,289						5.01
5.02	PURCHASING RECEIVING & STORES	46	60,492					5.02
5.03	ADMITTING	138	105	28,485				5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE	112			112			5.04
5.05	OTHER ADMIN & GENERAL	1,256	152			446,914		5.05
6	Maintenance & Repairs	46	62			24,761	488,123	6
7	Operation of Plant	151	27			11,686	27,570	7
8	Laundry & Linen Service	13	4			2,386	2,567	8
9	Housekeeping	79	145			10,728	10,527	9
10	Dietary	145	746			5,360	17,521	10
11	Cafeteria					6,103	5,713	11
12	Maintenance of Personnel							12
13	Nursing Administration	26	68			6,893	3,427	13
14	Central Services & Supply							14
15	Pharmacy	217	561			18,333	6,739	15
16	Medical Records & Library	125	4			10,117	5,300	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	670	7,911	3,413		71,319	101,531	30
31	Intensive Care Unit	85	1,947	305		13,342	14,500	31
40	Subprovider - IPF	92	243	555		7,852	11,795	40
41	Subprovider - IRF	177	1,164	374		13,036	22,742	41
43	Nursery			97		2,554	3,299	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	460	9,611	2,646		32,446	49,224	50
51	Recovery Room	26	97	157		1,986	1,907	51
52	Delivery Room & Labor Room			213		5,610	7,246	52
53	Anesthesiology	39	1,328	359		1,810	503	53
54	Radiology-Diagnostic	184	385	1,300		13,858	14,228	54
54.01	ULTRASOUND	53	391	376		2,886	1,707	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	59	111	619		5,145	2,810	56
57	CT Scan	26	633	1,699		5,743	1,905	57
59	Cardiac Catheterization	302	16,770	1,467		12,943	10,113	59
60	Laboratory	381	10,501	3,949	112	25,702	17,159	60
62	Whole Blood & Packed Red Blood Cells	46	801	138		3,171	1,156	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	53	151	833		4,643	3,321	63.02
65	Respiratory Therapy	66	606	575		6,856	2,989	65
66	Physical Therapy	237	883	578		11,682	14,041	66
67	Occupational Therapy		113	294		5,420	3,837	67
68	Speech Pathology	13	20	79		1,983	1,244	68
70	Electroencephalography	46	152	254		1,515	6,018	70
71	Medical Supplies Charged to Patients			590		14,279		71
72	Impl. Dev. Charged to Patients			512		15,707		72
73	Drugs Charged to Patients		1	3,092		15,586		73
74	Renal Dialysis		19	200		3,887	1,288	74
75.01	ONCOLOGY	13	271	138		2,067	1,891	75.01
76.97	CARDIAC REHABILITATION	39	54	40		2,569	8,718	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	53	279	23		2,092	7,606	90
90.01	OP PSYCH			41		634	1,005	90.01
91	Emergency	276	3,518	3,457		19,622	15,777	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	85	531	112		7,594	3,226	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,835	60,365	28,485	112	431,906	412,150	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					33	1,755	190
192	Physicians' Private Offices	20				1,955	44,964	192
194	OTHER NON REIM COST CENTER					32		194
194.01	RETAIL PHARMACY		118			9,514	1,685	194.01
194.03	ADVERTISING EXPENSE	33	1			2,281	1,579	194.03
194.04	REGENCY HOSPITAL	401	8			1,193	25,990	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	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	
		5.01	5.02	5.03	5.04	5.05	6	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	6,289	60,492	28,485	112	446,914	488,123	202

	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	219,692						7
8	Laundry & Linen Service	1,224	20,608					8
9	Housekeeping	5,022		106,516				9
10	Dietary	8,358		4,637	153,335			10
11	Cafeteria	2,725		1,512		80,568		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,635		907		1,487	171,290	13
14	Central Services & Supply							14
15	Pharmacy	3,214		1,783		2,225		15
16	Medical Records & Library	2,528		1,403		197		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	48,432	6,321	26,868	105,796	25,928	79,234	30
31	Intensive Care Unit	6,917	678	3,837	4,986	3,818	11,666	31
40	Subprovider - IPF	5,626	784	3,121	10,142	2,612	7,981	40
41	Subprovider - IRF	10,848	1,267	6,018	19,765	4,023	12,295	41
43	Nursery	1,574	255	873		633	1,933	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	23,481	3,116	13,027		5,987	18,299	50
51	Recovery Room	910	516	505		493	1,505	51
52	Delivery Room & Labor Room	3,456	560	1,918		1,389	4,245	52
53	Anesthesiology	240		133		883		53
54	Radiology-Diagnostic	6,787	808	3,765		3,579		54
54.01	ULTRASOUND	814	832	452		520		54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,340	296	744		557		56
57	CT Scan	909		504		721		57
59	Cardiac Catheterization	4,824	646	2,676		1,651	5,045	59
60	Laboratory	8,185		4,541		5,384		60
62	Whole Blood & Packed Red Blood Cells	551		306		287		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	1,584	257	879		1,391		63.02
65	Respiratory Therapy	1,426		791		2,083		65
66	Physical Therapy	6,698	710	3,716		2,267		66
67	Occupational Therapy	1,831		1,016		1,022		67
68	Speech Pathology	593		329		310		68
70	Electroencephalography	2,871	364	1,593		369		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	614		341				74
75.01	ONCOLOGY	902		500		748		75.01
76.97	CARDIAC REHABILITATION	4,159	369	2,307		775	2,369	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,628	296	2,013		3,386	10,347	90
90.01	OP PSYCH	480		266				90.01
91	Emergency	7,526	1,296	4,175		5,358	16,371	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,539		854				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	183,451	19,371	98,310	140,689	80,083	171,290	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	837		464				190
192	Physicians' Private Offices	21,449						192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY	804		446		433		194.01
194.03	ADVERTISING EXPENSE	753		418		52		194.03
194.04	REGENCY HOSPITAL	12,398	1,237	6,878	12,646			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	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)	219,692	20,608	106,516	153,335	80,568	171,290	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	332,422						15
16	Medical Records & Library		47,695					16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		5,796	1,213,433		1,213,433		30
31	Intensive Care Unit		519	236,039		236,039		31
40	Subprovider - IPF		943	156,702		156,702		40
41	Subprovider - IRF		636	272,539		272,539		41
43	Nursery		165	27,789		27,789		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4,493	1,017,371		1,017,371		50
51	Recovery Room		267	19,387		19,387		51
52	Delivery Room & Labor Room		362	61,036		61,036		52
53	Anesthesiology		610	100,195		100,195		53
54	Radiology-Diagnostic		2,207	899,903		899,903		54
54.01	ULTRASOUND		638	67,893		67,893		54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		1,051	63,025		63,025		56
57	CT Scan		2,885	373,749		373,749		57
59	Cardiac Catheterization		2,491	497,182		497,182		59
60	Laboratory		6,029	346,399		346,399		60
62	Whole Blood & Packed Red Blood Cells		234	45,967		45,967		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		1,415	221,019		221,019		63.02
65	Respiratory Therapy		976	82,736		82,736		65
66	Physical Therapy		981	142,171		142,171		66
67	Occupational Therapy		499	38,686		38,686		67
68	Speech Pathology		134	26,061		26,061		68
70	Electroencephalography		431	83,650		83,650		70
71	Medical Supplies Charged to Patients		1,002	15,871		15,871		71
72	Impl. Dev. Charged to Patients		870	17,089		17,089		72
73	Drugs Charged to Patients	332,422	5,251	356,352		356,352		73
74	Renal Dialysis		339	13,055		13,055		74
75.01	ONCOLOGY		234	17,348		17,348		75.01
76.97	CARDIAC REHABILITATION		68	97,492		97,492		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		40	74,124		74,124		90
90.01	OP PSYCH		70	7,465		7,465		90.01
91	Emergency		5,870	227,704		227,704		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		189	30,386		30,386		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	332,422	47,695	6,849,818		6,849,818		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			11,762		11,762		190
192	Physicians' Private Offices			292,098		292,098		192
194	OTHER NON REIM COST CENTER			8,337		8,337		194
194.01	RETAIL PHARMACY			21,401		21,401		194.01
194.03	ADVERTISING EXPENSE			13,966		13,966		194.03
194.04	REGENCY HOSPITAL			189,220		189,220		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	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)	332,422	47,695	7,386,602		7,386,602		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	426,564						1
2	Cap Rel Costs-Mvble Equip		2,579,654					2
4	Employee Benefits Department	171	359	55,735,367				4
4.01	MAINTENANCE OF PERSONNEL	1,942		359,920	96,615			4.01
5.01	NONPATIENT TELEPHONES	810				957		5.01
5.02	PURCHASING RECEIVING & STORES	7,607	787	272,137	838	7	902,787	5.02
5.03	ADMITTING	3,460	571	923,058	2,840	21	1,565	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE					17		5.04
5.05	OTHER ADMIN & GENERAL	42,202	74,002	4,170,962	5,158	191	2,268	5.05
6	Maintenance & Repairs	59,621		1,192,578	1,887	7	930	6
7	Operation of Plant	17,552	27,660	874,446	1,660	23	397	7
8	Laundry & Linen Service	1,634	1,069	75,036	223	2	54	8
9	Housekeeping	6,702	17,095	1,809,441	5,855	12	2,167	9
10	Dietary	11,154	18,741	725,110	2,155	22	11,134	10
11	Cafeteria	3,637	22,658	977,027	2,904			11
12	Maintenance of Personnel							12
13	Nursing Administration	2,182	88,420	1,108,203	1,318	4	1,017	13
14	Central Services & Supply							14
15	Pharmacy	4,290	168,200	1,694,458	1,972	33	8,370	15
16	Medical Records & Library	3,374	1,135	104,885	175	19	63	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,637	142,040	12,079,171	22,983	102	118,061	30
31	Intensive Care Unit	9,231	64,045	2,258,643	3,384	13	29,053	31
40	Subprovider - IPF	7,509	29,281	1,195,993	2,315	14	3,632	40
41	Subprovider - IRF	14,478	42,521	1,833,031	3,566	27	17,371	41
43	Nursery	2,100		378,026	561			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,337	386,398	3,470,390	5,307	70	143,436	50
51	Recovery Room	1,214	957	356,491	437	4	1,445	51
52	Delivery Room & Labor Room	4,613		830,408	1,231			52
53	Anesthesiology	320	58,043	75,803	783	6	19,812	53
54	Radiology-Diagnostic	9,058	495,038	1,734,320	3,172	28	5,748	54
54.01	ULTRASOUND	1,087	32,097	424,398	461	8	5,834	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,789	22,987	528,708	494	9	1,651	56
57	CT Scan	1,213	221,074	458,501	639	4	9,445	57
59	Cardiac Catheterization	6,438	245,645	1,088,614	1,463	46	250,335	59
60	Laboratory	10,924	113,202	2,590,588	4,772	58	156,711	60
62	Whole Blood & Packed Red Blood Cells	736	21,220	146,727	254	7	11,955	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,114	120,201	734,270	1,233	8	2,252	63.02
65	Respiratory Therapy	1,903	32,457	1,125,073	1,846	10	9,042	65
66	Physical Therapy	8,939	19,377	1,535,049	2,009	36	13,184	66
67	Occupational Therapy	2,443	3,497	591,576	906		1,680	67
68	Speech Pathology	792	9,595	258,023	275	2	293	68
70	Electroencephalography	3,831	25,473	184,324	327	7	2,270	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						13	73
74	Renal Dialysis	820					287	74
75.01	ONCOLOGY	1,204	709	356,180	663	2	4,045	75.01
76.97	CARDIAC REHABILITATION	5,550	20,772	469,728	687	6	800	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,842	3,941	2,124,609	3,001	8	4,163	90
90.01	OP PSYCH	640						90.01
91	Emergency	10,044	41,551	2,949,704	4,749	42	52,508	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,054		1,329,834	1,682	13	7,919	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	378,198	2,572,818	55,395,443	96,185	888	900,910	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,117						190
192	Physicians' Private Offices	28,625	921			3		192
194	OTHER NON REIM COST CENTER		5,258					194
194.01	RETAIL PHARMACY	1,073		306,135	384		1,755	194.01
194.03	ADVERTISING EXPENSE	1,005	657	33,789	46	5	10	194.03
194.04	REGENCY HOSPITAL	16,546				61	112	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)	3,311,993	4,074,609	8,592,945	602,856	525,923	452,757	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.764352	1.579518	0.154174	6.239776	549.553814	0.501510	203
204	Cost to be allocated (Per Wkst. B, Part II)			1,895	15,090	6,289	60,492	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000034	0.156187	6.571578	0.067006	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	COST 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	532,858,984						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE		532,858,984					5.04
5.05	OTHER ADMIN & GENERAL			-21,870,977	115,964,253			5.05
6	Maintenance & Repairs				6,424,635	310,751		6
7	Operation of Plant				3,032,130	17,552	293,199	7
8	Laundry & Linen Service				619,010	1,634	1,634	8
9	Housekeeping				2,783,580	6,702	6,702	9
10	Dietary				1,390,852	11,154	11,154	10
11	Cafeteria				1,583,660	3,637	3,637	11
12	Maintenance of Personnel							12
13	Nursing Administration				1,788,476	2,182	2,182	13
14	Central Services & Supply							14
15	Pharmacy				4,756,779	4,290	4,290	15
16	Medical Records & Library				2,625,152	3,374	3,374	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,399,985	64,399,985		18,508,029	64,637	64,637	30
31	Intensive Care Unit	5,761,947	5,761,947		3,461,771	9,231	9,231	31
40	Subprovider - IPF	10,476,369	10,476,369		2,037,391	7,509	7,509	40
41	Subprovider - IRF	7,064,485	7,064,485		3,382,469	14,478	14,478	41
43	Nursery	1,832,195	1,832,195		662,633	2,100	2,100	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	49,917,322	49,917,322		8,418,772	31,337	31,337	50
51	Recovery Room	2,968,219	2,968,219		515,268	1,214	1,214	51
52	Delivery Room & Labor Room	4,024,770	4,024,770		1,455,591	4,613	4,613	52
53	Anesthesiology	6,773,247	6,773,247		469,662	320	320	53
54	Radiology-Diagnostic	24,527,215	24,527,215		3,595,652	9,058	9,058	54
54.01	ULTRASOUND	7,094,043	7,094,043		748,810	1,087	1,087	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	11,679,683	11,679,683		1,335,070	1,789	1,789	56
57	CT Scan	32,051,694	32,051,694		1,490,077	1,213	1,213	57
59	Cardiac Catheterization	27,676,437	27,676,437		3,358,408	6,438	6,438	59
60	Laboratory	69,909,771	69,909,771		6,668,964	10,924	10,924	60
62	Whole Blood & Packed Red Blood Cells	2,603,628	2,603,628		822,659	736	736	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	15,719,714	15,719,714		1,204,796	2,114	2,114	63.02
65	Respiratory Therapy	10,840,421	10,840,421		1,778,971	1,903	1,903	65
66	Physical Therapy	10,901,985	10,901,985		3,031,033	8,939	8,939	66
67	Occupational Therapy	5,539,645	5,539,645		1,406,243	2,443	2,443	67
68	Speech Pathology	1,488,652	1,488,652		514,652	792	792	68
70	Electroencephalography	4,790,232	4,790,232		393,185	3,831	3,831	70
71	Medical Supplies Charged to Patients	11,138,136	11,138,136		3,705,042			71
72	Impl. Dev. Charged to Patients	9,667,381	9,667,381		4,075,627			72
73	Drugs Charged to Patients	58,340,620	58,340,620		4,044,154			73
74	Renal Dialysis	3,766,223	3,766,223		1,008,635	820	820	74
75.01	ONCOLOGY	2,598,840	2,598,840		536,323	1,204	1,204	75.01
76.97	CARDIAC REHABILITATION	759,019	759,019		666,650	5,550	5,550	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	441,223	441,223		542,889	4,842	4,842	90
90.01	OP PSYCH	780,439	780,439		164,579	640	640	90.01
91	Emergency	65,221,358	65,221,358		5,091,209	10,044	10,044	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,104,086	2,104,086		1,970,465	2,054	2,054	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	532,858,984	532,858,984	-21,870,977	112,069,953	262,385	244,833	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				8,673	1,117	1,117	190
192	Physicians' Private Offices				507,252	28,625	28,625	192
194	OTHER NON REIM COST CENTER				8,305			194
194.01	RETAIL PHARMACY				2,468,521	1,073	1,073	194.01
194.03	ADVERTISING EXPENSE				591,953	1,005	1,005	194.03
194.04	REGENCY HOSPITAL				309,596	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)	1,275,011	2,544,251		21,870,977	7,636,328	4,035,312	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.002393	0.004775		0.188601	24.573784	13.763048	203
204	Cost to be allocated (Per Wkst. B, Part II)	28,485	112		446,914	488,123	219,692	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000053			0.003854	1.570785	0.749293	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	COST 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	203,688						8
9	Housekeeping		256,238					9
10	Dietary		11,154	152,104				10
11	Cafeteria		3,637		71,413			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,182		1,318	1,033,461		13
14	Central Services & Supply							14
15	Pharmacy		4,290		1,972		10,000	15
16	Medical Records & Library		3,374		175			16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	62,472	64,637	104,947	22,983	478,047		30
31	Intensive Care Unit	6,701	9,231	4,946	3,384	70,388		31
40	Subprovider - IPF	7,746	7,509	10,061	2,315	48,151		40
41	Subprovider - IRF	12,527	14,478	19,606	3,566	74,179		41
43	Nursery	2,519	2,100		561	11,660		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	30,794	31,337		5,307	110,406		50
51	Recovery Room	5,104	1,214		437	9,082		51
52	Delivery Room & Labor Room	5,535	4,613		1,231	25,614		52
53	Anesthesiology		320		783			53
54	Radiology-Diagnostic	7,986	9,058		3,172			54
54.01	ULTRASOUND	8,227	1,087		461			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	2,929	1,789		494			56
57	CT Scan		1,213		639			57
59	Cardiac Catheterization	6,386	6,438		1,463	30,437		59
60	Laboratory		10,924		4,772			60
62	Whole Blood & Packed Red Blood Cells		736		254			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,537	2,114		1,233			63.02
65	Respiratory Therapy		1,903		1,846			65
66	Physical Therapy	7,013	8,939		2,009			66
67	Occupational Therapy		2,443		906			67
68	Speech Pathology		792		275			68
70	Electroencephalography	3,598	3,831		327			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		820					74
75.01	ONCOLOGY		1,204		663			75.01
76.97	CARDIAC REHABILITATION	3,645	5,550		687	14,294		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,926	4,842		3,001	62,429		90
90.01	OP PSYCH		640					90.01
91	Emergency	12,813	10,044		4,749	98,774		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,054					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	191,458	236,497	139,560	70,983	1,033,461	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		1,073		384			194.01
194.03	ADVERTISING EXPENSE		1,005		46			194.03
194.04	REGENCY HOSPITAL	12,230	16,546	12,544				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)	798,399	3,565,500	2,235,983	2,072,379	2,278,045	5,935,298	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.919715	13.914798	14.700356	29.019632	2.204287	593.529800	203
204	Cost to be allocated (Per Wkst. B, Part II)	20,608	106,516	153,335	80,568	171,290	332,422	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.101174	0.415692	1.008093	1.128198	0.165744	33.242200	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	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	532,858,984						16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,399,985						30
31	Intensive Care Unit	5,761,947						31
40	Subprovider - IPF	10,476,369						40
41	Subprovider - IRF	7,064,485						41
43	Nursery	1,832,195						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	49,917,322						50
51	Recovery Room	2,968,219						51
52	Delivery Room & Labor Room	4,024,770						52
53	Anesthesiology	6,773,247						53
54	Radiology-Diagnostic	24,527,215						54
54.01	ULTRASOUND	7,094,043						54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	11,679,683						56
57	CT Scan	32,051,694						57
59	Cardiac Catheterization	27,676,437						59
60	Laboratory	69,909,771						60
62	Whole Blood & Packed Red Blood Cells	2,603,628						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	15,719,714						63.02
65	Respiratory Therapy	10,840,421						65
66	Physical Therapy	10,901,985						66
67	Occupational Therapy	5,539,645						67
68	Speech Pathology	1,488,652						68
70	Electroencephalography	4,790,232						70
71	Medical Supplies Charged to Patients	11,138,136						71
72	Impl. Dev. Charged to Patients	9,667,381						72
73	Drugs Charged to Patients	58,340,620						73
74	Renal Dialysis	3,766,223						74
75.01	ONCOLOGY	2,598,840						75.01
76.97	CARDIAC REHABILITATION	759,019						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	441,223						90
90.01	OP PSYCH	780,439						90.01
91	Emergency	65,221,358						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,104,086						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	532,858,984						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)	3,301,634						202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.006196						203
204	Cost to be allocated (Per Wkst. B, Part II)	47,695						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000090						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	29,283,417		29,283,417		29,283,417	30
31	Intensive Care Unit	4,985,032		4,985,032	3,623	4,988,655	31
40	Subprovider - IPF	3,230,496		3,230,496		3,230,496	40
41	Subprovider - IRF	5,424,989		5,424,989		5,424,989	41
43	Nursery	960,542		960,542		960,542	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	12,471,337		12,471,337		12,471,337	50
51	Recovery Room	746,980		746,980		746,980	51
52	Delivery Room & Labor Room	2,109,971		2,109,971		2,109,971	52
53	Anesthesiology	639,651		639,651	233	639,884	53
54	Radiology-Diagnostic	5,022,415		5,022,415	11,157	5,033,572	54
54.01	ULTRASOUND	1,036,413		1,036,413		1,036,413	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,778,528		1,778,528		1,778,528	56
57	CT Scan	2,051,625		2,051,625		2,051,625	57
59	Cardiac Catheterization	4,634,265		4,634,265	36,745	4,671,010	59
60	Laboratory	9,069,216		9,069,216	8,971	9,078,187	60
62	Whole Blood & Packed Red Blood Cells	1,039,773		1,039,773		1,039,773	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,685,606		1,685,606		1,685,606	63.02
65	Respiratory Therapy	2,334,659		2,334,659		2,334,659	65
66	Physical Therapy	4,223,104		4,223,104		4,223,104	66
67	Occupational Therapy	1,859,729		1,859,729		1,859,729	67
68	Speech Pathology	670,303		670,303		670,303	68
70	Electroencephalography	720,788		720,788		720,788	70
71	Medical Supplies Charged to Patients	4,472,829		4,472,829		4,472,829	71
72	Impl. Dev. Charged to Patients	4,904,193		4,904,193		4,904,193	72
73	Drugs Charged to Patients	11,103,661		11,103,661		11,103,661	73
74	Renal Dialysis	1,265,048		1,265,048		1,265,048	74
75.01	ONCOLOGY	735,727		735,727		735,727	75.01
76.97	CARDIAC REHABILITATION	1,152,812		1,152,812		1,152,812	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,137,182		1,137,182	5,542	1,142,724	90
90.01	OP PSYCH	233,895		233,895		233,895	90.01
91	Emergency	7,386,106		7,386,106	123,355	7,509,461	91
92	Observation Beds (Non-Distinct Part)	5,997,772		5,997,772		5,997,772	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,462,459		2,462,459		2,462,459	101
200	Subtotal (sum of lines 30 thru 199)	136,830,523		136,830,523	189,626	137,020,149	200
201	Less Observation Beds	5,997,772		5,997,772		5,997,772	201
202	Total (line 200 minus line 201)	130,832,751		130,832,751		131,022,377	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	49,649,599		49,649,599				30
31	Intensive Care Unit	5,761,947		5,761,947				31
40	Subprovider - IPF	10,476,369		10,476,369				40
41	Subprovider - IRF	7,064,485		7,064,485				41
43	Nursery	1,832,195		1,832,195				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,381,263	36,536,059	49,917,322	0.249840	0.249840	0.249840	50
51	Recovery Room	954,938	2,013,281	2,968,219	0.251659	0.251659	0.251659	51
52	Delivery Room & Labor Room	2,536,718	1,488,052	4,024,770	0.524246	0.524246	0.524246	52
53	Anesthesiology	2,067,376	4,705,871	6,773,247	0.094438	0.094438	0.094472	53
54	Radiology-Diagnostic	5,709,405	18,817,810	24,527,215	0.204769	0.204769	0.205224	54
54.01	ULTRASOUND	979,416	6,114,627	7,094,043	0.146096	0.146096	0.146096	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	2,307,369	9,372,314	11,679,683	0.152275	0.152275	0.152275	56
57	CT Scan	8,764,850	23,286,844	32,051,694	0.064010	0.064010	0.064010	57
59	Cardiac Catheterization	12,316,004	15,360,433	27,676,437	0.167444	0.167444	0.168772	59
60	Laboratory	22,507,739	47,402,032	69,909,771	0.129727	0.129727	0.129856	60
62	Whole Blood & Packed Red Blood Cells	1,720,012	883,616	2,603,628	0.399355	0.399355	0.399355	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	5,376,814	10,342,900	15,719,714	0.107229	0.107229	0.107229	63.02
65	Respiratory Therapy	8,644,245	2,196,176	10,840,421	0.215366	0.215366	0.215366	65
66	Physical Therapy	5,751,916	5,150,069	10,901,985	0.387370	0.387370	0.387370	66
67	Occupational Therapy	4,245,187	1,294,458	5,539,645	0.335713	0.335713	0.335713	67
68	Speech Pathology	804,640	684,012	1,488,652	0.450275	0.450275	0.450275	68
70	Electroencephalography	800,949	3,989,283	4,790,232	0.150470	0.150470	0.150470	70
71	Medical Supplies Charged to Patients	5,267,431	5,870,705	11,138,136	0.401578	0.401578	0.401578	71
72	Impl. Dev. Charged to Patients	4,957,742	4,709,639	9,667,381	0.507293	0.507293	0.507293	72
73	Drugs Charged to Patients	26,998,410	31,342,210	58,340,620	0.190325	0.190325	0.190325	73
74	Renal Dialysis	3,326,033	440,190	3,766,223	0.335893	0.335893	0.335893	74
75.01	ONCOLOGY	4,856	2,593,984	2,598,840	0.283098	0.283098	0.283098	75.01
76.97	CARDIAC REHABILITATION	129,286	629,733	759,019	1.518818	1.518818	1.518818	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,555	439,668	441,223	2.577341	2.577341	2.589901	90
90.01	OP PSYCH	1,660	778,779	780,439	0.299697	0.299697	0.299697	90.01
91	Emergency	13,553,853	51,667,505	65,221,358	0.113247	0.113247	0.115138	91
92	Observation Beds (Non-Distinct Part)	2,122,766	12,627,620	14,750,386	0.406618	0.406618	0.406618	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,104,086	2,104,086				101
200	Subtotal (sum of lines 30 thru 199)	230,017,028	302,841,956	532,858,984				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	230,017,028	302,841,956	532,858,984				202

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	29,283,417		29,283,417		29,283,417	30
31	Intensive Care Unit	4,985,032		4,985,032		4,985,032	31
40	Subprovider - IPF	3,230,496		3,230,496		3,230,496	40
41	Subprovider - IRF	5,424,989		5,424,989		5,424,989	41
43	Nursery	960,542		960,542		960,542	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	12,471,337		12,471,337		12,471,337	50
51	Recovery Room	746,980		746,980		746,980	51
52	Delivery Room & Labor Room	2,109,971		2,109,971		2,109,971	52
53	Anesthesiology	639,651		639,651		639,651	53
54	Radiology-Diagnostic	5,022,415		5,022,415		5,022,415	54
54.01	ULTRASOUND	1,036,413		1,036,413		1,036,413	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,778,528		1,778,528		1,778,528	56
57	CT Scan	2,051,625		2,051,625		2,051,625	57
59	Cardiac Catheterization	4,634,265		4,634,265		4,634,265	59
60	Laboratory	9,069,216		9,069,216		9,069,216	60
62	Whole Blood & Packed Red Blood Cells	1,039,773		1,039,773		1,039,773	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,685,606		1,685,606		1,685,606	63.02
65	Respiratory Therapy	2,334,659		2,334,659		2,334,659	65
66	Physical Therapy	4,223,104		4,223,104		4,223,104	66
67	Occupational Therapy	1,859,729		1,859,729		1,859,729	67
68	Speech Pathology	670,303		670,303		670,303	68
70	Electroencephalography	720,788		720,788		720,788	70
71	Medical Supplies Charged to Patients	4,472,829		4,472,829		4,472,829	71
72	Impl. Dev. Charged to Patients	4,904,193		4,904,193		4,904,193	72
73	Drugs Charged to Patients	11,103,661		11,103,661		11,103,661	73
74	Renal Dialysis	1,265,048		1,265,048		1,265,048	74
75.01	ONCOLOGY	735,727		735,727		735,727	75.01
76.97	CARDIAC REHABILITATION	1,152,812		1,152,812		1,152,812	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,137,182		1,137,182		1,137,182	90
90.01	OP PSYCH	233,895		233,895		233,895	90.01
91	Emergency	7,386,106		7,386,106		7,386,106	91
92	Observation Beds (Non-Distinct Part)	5,997,772		5,997,772		5,997,772	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,462,459		2,462,459		2,462,459	101
200	Subtotal (sum of lines 30 thru 199)	136,830,523		136,830,523		136,830,523	200
201	Less Observation Beds	5,997,772		5,997,772		5,997,772	201
202	Total (line 200 minus line 201)	130,832,751		130,832,751		130,832,751	202

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	49,649,599		49,649,599				30
31	Intensive Care Unit	5,761,947		5,761,947				31
40	Subprovider - IPF	10,476,369		10,476,369				40
41	Subprovider - IRF	7,064,485		7,064,485				41
43	Nursery	1,832,195		1,832,195				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,381,263	36,536,059	49,917,322	0.249840	0.249840	0.249840	50
51	Recovery Room	954,938	2,013,281	2,968,219	0.251659	0.251659	0.251659	51
52	Delivery Room & Labor Room	2,536,718	1,488,052	4,024,770	0.524246	0.524246	0.524246	52
53	Anesthesiology	2,067,376	4,705,871	6,773,247	0.094438	0.094438	0.094438	53
54	Radiology-Diagnostic	5,709,405	18,817,810	24,527,215	0.204769	0.204769	0.204769	54
54.01	ULTRASOUND	979,416	6,114,627	7,094,043	0.146096	0.146096	0.146096	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	2,307,369	9,372,314	11,679,683	0.152275	0.152275	0.152275	56
57	CT Scan	8,764,850	23,286,844	32,051,694	0.064010	0.064010	0.064010	57
59	Cardiac Catheterization	12,316,004	15,360,433	27,676,437	0.167444	0.167444	0.167444	59
60	Laboratory	22,507,739	47,402,032	69,909,771	0.129727	0.129727	0.129727	60
62	Whole Blood & Packed Red Blood Cells	1,720,012	883,616	2,603,628	0.399355	0.399355	0.399355	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	5,376,814	10,342,900	15,719,714	0.107229	0.107229	0.107229	63.02
65	Respiratory Therapy	8,644,245	2,196,176	10,840,421	0.215366	0.215366	0.215366	65
66	Physical Therapy	5,751,916	5,150,069	10,901,985	0.387370	0.387370	0.387370	66
67	Occupational Therapy	4,245,187	1,294,458	5,539,645	0.335713	0.335713	0.335713	67
68	Speech Pathology	804,640	684,012	1,488,652	0.450275	0.450275	0.450275	68
70	Electroencephalography	800,949	3,989,283	4,790,232	0.150470	0.150470	0.150470	70
71	Medical Supplies Charged to Patients	5,267,431	5,870,705	11,138,136	0.401578	0.401578	0.401578	71
72	Impl. Dev. Charged to Patients	4,957,742	4,709,639	9,667,381	0.507293	0.507293	0.507293	72
73	Drugs Charged to Patients	26,998,410	31,342,210	58,340,620	0.190325	0.190325	0.190325	73
74	Renal Dialysis	3,326,033	440,190	3,766,223	0.335893	0.335893	0.335893	74
75.01	ONCOLOGY	4,856	2,593,984	2,598,840	0.283098	0.283098	0.283098	75.01
76.97	CARDIAC REHABILITATION	129,286	629,733	759,019	1.518818	1.518818	1.518818	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,555	439,668	441,223	2.577341	2.577341	2.577341	90
90.01	OP PSYCH	1,660	778,779	780,439	0.299697	0.299697	0.299697	90.01
91	Emergency	13,553,853	51,667,505	65,221,358	0.113247	0.113247	0.113247	91
92	Observation Beds (Non-Distinct Part)	2,122,766	12,627,620	14,750,386	0.406618	0.406618	0.406618	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,104,086	2,104,086				101
200	Subtotal (sum of lines 30 thru 199)	230,017,028	302,841,956	532,858,984				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	230,017,028	302,841,956	532,858,984				202

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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

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

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	12,471,337	1,017,371	11,453,966		50
51	Recovery Room	746,980	19,387	727,593		51
52	Delivery Room & Labor Room	2,109,971	61,036	2,048,935		52
53	Anesthesiology	639,651	100,195	539,456		53
54	Radiology-Diagnostic	5,022,415	899,903	4,122,512		54
54.01	ULTRASOUND	1,036,413	67,893	968,520		54.01
54.02	AUDIOLOGY					54.02
56	Radioisotope	1,778,528	63,025	1,715,503		56
57	CT Scan	2,051,625	373,749	1,677,876		57
59	Cardiac Catheterization	4,634,265	497,182	4,137,083		59
60	Laboratory	9,069,216	346,399	8,722,817		60
62	Whole Blood & Packed Red Blood Cells	1,039,773	45,967	993,806		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63.02	NONINVASIVE LAB	1,685,606	221,019	1,464,587		63.02
65	Respiratory Therapy	2,334,659	82,736	2,251,923		65
66	Physical Therapy	4,223,104	142,171	4,080,933		66
67	Occupational Therapy	1,859,729	38,686	1,821,043		67
68	Speech Pathology	670,303	26,061	644,242		68
70	Electroencephalography	720,788	83,650	637,138		70
71	Medical Supplies Charged to Patients	4,472,829	15,871	4,456,958		71
72	Impl. Dev. Charged to Patients	4,904,193	17,089	4,887,104		72
73	Drugs Charged to Patients	11,103,661	356,352	10,747,309		73
74	Renal Dialysis	1,265,048	13,055	1,251,993		74
75.01	ONCOLOGY	735,727	17,348	718,379		75.01
76.97	CARDIAC REHABILITATION	1,152,812	97,492	1,055,320		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	1,137,182	74,124	1,063,058		90
90.01	OP PSYCH	233,895	7,465	226,430		90.01
91	Emergency	7,386,106	227,704	7,158,402		91
92	Observation Beds (Non-Distinct Part)	5,997,772	248,536	5,749,236		92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	2,462,459	30,386	2,432,073		101
200	Subtotal	92,946,047	5,191,852	87,754,195		200
201	Less Observation Beds	5,997,772	248,536	5,749,236		201
202	Total	86,948,275	4,943,316	82,004,959		202

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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

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

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		12,471,337	49,917,322	0.249840	50
51	Recovery Room		746,980	2,968,219	0.251659	51
52	Delivery Room & Labor Room		2,109,971	4,024,770	0.524246	52
53	Anesthesiology		639,651	6,773,247	0.094438	53
54	Radiology-Diagnostic		5,022,415	24,527,215	0.204769	54
54.01	ULTRASOUND		1,036,413	7,094,043	0.146096	54.01
54.02	AUDIOLOGY					54.02
56	Radioisotope		1,778,528	11,679,683	0.152275	56
57	CT Scan		2,051,625	32,051,694	0.064010	57
59	Cardiac Catheterization		4,634,265	27,676,437	0.167444	59
60	Laboratory		9,069,216	69,909,771	0.129727	60
62	Whole Blood & Packed Red Blood Cells		1,039,773	2,603,628	0.399355	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63.02	NONINVASIVE LAB		1,685,606	15,719,714	0.107229	63.02
65	Respiratory Therapy		2,334,659	10,840,421	0.215366	65
66	Physical Therapy		4,223,104	10,901,985	0.387370	66
67	Occupational Therapy		1,859,729	5,539,645	0.335713	67
68	Speech Pathology		670,303	1,488,652	0.450275	68
70	Electroencephalography		720,788	4,790,232	0.150470	70
71	Medical Supplies Charged to Patients		4,472,829	11,138,136	0.401578	71
72	Impl. Dev. Charged to Patients		4,904,193	9,667,381	0.507293	72
73	Drugs Charged to Patients		11,103,661	58,340,620	0.190325	73
74	Renal Dialysis		1,265,048	3,766,223	0.335893	74
75.01	ONCOLOGY		735,727	2,598,840	0.283098	75.01
76.97	CARDIAC REHABILITATION		1,152,812	759,019	1.518818	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		1,137,182	441,223	2.577341	90
90.01	OP PSYCH		233,895	780,439	0.299697	90.01
91	Emergency		7,386,106	65,221,358	0.113247	91
92	Observation Beds (Non-Distinct Part)		5,997,772	14,750,386	0.406618	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		2,462,459	2,104,086	1.170322	101
200	Subtotal		92,946,047	458,074,389		200
201	Less Observation Beds		5,997,772	14,750,386		201
202	Total		86,948,275	443,324,003		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)	1,213,433		1,213,433	32,878	36.91	8,520	314,473	30
31	Intensive Care Unit	236,039		236,039	2,568	91.92	864	79,419	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	156,702		156,702	3,211	48.80	1,884	91,939	40
41	Subprovider - IRF	272,539		272,539	6,659	40.93	4,126	168,877	41
42	Subprovider I								42
43	Nursery	27,789		27,789	1,236	22.48			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,906,502		1,906,502	46,552		15,394	654,708	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**

		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	1,017,371	49,917,322	0.020381	4,341,527	88,485	50
51	Recovery Room	19,387	2,968,219	0.006532	307,990	2,012	51
52	Delivery Room & Labor Room	61,036	4,024,770	0.015165	8,512	129	52
53	Anesthesiology	100,195	6,773,247	0.014793	619,224	9,160	53
54	Radiology-Diagnostic	899,903	24,527,215	0.036690	2,050,215	75,222	54
54.01	ULTRASOUND	67,893	7,094,043	0.009570	262,161	2,509	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	63,025	11,679,683	0.005396	1,107,178	5,974	56
57	CT Scan	373,749	32,051,694	0.011661	3,360,790	39,190	57
59	Cardiac Catheterization	497,182	27,676,437	0.017964	4,861,447	87,331	59
60	Laboratory	346,399	69,909,771	0.004955	7,551,563	37,418	60
62	Whole Blood & Packed Red Blood	45,967	2,603,628	0.017655	503,126	8,883	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	221,019	15,719,714	0.014060	2,333,081	32,803	63.02
65	Respiratory Therapy	82,736	10,840,421	0.007632	2,830,409	21,602	65
66	Physical Therapy	142,171	10,901,985	0.013041	960,284	12,523	66
67	Occupational Therapy	38,686	5,539,645	0.006983	495,648	3,461	67
68	Speech Pathology	26,061	1,488,652	0.017506	137,384	2,405	68
70	Electroencephalography	83,650	4,790,232	0.017463	258,019	4,506	70
71	Medical Supplies Charged to Pat	15,871	11,138,136	0.001425	2,279,481	3,248	71
72	Impl. Dev. Charged to Patients	17,089	9,667,381	0.001768	1,755,288	3,103	72
73	Drugs Charged to Patients	356,352	58,340,620	0.006108	8,195,472	50,058	73
74	Renal Dialysis	13,055	3,766,223	0.003466	1,408,203	4,881	74
75.01	ONCOLOGY	17,348	2,598,840	0.006675			75.01
76.97	CARDIAC REHABILITATION	97,492	759,019	0.128445	48,747	6,261	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	74,124	441,223	0.167997			90
90.01	OP PSYCH	7,465	780,439	0.009565			90.01
91	Emergency	227,704	65,221,358	0.003491	4,951,358	17,285	91
92	Observation Beds (Non-Distinct	248,536	14,750,386	0.016849	786,276	13,248	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,161,466	455,970,303		51,413,383	531,697	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [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)	32,878		8,520		30
31	Intensive Care Unit	2,568		864		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	3,211		1,884		40
41	Subprovider - IRF	6,659		4,126		41
42	Subprovider I					42
43	Nursery	1,236				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	46,552		15,394		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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
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

(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	49,917,322			4,341,527		8,877,134		50
51	Recovery Room	2,968,219			307,990		295,744		51
52	Delivery Room & Labor Room	4,024,770			8,512				52
53	Anesthesiology	6,773,247			619,224		813,317		53
54	Radiology-Diagnostic	24,527,215			2,050,215		3,233,202		54
54.01	ULTRASOUND	7,094,043			262,161		588,435		54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	11,679,683			1,107,178		3,374,125		56
57	CT Scan	32,051,694			3,360,790		4,253,697		57
59	Cardiac Catheterization	27,676,437			4,861,447		5,895,207		59
60	Laboratory	69,909,771			7,551,563		3,430,169		60
62	Whole Blood & Packed Red Blood	2,603,628			503,126		19,026		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	15,719,714			2,333,081		2,867,946		63.02
65	Respiratory Therapy	10,840,421			2,830,409		488,758		65
66	Physical Therapy	10,901,985			960,284		258,255		66
67	Occupational Therapy	5,539,645			495,648		26,248		67
68	Speech Pathology	1,488,652			137,384		31,917		68
70	Electroencephalography	4,790,232			258,019		669,411		70
71	Medical Supplies Charged to Pat	11,138,136			2,279,481		1,366,229		71
72	Impl. Dev. Charged to Patients	9,667,381			1,755,288		2,088,106		72
73	Drugs Charged to Patients	58,340,620			8,195,472		8,966,256		73
74	Renal Dialysis	3,766,223			1,408,203		131,490		74
75.01	ONCOLOGY	2,598,840					765,702		75.01
76.97	CARDIAC REHABILITATION	759,019			48,747		153,094		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	441,223					149,193		90
90.01	OP PSYCH	780,439					127,918		90.01
91	Emergency	65,221,358			4,951,358		5,712,230		91
92	Observation Beds (Non-Distinct	14,750,386			786,276		1,341,201		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	455,970,303			51,413,383		55,924,010		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] 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	0.249840	8,877,134		64,323	2,217,863		16,070	50
51	Recovery Room	0.251659	295,744			74,427			51
52	Delivery Room & Labor Room	0.524246							52
53	Anesthesiology	0.094438	813,317			76,808			53
54	Radiology-Diagnostic	0.204769	3,233,202			662,060			54
54.01	ULTRASOUND	0.146096	588,435			85,968			54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.152275	3,374,125			513,795			56
57	CT Scan	0.064010	4,253,697			272,279			57
59	Cardiac Catheterization	0.167444	5,895,207			987,117			59
60	Laboratory	0.129727	3,430,169			444,986			60
62	Whole Blood & Packed Red Blood	0.399355	19,026			7,598			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.107229	2,867,946			307,527			63.02
65	Respiratory Therapy	0.215366	488,758			105,262			65
66	Physical Therapy	0.387370	258,255			100,040			66
67	Occupational Therapy	0.335713	26,248			8,812			67
68	Speech Pathology	0.450275	31,917			14,371			68
70	Electroencephalography	0.150470	669,411			100,726			70
71	Medical Supplies Charged to Pat	0.401578	1,366,229			548,648			71
72	Impl. Dev. Charged to Patients	0.507293	2,088,106			1,059,282			72
73	Drugs Charged to Patients	0.190325	8,966,256		21,511	1,706,503		4,094	73
74	Renal Dialysis	0.335893	131,490			44,167			74
75.01	ONCOLOGY	0.283098	765,702			216,769			75.01
76.97	CARDIAC REHABILITATION	1.518818	153,094			232,522			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.577341	149,193			384,521			90
90.01	OP PSYCH	0.299697	127,918			38,337			90.01
91	Emergency	0.113247	5,712,230			646,893			91
92	Observation Beds (Non-Distinct	0.406618	1,341,201			545,356			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		55,924,010		85,834	11,402,637		20,164	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		55,924,010		85,834	11,402,637		20,164	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	1,017,371	49,917,322	0.020381	35,310	720	50
51	Recovery Room	19,387	2,968,219	0.006532	33,516	219	51
52	Delivery Room & Labor Room	61,036	4,024,770	0.015165			52
53	Anesthesiology	100,195	6,773,247	0.014793	41,803	618	53
54	Radiology-Diagnostic	899,903	24,527,215	0.036690	66,602	2,444	54
54.01	ULTRASOUND	67,893	7,094,043	0.009570	9,555	91	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	63,025	11,679,683	0.005396	8,092	44	56
57	CT Scan	373,749	32,051,694	0.011661	83,938	979	57
59	Cardiac Catheterization	497,182	27,676,437	0.017964	8,963	161	59
60	Laboratory	346,399	69,909,771	0.004955	543,889	2,695	60
62	Whole Blood & Packed Red Blood	45,967	2,603,628	0.017655			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	221,019	15,719,714	0.014060	60,324	848	63.02
65	Respiratory Therapy	82,736	10,840,421	0.007632	59,522	454	65
66	Physical Therapy	142,171	10,901,985	0.013041	62,573	816	66
67	Occupational Therapy	38,686	5,539,645	0.006983	37,780	264	67
68	Speech Pathology	26,061	1,488,652	0.017506	6,550	115	68
70	Electroencephalography	83,650	4,790,232	0.017463	6,006	105	70
71	Medical Supplies Charged to Pat	15,871	11,138,136	0.001425	33,364	48	71
72	Impl. Dev. Charged to Patients	17,089	9,667,381	0.001768			72
73	Drugs Charged to Patients	356,352	58,340,620	0.006108	700,052	4,276	73
74	Renal Dialysis	13,055	3,766,223	0.003466	36,000	125	74
75.01	ONCOLOGY	17,348	2,598,840	0.006675			75.01
76.97	CARDIAC REHABILITATION	97,492	759,019	0.128445			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	74,124	441,223	0.167997			90
90.01	OP PSYCH	7,465	780,439	0.009565			90.01
91	Emergency	227,704	65,221,358	0.003491	229,225	800	91
92	Observation Beds (Non-Distinct		14,750,386				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,912,930	455,970,303		2,063,064	15,822	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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
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
[XX] Title XVIII, Part A [XX] IPF [ ] SNF [ ] TEFRA
[ ] 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	49,917,322			35,310				50
51	Recovery Room	2,968,219			33,516				51
52	Delivery Room & Labor Room	4,024,770							52
53	Anesthesiology	6,773,247			41,803				53
54	Radiology-Diagnostic	24,527,215			66,602				54
54.01	ULTRASOUND	7,094,043			9,555				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	11,679,683			8,092				56
57	CT Scan	32,051,694			83,938				57
59	Cardiac Catheterization	27,676,437			8,963				59
60	Laboratory	69,909,771			543,889				60
62	Whole Blood & Packed Red Blood	2,603,628							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	15,719,714			60,324				63.02
65	Respiratory Therapy	10,840,421			59,522				65
66	Physical Therapy	10,901,985			62,573				66
67	Occupational Therapy	5,539,645			37,780				67
68	Speech Pathology	1,488,652			6,550				68
70	Electroencephalography	4,790,232			6,006				70
71	Medical Supplies Charged to Pat	11,138,136			33,364				71
72	Impl. Dev. Charged to Patients	9,667,381							72
73	Drugs Charged to Patients	58,340,620			700,052				73
74	Renal Dialysis	3,766,223			36,000				74
75.01	ONCOLOGY	2,598,840							75.01
76.97	CARDIAC REHABILITATION	759,019							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	441,223							90
90.01	OP PSYCH	780,439							90.01
91	Emergency	65,221,358			229,225				91
92	Observation Beds (Non-Distinct	14,750,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	455,970,303			2,063,064				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	0.249840							50
51	Recovery Room	0.251659							51
52	Delivery Room & Labor Room	0.524246							52
53	Anesthesiology	0.094438							53
54	Radiology-Diagnostic	0.204769							54
54.01	ULTRASOUND	0.146096							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.152275							56
57	CT Scan	0.064010							57
59	Cardiac Catheterization	0.167444							59
60	Laboratory	0.129727							60
62	Whole Blood & Packed Red Blood	0.399355							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.107229							63.02
65	Respiratory Therapy	0.215366							65
66	Physical Therapy	0.387370							66
67	Occupational Therapy	0.335713							67
68	Speech Pathology	0.450275							68
70	Electroencephalography	0.150470							70
71	Medical Supplies Charged to Pat	0.401578							71
72	Impl. Dev. Charged to Patients	0.507293							72
73	Drugs Charged to Patients	0.190325							73
74	Renal Dialysis	0.335893							74
75.01	ONCOLOGY	0.283098							75.01
76.97	CARDIAC REHABILITATION	1.518818							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.577341							90
90.01	OP PSYCH	0.299697							90.01
91	Emergency	0.113247							91
92	Observation Beds (Non-Distinct	0.406618							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	1,017,371	49,917,322	0.020381	19,979	407	50
51	Recovery Room	19,387	2,968,219	0.006532	4,018	26	51
52	Delivery Room & Labor Room	61,036	4,024,770	0.015165			52
53	Anesthesiology	100,195	6,773,247	0.014793	22,731	336	53
54	Radiology-Diagnostic	899,903	24,527,215	0.036690	132,431	4,859	54
54.01	ULTRASOUND	67,893	7,094,043	0.009570	12,295	118	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	63,025	11,679,683	0.005396	27,093	146	56
57	CT Scan	373,749	32,051,694	0.011661	105,894	1,235	57
59	Cardiac Catheterization	497,182	27,676,437	0.017964	26,784	481	59
60	Laboratory	346,399	69,909,771	0.004955	938,860	4,652	60
62	Whole Blood & Packed Red Blood	45,967	2,603,628	0.017655	42,669	753	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	221,019	15,719,714	0.014060	259,388	3,647	63.02
65	Respiratory Therapy	82,736	10,840,421	0.007632	495,848	3,784	65
66	Physical Therapy	142,171	10,901,985	0.013041	2,100,242	27,389	66
67	Occupational Therapy	38,686	5,539,645	0.006983	1,878,899	13,120	67
68	Speech Pathology	26,061	1,488,652	0.017506	261,453	4,577	68
70	Electroencephalography	83,650	4,790,232	0.017463	56,581	988	70
71	Medical Supplies Charged to Pat	15,871	11,138,136	0.001425	362,548	517	71
72	Impl. Dev. Charged to Patients	17,089	9,667,381	0.001768	8,610	15	72
73	Drugs Charged to Patients	356,352	58,340,620	0.006108	2,224,236	13,586	73
74	Renal Dialysis	13,055	3,766,223	0.003466	584,370	2,025	74
75.01	ONCOLOGY	17,348	2,598,840	0.006675			75.01
76.97	CARDIAC REHABILITATION	97,492	759,019	0.128445			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	74,124	441,223	0.167997			90
90.01	OP PSYCH	7,465	780,439	0.009565			90.01
91	Emergency	227,704	65,221,358	0.003491	8,709	30	91
92	Observation Beds (Non-Distinct		14,750,386				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,912,930	455,970,303		9,573,638	82,691	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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
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	49,917,322			19,979				50
51	Recovery Room	2,968,219			4,018				51
52	Delivery Room & Labor Room	4,024,770							52
53	Anesthesiology	6,773,247			22,731				53
54	Radiology-Diagnostic	24,527,215			132,431				54
54.01	ULTRASOUND	7,094,043			12,295				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	11,679,683			27,093				56
57	CT Scan	32,051,694			105,894				57
59	Cardiac Catheterization	27,676,437			26,784				59
60	Laboratory	69,909,771			938,860				60
62	Whole Blood & Packed Red Blood	2,603,628			42,669				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	15,719,714			259,388				63.02
65	Respiratory Therapy	10,840,421			495,848				65
66	Physical Therapy	10,901,985			2,100,242				66
67	Occupational Therapy	5,539,645			1,878,899				67
68	Speech Pathology	1,488,652			261,453				68
70	Electroencephalography	4,790,232			56,581				70
71	Medical Supplies Charged to Pat	11,138,136			362,548				71
72	Impl. Dev. Charged to Patients	9,667,381			8,610				72
73	Drugs Charged to Patients	58,340,620			2,224,236		822		73
74	Renal Dialysis	3,766,223			584,370				74
75.01	ONCOLOGY	2,598,840							75.01
76.97	CARDIAC REHABILITATION	759,019							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	441,223							90
90.01	OP PSYCH	780,439							90.01
91	Emergency	65,221,358			8,709				91
92	Observation Beds (Non-Distinct	14,750,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	455,970,303			9,573,638		822		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	0.249840							50
51	Recovery Room	0.251659							51
52	Delivery Room & Labor Room	0.524246							52
53	Anesthesiology	0.094438							53
54	Radiology-Diagnostic	0.204769							54
54.01	ULTRASOUND	0.146096							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.152275							56
57	CT Scan	0.064010							57
59	Cardiac Catheterization	0.167444							59
60	Laboratory	0.129727							60
62	Whole Blood & Packed Red Blood	0.399355							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.107229							63.02
65	Respiratory Therapy	0.215366							65
66	Physical Therapy	0.387370							66
67	Occupational Therapy	0.335713							67
68	Speech Pathology	0.450275							68
70	Electroencephalography	0.150470							70
71	Medical Supplies Charged to Pat	0.401578							71
72	Impl. Dev. Charged to Patients	0.507293							72
73	Drugs Charged to Patients	0.190325	822		1,127	156		214	73
74	Renal Dialysis	0.335893							74
75.01	ONCOLOGY	0.283098							75.01
76.97	CARDIAC REHABILITATION	1.518818							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.577341							90
90.01	OP PSYCH	0.299697							90.01
91	Emergency	0.113247							91
92	Observation Beds (Non-Distinct	0.406618							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		822		1,127	156		214	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		822		1,127	156		214	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,213,433		1,213,433	32,878	36.91	1,136	41,930	30
31	Intensive Care Unit	236,039		236,039	2,568	91.92	101	9,284	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	156,702		156,702	3,211	48.80	133	6,490	40
41	Subprovider - IRF	272,539		272,539	6,659	40.93	14	573	41
42	Subprovider I								42
43	Nursery	27,789		27,789	1,236	22.48	56	1,259	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,906,502		1,906,502	46,552		1,440	59,536	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) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,017,371	49,917,322	0.020381	480,825	9,800	50
51	Recovery Room	19,387	2,968,219	0.006532	54,308	355	51
52	Delivery Room & Labor Room	61,036	4,024,770	0.015165	282,064	4,278	52
53	Anesthesiology	100,195	6,773,247	0.014793	124,579	1,843	53
54	Radiology-Diagnostic	899,903	24,527,215	0.036690	254,222	9,327	54
54.01	ULTRASOUND	67,893	7,094,043	0.009570	55,720	533	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	63,025	11,679,683	0.005396	62,573	338	56
57	CT Scan	373,749	32,051,694	0.011661	282,416	3,293	57
59	Cardiac Catheterization	497,182	27,676,437	0.017964	263,123	4,727	59
60	Laboratory	346,399	69,909,771	0.004955	828,077	4,103	60
62	Whole Blood & Packed Red Blood	45,967	2,603,628	0.017655	19,260	340	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	221,019	15,719,714	0.014060	132,950	1,869	63.02
65	Respiratory Therapy	82,736	10,840,421	0.007632	157,961	1,206	65
66	Physical Therapy	142,171	10,901,985	0.013041	94,654	1,234	66
67	Occupational Therapy	38,686	5,539,645	0.006983	32,064	224	67
68	Speech Pathology	26,061	1,488,652	0.017506	16,298	285	68
70	Electroencephalography	83,650	4,790,232	0.017463	11,970	209	70
71	Medical Supplies Charged to Pat	15,871	11,138,136	0.001425	222,660	317	71
72	Impl. Dev. Charged to Patients	17,089	9,667,381	0.001768	70,976	125	72
73	Drugs Charged to Patients	356,352	58,340,620	0.006108	947,808	5,789	73
74	Renal Dialysis	13,055	3,766,223	0.003466	96,582	335	74
75.01	ONCOLOGY	17,348	2,598,840	0.006675			75.01
76.97	CARDIAC REHABILITATION	97,492	759,019	0.128445	1,245	160	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	74,124	441,223	0.167997	1,242	209	90
90.01	OP PSYCH	7,465	780,439	0.009565			90.01
91	Emergency	227,704	65,221,358	0.003491	328,994	1,149	91
92	Observation Beds (Non-Distinct	248,536	14,750,386	0.016849			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,161,466	455,970,303		4,822,571	52,048	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [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)	32,878		1,136		30
31	Intensive Care Unit	2,568		101		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	3,211		133		40
41	Subprovider - IRF	6,659		14		41
42	Subprovider I					42
43	Nursery	1,236		56		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	46,552		1,440		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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
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] Hospital | [ ] SUB (Other) | [ ] ICF/IID | [XX] PPS
[ ] Title XVIII, Part A | [ ] 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	49,917,322			480,825				50
51	Recovery Room	2,968,219			54,308				51
52	Delivery Room & Labor Room	4,024,770			282,064				52
53	Anesthesiology	6,773,247			124,579				53
54	Radiology-Diagnostic	24,527,215			254,222				54
54.01	ULTRASOUND	7,094,043			55,720				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	11,679,683			62,573				56
57	CT Scan	32,051,694			282,416				57
59	Cardiac Catheterization	27,676,437			263,123				59
60	Laboratory	69,909,771			828,077				60
62	Whole Blood & Packed Red Blood	2,603,628			19,260				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	15,719,714			132,950				63.02
65	Respiratory Therapy	10,840,421			157,961				65
66	Physical Therapy	10,901,985			94,654				66
67	Occupational Therapy	5,539,645			32,064				67
68	Speech Pathology	1,488,652			16,298				68
70	Electroencephalography	4,790,232			11,970				70
71	Medical Supplies Charged to Pat	11,138,136			222,660				71
72	Impl. Dev. Charged to Patients	9,667,381			70,976				72
73	Drugs Charged to Patients	58,340,620			947,808				73
74	Renal Dialysis	3,766,223			96,582				74
75.01	ONCOLOGY	2,598,840							75.01
76.97	CARDIAC REHABILITATION	759,019			1,245				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	441,223			1,242				90
90.01	OP PSYCH	780,439							90.01
91	Emergency	65,221,358			328,994				91
92	Observation Beds (Non-Distinct	14,750,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	455,970,303			4,822,571				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	0.249840							50
51	Recovery Room	0.251659							51
52	Delivery Room & Labor Room	0.524246							52
53	Anesthesiology	0.094438							53
54	Radiology-Diagnostic	0.204769							54
54.01	ULTRASOUND	0.146096							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.152275							56
57	CT Scan	0.064010							57
59	Cardiac Catheterization	0.167444							59
60	Laboratory	0.129727							60
62	Whole Blood & Packed Red Blood	0.399355							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.107229							63.02
65	Respiratory Therapy	0.215366							65
66	Physical Therapy	0.387370							66
67	Occupational Therapy	0.335713							67
68	Speech Pathology	0.450275							68
70	Electroencephalography	0.150470							70
71	Medical Supplies Charged to Pat	0.401578							71
72	Impl. Dev. Charged to Patients	0.507293							72
73	Drugs Charged to Patients	0.190325							73
74	Renal Dialysis	0.335893							74
75.01	ONCOLOGY	0.283098							75.01
76.97	CARDIAC REHABILITATION	1.518818							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.577341							90
90.01	OP PSYCH	0.299697							90.01
91	Emergency	0.113247							91
92	Observation Beds (Non-Distinct	0.406618							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**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,017,371	49,917,322	0.020381			50
51	Recovery Room	19,387	2,968,219	0.006532	1,151	8	51
52	Delivery Room & Labor Room	61,036	4,024,770	0.015165			52
53	Anesthesiology	100,195	6,773,247	0.014793	1,617	24	53
54	Radiology-Diagnostic	899,903	24,527,215	0.036690	3,132	115	54
54.01	ULTRASOUND	67,893	7,094,043	0.009570			54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	63,025	11,679,683	0.005396			56
57	CT Scan	373,749	32,051,694	0.011661			57
59	Cardiac Catheterization	497,182	27,676,437	0.017964	7,690	138	59
60	Laboratory	346,399	69,909,771	0.004955	32,165	159	60
62	Whole Blood & Packed Red Blood	45,967	2,603,628	0.017655			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	221,019	15,719,714	0.014060	2,795	39	63.02
65	Respiratory Therapy	82,736	10,840,421	0.007632	9,164	70	65
66	Physical Therapy	142,171	10,901,985	0.013041	3,954	52	66
67	Occupational Therapy	38,686	5,539,645	0.006983	2,634	18	67
68	Speech Pathology	26,061	1,488,652	0.017506	1,016	18	68
70	Electroencephalography	83,650	4,790,232	0.017463			70
71	Medical Supplies Charged to Pat	15,871	11,138,136	0.001425	4,426	6	71
72	Impl. Dev. Charged to Patients	17,089	9,667,381	0.001768			72
73	Drugs Charged to Patients	356,352	58,340,620	0.006108	76,333	466	73
74	Renal Dialysis	13,055	3,766,223	0.003466	1,271	4	74
75.01	ONCOLOGY	17,348	2,598,840	0.006675			75.01
76.97	CARDIAC REHABILITATION	97,492	759,019	0.128445			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	74,124	441,223	0.167997			90
90.01	OP PSYCH	7,465	780,439	0.009565			90.01
91	Emergency	227,704	65,221,358	0.003491	10,053	35	91
92	Observation Beds (Non-Distinct		14,750,386				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,912,930	455,970,303		157,401	1,152	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 [XX] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
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	49,917,322							50
51	Recovery Room	2,968,219			1,151				51
52	Delivery Room & Labor Room	4,024,770							52
53	Anesthesiology	6,773,247			1,617				53
54	Radiology-Diagnostic	24,527,215			3,132				54
54.01	ULTRASOUND	7,094,043							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	11,679,683							56
57	CT Scan	32,051,694							57
59	Cardiac Catheterization	27,676,437			7,690				59
60	Laboratory	69,909,771			32,165				60
62	Whole Blood & Packed Red Blood	2,603,628							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	15,719,714			2,795				63.02
65	Respiratory Therapy	10,840,421			9,164				65
66	Physical Therapy	10,901,985			3,954				66
67	Occupational Therapy	5,539,645			2,634				67
68	Speech Pathology	1,488,652			1,016				68
70	Electroencephalography	4,790,232							70
71	Medical Supplies Charged to Pat	11,138,136			4,426				71
72	Impl. Dev. Charged to Patients	9,667,381							72
73	Drugs Charged to Patients	58,340,620			76,333				73
74	Renal Dialysis	3,766,223			1,271				74
75.01	ONCOLOGY	2,598,840							75.01
76.97	CARDIAC REHABILITATION	759,019							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	441,223							90
90.01	OP PSYCH	780,439							90.01
91	Emergency	65,221,358			10,053				91
92	Observation Beds (Non-Distinct	14,750,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	455,970,303			157,401				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	0.249840							50
51	Recovery Room	0.251659							51
52	Delivery Room & Labor Room	0.524246							52
53	Anesthesiology	0.094438							53
54	Radiology-Diagnostic	0.204769							54
54.01	ULTRASOUND	0.146096							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.152275							56
57	CT Scan	0.064010							57
59	Cardiac Catheterization	0.167444							59
60	Laboratory	0.129727							60
62	Whole Blood & Packed Red Blood	0.399355							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.107229							63.02
65	Respiratory Therapy	0.215366							65
66	Physical Therapy	0.387370							66
67	Occupational Therapy	0.335713							67
68	Speech Pathology	0.450275							68
70	Electroencephalography	0.150470							70
71	Medical Supplies Charged to Pat	0.401578							71
72	Impl. Dev. Charged to Patients	0.507293							72
73	Drugs Charged to Patients	0.190325							73
74	Renal Dialysis	0.335893							74
75.01	ONCOLOGY	0.283098							75.01
76.97	CARDIAC REHABILITATION	1.518818							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.577341							90
90.01	OP PSYCH	0.299697							90.01
91	Emergency	0.113247							91
92	Observation Beds (Non-Distinct	0.406618							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**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,017,371	49,917,322	0.020381			50
51	Recovery Room	19,387	2,968,219	0.006532			51
52	Delivery Room & Labor Room	61,036	4,024,770	0.015165			52
53	Anesthesiology	100,195	6,773,247	0.014793			53
54	Radiology-Diagnostic	899,903	24,527,215	0.036690	179	7	54
54.01	ULTRASOUND	67,893	7,094,043	0.009570			54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	63,025	11,679,683	0.005396			56
57	CT Scan	373,749	32,051,694	0.011661			57
59	Cardiac Catheterization	497,182	27,676,437	0.017964			59
60	Laboratory	346,399	69,909,771	0.004955	3,110	15	60
62	Whole Blood & Packed Red Blood	45,967	2,603,628	0.017655			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	221,019	15,719,714	0.014060			63.02
65	Respiratory Therapy	82,736	10,840,421	0.007632	4,730	36	65
66	Physical Therapy	142,171	10,901,985	0.013041	6,885	90	66
67	Occupational Therapy	38,686	5,539,645	0.006983	7,123	50	67
68	Speech Pathology	26,061	1,488,652	0.017506			68
70	Electroencephalography	83,650	4,790,232	0.017463			70
71	Medical Supplies Charged to Pat	15,871	11,138,136	0.001425	7,121	10	71
72	Impl. Dev. Charged to Patients	17,089	9,667,381	0.001768			72
73	Drugs Charged to Patients	356,352	58,340,620	0.006108	5,058	31	73
74	Renal Dialysis	13,055	3,766,223	0.003466			74
75.01	ONCOLOGY	17,348	2,598,840	0.006675			75.01
76.97	CARDIAC REHABILITATION	97,492	759,019	0.128445			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	74,124	441,223	0.167997			90
90.01	OP PSYCH	7,465	780,439	0.009565			90.01
91	Emergency	227,704	65,221,358	0.003491			91
92	Observation Beds (Non-Distinct		14,750,386				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,912,930	455,970,303		34,206	239	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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
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	49,917,322							50
51	Recovery Room	2,968,219							51
52	Delivery Room & Labor Room	4,024,770							52
53	Anesthesiology	6,773,247							53
54	Radiology-Diagnostic	24,527,215			179				54
54.01	ULTRASOUND	7,094,043							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	11,679,683							56
57	CT Scan	32,051,694							57
59	Cardiac Catheterization	27,676,437							59
60	Laboratory	69,909,771			3,110				60
62	Whole Blood & Packed Red Blood	2,603,628							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	15,719,714							63.02
65	Respiratory Therapy	10,840,421			4,730				65
66	Physical Therapy	10,901,985			6,885				66
67	Occupational Therapy	5,539,645			7,123				67
68	Speech Pathology	1,488,652							68
70	Electroencephalography	4,790,232							70
71	Medical Supplies Charged to Pat	11,138,136			7,121				71
72	Impl. Dev. Charged to Patients	9,667,381							72
73	Drugs Charged to Patients	58,340,620			5,058				73
74	Renal Dialysis	3,766,223							74
75.01	ONCOLOGY	2,598,840							75.01
76.97	CARDIAC REHABILITATION	759,019							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	441,223							90
90.01	OP PSYCH	780,439							90.01
91	Emergency	65,221,358							91
92	Observation Beds (Non-Distinct	14,750,386							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	455,970,303			34,206				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	0.249840							50
51	Recovery Room	0.251659							51
52	Delivery Room & Labor Room	0.524246							52
53	Anesthesiology	0.094438							53
54	Radiology-Diagnostic	0.204769							54
54.01	ULTRASOUND	0.146096							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.152275							56
57	CT Scan	0.064010							57
59	Cardiac Catheterization	0.167444							59
60	Laboratory	0.129727							60
62	Whole Blood & Packed Red Blood	0.399355							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.107229							63.02
65	Respiratory Therapy	0.215366							65
66	Physical Therapy	0.387370							66
67	Occupational Therapy	0.335713							67
68	Speech Pathology	0.450275							68
70	Electroencephalography	0.150470							70
71	Medical Supplies Charged to Pat	0.401578							71
72	Impl. Dev. Charged to Patients	0.507293							72
73	Drugs Charged to Patients	0.190325							73
74	Renal Dialysis	0.335893							74
75.01	ONCOLOGY	0.283098							75.01
76.97	CARDIAC REHABILITATION	1.518818							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	2.577341							90
90.01	OP PSYCH	0.299697							90.01
91	Emergency	0.113247							91
92	Observation Beds (Non-Distinct	0.406618							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)	32,878	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	32,878	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)	26,144	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)	8,520	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)	29,283,417	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)	29,283,417	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)	29,283,417	37

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)					890.67	38
39	Program general inpatient routine service cost (line 9 x line 38)					7,588,508	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)					7,588,508	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,988,655	2,568	1,942.62	864	1,678,424	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)					10,371,245	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					19,638,177	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					393,892	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					531,697	51
52	Total Program excludable cost (sum of lines 50 and 51)					925,589	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					18,712,588	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)					6,734	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					890.67	88
89	Observation bed cost (line 87 x line 88) (see instructions)					5,997,772	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	1,213,433	29,283,417	0.041438	5,997,772	248,536	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**
	[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)	3,211	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,211	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)	3,211	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,884	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)	3,230,496	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)	3,230,496	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)	3,230,496	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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)	1,006.07	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,895,436	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,895,436	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	360,197	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,255,633	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	91,939	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	15,822	51
52	Total Program excludable cost (sum of lines 50 and 51)	107,761	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,147,872	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)	6,659	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,659	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)	6,659	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)	4,126	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)	5,424,989	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)	5,424,989	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)	5,424,989	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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)	814.69	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,361,411	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)	3,361,411	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,667,266	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	6,028,677	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	168,877	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	82,691	51
52	Total Program excludable cost (sum of lines 50 and 51)	251,568	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	5,777,109	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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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)	32,878	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	32,878	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)	26,144	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,136	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)	1,236	15
16	Nursery days (title V or XIX only)	56	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)	29,283,417	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)	29,283,417	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)	29,283,417	37

Check Applicable Boxes: **[ ] Title V - I/P** **[ ] Title XVIII, Part A** **[XX] 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)					890.67	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,011,801	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,011,801	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)	960,542	1,236	777.14	56	43,520	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,985,032	2,568	1,941.21	101	196,062	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)					1,025,857	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,277,240	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					52,473	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					52,048	51
52	Total Program excludable cost (sum of lines 50 and 51)					104,521	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,172,719	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)					6,734	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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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)	3,211	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,211	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)	3,211	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)	3,230,496	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)	3,230,496	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)	3,230,496	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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)	1,006.07	38
39	Program general inpatient routine service cost (line 9 x line 38)	133,807	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)	133,807	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	29,562	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	163,369	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	6,490	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,152	51
52	Total Program excludable cost (sum of lines 50 and 51)	7,642	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	155,727	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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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)	6,659	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,659	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)	6,659	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)	14	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)	5,424,989	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)	5,424,989	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)	5,424,989	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	814.69	38
39	Program general inpatient routine service cost (line 9 x line 38)	11,406	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)	11,406	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,340	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	21,746	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	573	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	239	51
52	Total Program excludable cost (sum of lines 50 and 51)	812	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	20,934	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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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		13,884,906		30
31	Intensive Care Unit		2,084,673		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.249840	4,341,527	1,084,687	50
51	Recovery Room	0.251659	307,990	77,508	51
52	Delivery Room & Labor Room	0.524246	8,512	4,462	52
53	Anesthesiology	0.094472	619,224	58,499	53
54	Radiology-Diagnostic	0.205224	2,050,215	420,753	54
54.01	ULTRASOUND	0.146096	262,161	38,301	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.152275	1,107,178	168,596	56
57	CT Scan	0.064010	3,360,790	215,124	57
59	Cardiac Catheterization	0.168772	4,861,447	820,476	59
60	Laboratory	0.129856	7,551,563	980,616	60
62	Whole Blood & Packed Red Blood Cells	0.399355	503,126	200,926	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.107229	2,333,081	250,174	63.02
65	Respiratory Therapy	0.215366	2,830,409	609,574	65
66	Physical Therapy	0.387370	960,284	371,985	66
67	Occupational Therapy	0.335713	495,648	166,395	67
68	Speech Pathology	0.450275	137,384	61,861	68
70	Electroencephalography	0.150470	258,019	38,824	70
71	Medical Supplies Charged to Patients	0.401578	2,279,481	915,389	71
72	Impl. Dev. Charged to Patients	0.507293	1,755,288	890,445	72
73	Drugs Charged to Patients	0.190325	8,195,472	1,559,803	73
74	Renal Dialysis	0.335893	1,408,203	473,006	74
75.01	ONCOLOGY	0.283098			75.01
76.97	CARDIAC REHABILITATION	1.518818	48,747	74,038	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.589901			90
90.01	OP PSYCH	0.299697			90.01
91	Emergency	0.115138	4,951,358	570,089	91
92	Observation Beds (Non-Distinct Part)	0.406618	786,276	319,714	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		51,413,383	10,371,245	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		51,413,383		202

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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
[XX] Title XVIII, Part A [XX] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [ ] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		6,109,220		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.249840	35,310	8,822	50
51	Recovery Room	0.251659	33,516	8,435	51
52	Delivery Room & Labor Room	0.524246			52
53	Anesthesiology	0.094472	41,803	3,949	53
54	Radiology-Diagnostic	0.205224	66,602	13,668	54
54.01	ULTRASOUND	0.146096	9,555	1,396	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.152275	8,092	1,232	56
57	CT Scan	0.064010	83,938	5,373	57
59	Cardiac Catheterization	0.168772	8,963	1,513	59
60	Laboratory	0.129856	543,889	70,627	60
62	Whole Blood & Packed Red Blood Cells	0.399355			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.107229	60,324	6,468	63.02
65	Respiratory Therapy	0.215366	59,522	12,819	65
66	Physical Therapy	0.387370	62,573	24,239	66
67	Occupational Therapy	0.335713	37,780	12,683	67
68	Speech Pathology	0.450275	6,550	2,949	68
70	Electroencephalography	0.150470	6,006	904	70
71	Medical Supplies Charged to Patients	0.401578	33,364	13,398	71
72	Impl. Dev. Charged to Patients	0.507293			72
73	Drugs Charged to Patients	0.190325	700,052	133,237	73
74	Renal Dialysis	0.335893	36,000	12,092	74
75.01	ONCOLOGY	0.283098			75.01
76.97	CARDIAC REHABILITATION	1.518818			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.589901			90
90.01	OP PSYCH	0.299697			90.01
91	Emergency	0.115138	229,225	26,393	91
92	Observation Beds (Non-Distinct Part)	0.406618			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,063,064	360,197	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,063,064		202

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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	
[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA	
[ ] Title XIX	[XX] IRF	[ ] NF	[ ] ICF/IID	[ ] Other	

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF		4,360,746		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.249840	19,979	4,992	50
51	Recovery Room	0.251659	4,018	1,011	51
52	Delivery Room & Labor Room	0.524246			52
53	Anesthesiology	0.094472	22,731	2,147	53
54	Radiology-Diagnostic	0.205224	132,431	27,178	54
54.01	ULTRASOUND	0.146096	12,295	1,796	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.152275	27,093	4,126	56
57	CT Scan	0.064010	105,894	6,778	57
59	Cardiac Catheterization	0.168772	26,784	4,520	59
60	Laboratory	0.129856	938,860	121,917	60
62	Whole Blood & Packed Red Blood Cells	0.399355	42,669	17,040	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.107229	259,388	27,814	63.02
65	Respiratory Therapy	0.215366	495,848	106,789	65
66	Physical Therapy	0.387370	2,100,242	813,571	66
67	Occupational Therapy	0.335713	1,878,899	630,771	67
68	Speech Pathology	0.450275	261,453	117,726	68
70	Electroencephalography	0.150470	56,581	8,514	70
71	Medical Supplies Charged to Patients	0.401578	362,548	145,591	71
72	Impl. Dev. Charged to Patients	0.507293	8,610	4,368	72
73	Drugs Charged to Patients	0.190325	2,224,236	423,328	73
74	Renal Dialysis	0.335893	584,370	196,286	74
75.01	ONCOLOGY	0.283098			75.01
76.97	CARDIAC REHABILITATION	1.518818			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.589901			90
90.01	OP PSYCH	0.299697			90.01
91	Emergency	0.115138	8,709	1,003	91
92	Observation Beds (Non-Distinct Part)	0.406618			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		9,573,638	2,667,266	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,573,638		202

(A) Worksheet A line numbers

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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
[ ] Title XVIII, Part A [ ] 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		2,408,783		30
31	Intensive Care Unit		177,950		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery		62,412		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.249840	480,825	120,129	50
51	Recovery Room	0.251659	54,308	13,667	51
52	Delivery Room & Labor Room	0.524246	282,064	147,871	52
53	Anesthesiology	0.094438	124,579	11,765	53
54	Radiology-Diagnostic	0.204769	254,222	52,057	54
54.01	ULTRASOUND	0.146096	55,720	8,140	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.152275	62,573	9,528	56
57	CT Scan	0.064010	282,416	18,077	57
59	Cardiac Catheterization	0.167444	263,123	44,058	59
60	Laboratory	0.129727	828,077	107,424	60
62	Whole Blood & Packed Red Blood Cells	0.399355	19,260	7,692	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.107229	132,950	14,256	63.02
65	Respiratory Therapy	0.215366	157,961	34,019	65
66	Physical Therapy	0.387370	94,654	36,666	66
67	Occupational Therapy	0.335713	32,064	10,764	67
68	Speech Pathology	0.450275	16,298	7,339	68
70	Electroencephalography	0.150470	11,970	1,801	70
71	Medical Supplies Charged to Patients	0.401578	222,660	89,415	71
72	Impl. Dev. Charged to Patients	0.507293	70,976	36,006	72
73	Drugs Charged to Patients	0.190325	947,808	180,392	73
74	Renal Dialysis	0.335893	96,582	32,441	74
75.01	ONCOLOGY	0.283098			75.01
76.97	CARDIAC REHABILITATION	1.518818	1,245	1,891	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.577341	1,242	3,201	90
90.01	OP PSYCH	0.299697			90.01
91	Emergency	0.113247	328,994	37,258	91
92	Observation Beds (Non-Distinct Part)	0.406618			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,822,571	1,025,857	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,822,571		202

(A) Worksheet A line numbers

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		431,164		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.249840			50
51	Recovery Room	0.251659	1,151	290	51
52	Delivery Room & Labor Room	0.524246			52
53	Anesthesiology	0.094438	1,617	153	53
54	Radiology-Diagnostic	0.204769	3,132	641	54
54.01	ULTRASOUND	0.146096			54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.152275			56
57	CT Scan	0.064010			57
59	Cardiac Catheterization	0.167444	7,690	1,288	59
60	Laboratory	0.129727	32,165	4,173	60
62	Whole Blood & Packed Red Blood Cells	0.399355			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.107229	2,795	300	63.02
65	Respiratory Therapy	0.215366	9,164	1,974	65
66	Physical Therapy	0.387370	3,954	1,532	66
67	Occupational Therapy	0.335713	2,634	884	67
68	Speech Pathology	0.450275	1,016	457	68
70	Electroencephalography	0.150470			70
71	Medical Supplies Charged to Patients	0.401578	4,426	1,777	71
72	Impl. Dev. Charged to Patients	0.507293			72
73	Drugs Charged to Patients	0.190325	76,333	14,528	73
74	Renal Dialysis	0.335893	1,271	427	74
75.01	ONCOLOGY	0.283098			75.01
76.97	CARDIAC REHABILITATION	1.518818			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.577341			90
90.01	OP PSYCH	0.299697			90.01
91	Emergency	0.113247	10,053	1,138	91
92	Observation Beds (Non-Distinct Part)	0.406618			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		157,401	29,562	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		157,401		202

(A) Worksheet A line numbers

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		15,120		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.249840			50
51	Recovery Room	0.251659			51
52	Delivery Room & Labor Room	0.524246			52
53	Anesthesiology	0.094438			53
54	Radiology-Diagnostic	0.204769	179	37	54
54.01	ULTRASOUND	0.146096			54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.152275			56
57	CT Scan	0.064010			57
59	Cardiac Catheterization	0.167444			59
60	Laboratory	0.129727	3,110	403	60
62	Whole Blood & Packed Red Blood Cells	0.399355			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.107229			63.02
65	Respiratory Therapy	0.215366	4,730	1,019	65
66	Physical Therapy	0.387370	6,885	2,667	66
67	Occupational Therapy	0.335713	7,123	2,391	67
68	Speech Pathology	0.450275			68
70	Electroencephalography	0.150470			70
71	Medical Supplies Charged to Patients	0.401578	7,121	2,860	71
72	Impl. Dev. Charged to Patients	0.507293			72
73	Drugs Charged to Patients	0.190325	5,058	963	73
74	Renal Dialysis	0.335893			74
75.01	ONCOLOGY	0.283098			75.01
76.97	CARDIAC REHABILITATION	1.518818			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	2.577341			90
90.01	OP PSYCH	0.299697			90.01
91	Emergency	0.113247			91
92	Observation Beds (Non-Distinct Part)	0.406618			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		34,206	10,340	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		34,206		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)	4,124,610			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	12,843,160			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)	114,181			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)	146.37			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)	0.1359			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3961			31
32	Sum of lines 30 and 31	0.5320			32
33	Allowable disproportionate share percentage (see instructions)	0.3311			33
34	Disproportionate share adjustment (see instructions)	1,404,508			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000300872	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,740,252		2,035,909	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	438,639		1,522,748	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,961,387			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)	2,627			40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	295			41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	295			41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	11.23			42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	1,486			43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)	0.719613			44
45	Average weekly cost for dialysis treatments (see instructions)	405.45			45
46	Total additional payment (line 45 times line 44 times line 41.01)	86,072			46

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	20,533,918			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)	20,533,918			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,540,013			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	4,143			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)	22,078,074			59
60	Primary payer payments	7,368			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	22,070,706			61
62	Deductibles billed to program beneficiaries	1,567,472			62
63	Coinsurance billed to program beneficiaries	159,778			63
64	Allowable bad debts (see instructions)	487,158			64
65	Adjusted reimbursable bad debts (see instructions)	316,653			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	191,635			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	20,660,109			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)	92,260			70.93
70.94	HRR adjustment amount (see instructions)	-28,486			70.94
71	Amount due provider (see instructions)	20,723,883			71
71.01	Sequestration adjustment (see instructions)	414,478			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	19,776,584			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	532,821			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	658,617			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)	20,164			1
2	Medical and other services reimbursed under OPPS (see instructions)	11,402,637			2
3	OPPS payments	9,452,943			3
4	Outlier payment (see instructions)	22,405			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	20,164			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	85,834			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)	85,834			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)	85,834			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	65,670			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	20,164			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	9,475,348			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	12,865			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,775,877			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)	7,706,770			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)	7,706,770			30
31	Primary payer payments	2,235			31
32	Subtotal (line 30 minus line 31)	7,704,535			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)	704,477			34
35	Adjusted reimbursable bad debts (see instructions)	457,910			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	455,467			36
37	Subtotal (see instructions)	8,162,445			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)	8,162,445			40
40.01	Sequestration adjustment (see instructions)	163,249			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	7,877,542			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	121,654			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	214			1
2	Medical and other services reimbursed under OPPS (see instructions)	156			2
3	OPPS payments	248			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	214			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,127			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)	1,127			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)	1,127			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	913			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	214			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	248			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)	462			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)	462			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	462			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)	462			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)	462			40
40.01	Sequestration adjustment (see instructions)	9			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	503			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-50			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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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				19,454,049		7,550,308	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				322,535		327,234	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)				19,776,584		7,877,542	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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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				1,589,275			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,589,275			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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes: **[ ] Hospital [ ] IPF [XX] 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				6,987,961		503	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)				6,987,961		503	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.

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)	1,720,946	1
2	Net IPF PPS Outlier payment	66,757	2
3	Net IPF PPS ECT payment	9,796	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)	8.797260	9
10	Teaching adjustment factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,797,499	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	1,797,499	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,797,499	18
19	Deductibles	130,144	19
20	Subtotal (line 18 minus line 19)	1,667,355	20
21	Coinsurance	45,618	21
22	Subtotal (line 20 minus line 21)	1,621,737	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,997	23
24	Adjusted reimbursable bad debts (see instructions)	12,348	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,157	25
26	Subtotal (sum of lines 22 and 24)	1,634,085	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	1,634,085	31
31.01	Sequestration adjustment (see instructions)	32,682	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	1,589,275	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	12,128	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)	6,797,559		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.090200		2
3	Inpatient Rehabilitation LIP payments (see instructions)	529,530		3
4	Outlier payments	31,226		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)	18.243836		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	7,358,315		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)	7,358,315		17
18	Primary payer payments	5,721		18
19	Subtotal (line 17 less line 18)	7,352,594		19
20	Deductibles	31,872		20
21	Subtotal (line 19 minus line 20)	7,320,722		21
22	Coinsurance	94,384		22
23	Subtotal (line 21 minus line 22)	7,226,338		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	83,233		24
25	Adjusted reimbursable bad debts (see instructions)	54,101		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	57,156		26
27	Subtotal (sum of lines 23 and 25)	7,280,439		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)	7,280,439		32
32.01	Sequestration adjustment (see instructions)	145,609		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	6,987,961		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	146,869		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	176,740		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

Check Applicable Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [XX] PPS [ ] TEFRA [ ] 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	2,649,145		8
9	Ancillary service charges	4,822,571		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)	7,471,716		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)	7,471,716		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,471,716		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** **[XX] Title XIX** **[ ] Hospital** **[XX] Subprovider IPF** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] 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	431,164		8
9	Ancillary service charges	157,401		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)	588,565		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)	588,565		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	588,565		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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-T008** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[ ] Hospital** **[XX] Subprovider IRF** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] 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	15,120		8
9	Ancillary service charges	34,206		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)	49,326		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)	49,326		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	49,326		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	135,976				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	15,561,507				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	6,501,002				7
8	Prepaid expenses	5,505,625				8
9	Other current assets	638,677				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	28,342,787				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	33,401,926				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)	33,401,926				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	12,543,293				34
35	Total other assets (sum of lines 31-34)	12,543,293				35
36	Total assets (sum of lines 11, 30 and 35)	74,288,006				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	959,687				37
38	Salaries, wages and fees payable	5,052,095				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	182,435				43
44	Other current liabilities	20,507,153				44
45	Total current liabilities (sum of lines 37 thru 44)	26,701,370				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	1,772,081				49
50	Total long term liabilities (sum of lines 46 thru 49)	1,772,081				50
51	Total liabilities (sum of lines 45 and 50)	28,473,451				51
	CAPITAL ACCOUNTS					
52	General fund balance	45,814,555				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)	45,814,555				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	74,288,006				60

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		41,949,123			1
2	Net income (loss) (from Worksheet G-3, line 29)		6,965,034			2
3	Total (sum of line 1 and line 2)		48,914,157			3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS RELEASED FROM RESTRICTIO					5
6	NET ASSETS TRANSFERRED	79,000				6
7	CONTRIBUTIONS	127,000				7
8						8
9						9
10	Total additions (sum of lines 4-9)		206,000			10
11	Subtotal (line 3 plus line 10)		49,120,157			11
12	Deductions (debit adjustments) (specify)	3,158,602				12
13	TRANSFERS	147,000				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		3,305,602			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		45,814,555			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	56,810,920		56,810,920	1
2	Subprovider IPF	10,479,661		10,479,661	2
3	Subprovider IRF	7,128,101		7,128,101	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)	74,418,682		74,418,682	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,000,069		6,000,069	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)	6,000,069		6,000,069	16
17	Total inpatient routine care services (sum of lines 10 and 16)	80,418,751		80,418,751	17
18	Ancillary services	149,598,278		149,598,278	18
19	Outpatient services		296,243,462	296,243,462	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		2,104,086	2,104,086	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	ANESTHESIOLOGISTS REVENUE	2,962,674	3,572,645	6,535,319	27
27.01	PHYSICIAN REVENUE	447,204	952,590	1,399,794	27.01
27.02	CAPITATION		-8,743,155	-8,743,155	27.02
27.03	OCCUPATIONAL HEALTH		780,580	780,580	27.03
27.04	REGENCY REVENUE		4,494,408	4,494,408	27.04
27.05	DIETARY INCOME		4,350	4,350	27.05
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	233,426,907	299,408,966	532,835,873	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		219,739,384	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)		219,739,384	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	532,835,873	1
2	Less contractual allowances and discounts on patients' accounts	388,565,182	2
3	Net patient revenues (line 1 minus line 2)	144,270,691	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	219,739,384	4
5	Net income from service to patients (line 3 minus line 4)	-75,468,693	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	1,350	6
7	Income from investments	112,168	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	1,422	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	788,872	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	438,512	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	1,553	21
22	Rental of hosptial space	815,406	22
23	Governmental appropriations		23
24	Other (GAIN ON SALE OF ASSETS)	23,850	24
24.01	Other (CAPITATION REVENUE)	72,767,186	24.01
24.02	Other (GRANT INCOME)	32,520	24.02
24.03	Other (OTHER INCOME)	3,480,789	24.03
24.04	Other (PHARMACY INCOME)	3,865,900	24.04
24.05	Other (CLASSES)	35,759	24.05
24.06	Other (TEMP RESTRICTED)	68,440	24.06
25	Total other income (sum of lines 6-24)	82,433,727	25
26	Total (line 5 plus line 25)	6,965,034	26
29	Net income (or loss) for the period (line 26 minus line 28)	6,965,034	29

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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	395,463	326,014	35,787		33,169	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	541,710					6
7	Physical Therapy	238,385			59,740		7
8	Occupational Therapy	99,869			24,215		8
9	Speech Pathology	2,243			15,620		9
10	Medical Social Services	1,215					10
11	Home Health Aide	50,949					11
12	Supplies (see instructions)					84,376	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)	1,329,834	326,014	35,787	99,575	117,545	24

	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	790,433	-195,682	594,751	-274	594,477	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	541,710		541,710		541,710	6
7	Physical Therapy	298,125		298,125		298,125	7
8	Occupational Therapy	124,084		124,084		124,084	8
9	Speech Pathology	17,863		17,863		17,863	9
10	Medical Social Services	1,215		1,215		1,215	10
11	Home Health Aide	50,949		50,949		50,949	11
12	Supplies (see instructions)	84,376		84,376		84,376	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)	1,908,755	-195,682	1,713,073	-274	1,712,799	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: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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	594,477				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	541,710				6
7	Physical Therapy	298,125				7
8	Occupational Therapy	124,084				8
9	Speech Pathology	17,863				9
10	Medical Social Services	1,215				10
11	Home Health Aide	50,949				11
12	Supplies (see instructions)	84,376				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)	1,712,799				24

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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		594,477	594,477		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		541,710	287,962	829,672	6
7	Physical Therapy		298,125	158,477	456,602	7
8	Occupational Therapy		124,084	65,960	190,044	8
9	Speech Pathology		17,863	9,496	27,359	9
10	Medical Social Services		1,215	646	1,861	10
11	Home Health Aide		50,949	27,083	78,032	11
12	Supplies (see instructions)		84,376	44,853	129,229	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)		1,712,799		1,712,799	24

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 15-7453** **WORKSHEET H-1 PART II**

		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					-594,477	1,118,322	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						541,710	6
7	Physical Therapy						298,125	7
8	Occupational Therapy						124,084	8
9	Speech Pathology						17,863	9
10	Medical Social Services						1,215	10
11	Home Health Aide						50,949	11
12	Supplies (see instructions)						84,376	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)					-594,477	1,118,322	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						594,477	25
26	Unit Cost Multiplier						0.531579	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		15,948		205,026	10,495	7,144	1
2	Skilled Nursing Care	829,672						2
3	Physical Therapy	456,602						3
4	Occupational Therapy	190,044						4
5	Speech Pathology	27,359						5
6	Medical Social Services	1,861						6
7	Home Health Aide	78,032						7
8	Supplies	129,229						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)	1,712,799	15,948		205,026	10,495	7,144	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	3,971	5,035	10,047	257,666	48,596	50,475	1
2	Skilled Nursing Care				829,672	156,477		2
3	Physical Therapy				456,602	86,116		3
4	Occupational Therapy				190,044	35,842		4
5	Speech Pathology				27,359	5,160		5
6	Medical Social Services				1,861	351		6
7	Home Health Aide				78,032	14,717		7
8	Supplies				129,229	24,373		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)	3,971	5,035	10,047	1,970,465	371,632	50,475	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	28,269		28,581				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)	28,269		28,581				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				13,037			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)				13,037			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.

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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	426,624		426,624				1
2	Skilled Nursing Care	986,149		986,149	206,655	1,192,804		2
3	Physical Therapy	542,718		542,718	113,730	656,448		3
4	Occupational Therapy	225,886		225,886	47,336	273,222		4
5	Speech Pathology	32,519		32,519	6,815	39,334		5
6	Medical Social Services	2,212		2,212	464	2,676		6
7	Home Health Aide	92,749		92,749	19,436	112,185		7
8	Supplies	153,602		153,602	32,188	185,790		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)	2,462,459		2,462,459	426,624	2,462,459		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.				0.209557			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	2,054		1,329,834	1,682	13	7,919	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)	2,054		1,329,834	1,682	13	7,919	20
21	Total cost to be allocated	15,948		205,026	10,495	7,144	3,971	21
22	Unit Cost Multiplier	7.764362		0.154174		549.538462		22
22	Unit Cost Multiplier				6.239596		0.501452	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	2,104,086	2,104,086		257,666	2,054	2,054	1
2	Skilled Nursing Care				829,672			2
3	Physical Therapy				456,602			3
4	Occupational Therapy				190,044			4
5	Speech Pathology				27,359			5
6	Medical Social Services				1,861			6
7	Home Health Aide				78,032			7
8	Supplies				129,229			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)	2,104,086	2,104,086		1,970,465	2,054	2,054	20
21	Total cost to be allocated	5,035	10,047		371,632	50,475	28,269	21
22	Unit Cost Multiplier	0.002393				24.574002		22
22	Unit Cost Multiplier		0.004775		0.188601		13.762902	22

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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		2,054					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)		2,054					20
21	Total cost to be allocated		28,581					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		13.914800					22

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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			2,104,086				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)			2,104,086				20
21	Total cost to be allocated			13,037				21
22	Unit Cost Multiplier			0.006196				22
22	Unit Cost Multiplier							22

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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	1,192,804		1,192,804	8,484	140.59	1
2	Physical Therapy	3	656,448		656,448	3,379	194.27	2
3	Occupational Therapy	4	273,222		273,222	1,735	157.48	3
4	Speech Pathology	5	39,334		39,334	192	204.86	4
5	Medical Social Services	6	2,676		2,676	13	205.85	5
6	Home Health Aide	7	112,185		112,185	2,445	45.88	6
7	Total (sum of lines 1-6)		2,276,669		2,276,669	16,248		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		4,343		8
9	Physical Therapy	23844		1,851		9
10	Occupational Therapy	23844		998		10
11	Speech Pathology	23844		79		11
12	Medical Social Services	23844		10		12
13	Home Health Aide	23844		1,545		13
14	Total (sum of lines 8-13)			8,826		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	185,790		185,790	153,369	1.211392	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	0.387370			col. 2, line 2	1
2	Occupational Therapy	67	0.335713			col. 2, line 3	2
3	Speech Pathology	68	0.450275			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.401578			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.190325			col. 2, line 16	5

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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		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		4,343			610,582		610,582	1
2	Physical Therapy		1,851			359,594		359,594	2
3	Occupational Therapy		998			157,165		157,165	3
4	Speech Pathology		79			16,184		16,184	4
5	Medical Social Services		10			2,059		2,059	5
6	Home Health Aide		1,545			70,885		70,885	6
7	Total (sum of lines 1-6)		8,826			1,216,469		1,216,469	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		142,663			172,821		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		685		9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)		-685	10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,034,836	11
12	Total PPS Reimbursement - Full Episodes with Outliers		69,593	12
13	Total PPS Reimbursement - LUPA Episodes		8,369	13
14	Total PPS Reimbursement - PEP Episodes		26,487	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		3,959	15
16	Total PPS Outlier Reimbursement - PSP Episodes		963	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)		1,143,522	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,143,522	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,143,522	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)		1,143,522	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,143,522	31
31.01	Sequestration adjustment (see instructions)		22,870	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		1,120,652	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						1,120,652	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)						1,120,652	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.

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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	1,380,266	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	2,811	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)	79.35	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)	0.1359	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.3961	8
9	Sum of lines 7 and 8	0.5320	9
10	Allowable disproportionate share percentage (see instructions)	0.1137	10
11	Disproportionate share adjustment (see instructions)	156,936	11
12	Total prospective capital payments (see instructions)	1,540,013	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

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

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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/27/2018 Run Time: 15:23 Version: 2018.04 (09/26/2018)

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