

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 11/25/2019 Time: 15:09	
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 07/01/2018 and ending 06/30/2019, 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 certification statement to be the legally binding equivalent of my original signature.

(Signed) LEO CORREA
Chief Financial Officer or Administrator of Provider(s).

CHIEF EXECUTIVE OFFICER _____
Title

11/25/2019 15:09
Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		518,760	-10,281			1
2	SUBPROVIDER - IPF		11,643				2
3	SUBPROVIDER - IRF		-21,783	-134			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		508,620	-10,415			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 respond 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 applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

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

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
4	Subprovider - IPF	ST. CATHERINE HOSPITAL OA BHS	15-S008	23844	4	07 / 01 / 2015	N	P	P
5	Subprovider - IRF	ST. CATHERINE HOSPITAL - REHAB	15-T008	23844	5	01 / 01 / 2002	N	P	P
6	Subprovider - (OTHER)								
7	Swing Beds - SNF								
8	Swing Beds - NF								
9	Hospital-Based SNF								
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA								
13	Separately Certified ASC								
14	Hospital-Based Hospice								
15	Hospital-Based Health Clinic - RHC								
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis								
19	Other								

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2018	To: 06 / 30 / 2019	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.	2,051	127		828	9,288		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 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.	24	542			416		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 eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)			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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
		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
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
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

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 as 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 osteopathic 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 received 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
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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 column 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 Facility 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	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)			107
108	If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			
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
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.	Physical	Occupational	Speech
		N	N	Respiratory

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete 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-health 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 §1903(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 certified 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 certified 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

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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: COMM FOUNDATION OF NW IN	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.	Y		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		Title V	Title XIX	
		Part A	Part B			
		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.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2018	06 / 30 / 2019		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

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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 instructions.	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

		Y/N	
Bad Debts		Y	
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	10/10/2019	Y	10/10/2019	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 Report 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

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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
42	Employer: BACHMANN ASSOCIATES		
43	Phone number: 3122852828	E-mail Address: JBOPIL@ATT.NET	

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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			7,290	1,740	26,270	1
2	HMO and other (see instructions)						4,415	10,083		2
3	HMO IPF Subprovider						578	507		3
4	HMO IRF Subprovider						633	958		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			7,290	1,740	26,270	7
8	Intensive Care Unit	31	16	5,840			741	135	2,410	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						176	1,129	13
14	Total (see instructions)		165	60,225			8,031	2,051	29,809	14
15	CAH Visits									15
16	Subprovider - IPF	40	16	5,840			1,819	271	3,567	16
17	Subprovider - IRF	41	30	10,950			4,155	24	6,617	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30							57	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		211							27
28	Observation Bed Days								5,279	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							160	186	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		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)					1,756	393	6,183	1
2	HMO and other (see instructions)					883	2,051		2
3	HMO IPF Subprovider						114		3
4	HMO IRF Subprovider						85		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)		830.05			1,756	393	6,183	14
15	CAH Visits								15
16	Subprovider - IPF		25.50			201	30	448	16
17	Subprovider - IRF		34.20			350	2	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								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)		889.75						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

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclass- ification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	56,254,083		56,254,083	1,850,673.10	30.40	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B		631,109		631,109	5,715.20	110.43	3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		1,641,214		1,641,214	10,400.00	157.81	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		3,659,222		3,659,222	134,543.00	27.20	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,069,886		1,069,886	9,396.00	113.87	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		385,051		385,051	2,581.00	149.19	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		7,408,859		7,408,859	219,505.00	33.75	14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		12,752,922		12,752,922			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		974,485		974,485			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		85,666		85,666			21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		175,105		175,105			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		1,859,282		1,859,282			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		462,531		462,531	12,090.00	38.26	26
27	Administrative & General		5,701,024		5,701,024	181,816.00	31.36	27
28	Administrative & General under contract (see instructions)		1,285,873		1,285,873	9,670.00	132.98	28
29	Maintenance & Repairs		1,272,192		1,272,192	39,491.00	32.21	29
30	Operation of Plant		850,766		850,766	30,846.00	27.58	30
31	Laundry & Linen Service		117,377		117,377	6,711.00	17.49	31
32	Housekeeping		1,888,826		1,888,826	117,717.00	16.05	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		1,729,692	-992,843	736,849	42,509.00	17.33	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			992,843	992,843	57,277.00	17.33	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,026,833		1,026,833	23,784.00	43.17	38
39	Central Services and Supply							39
40	Pharmacy		1,810,946		1,810,946	41,528.00	43.61	40
41	Medical Records & Medical Records Library		62,606		62,606	1,410.00	44.40	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		55,267,633		55,267,633	1,844,227.90	29.97	1
2	Excluded area salaries (see instructions)		3,659,222		3,659,222	134,543.00	27.20	2
3	Subtotal salaries (line 1 minus line 2)		51,608,411		51,608,411	1,709,684.90	30.19	3
4	Subtotal other wages & related costs (see instructions)		8,863,796		8,863,796	231,482.00	38.29	4
5	Subtotal wage-related costs (see instructions)		14,612,204		14,612,204		28.31%	5
6	Total (sum of lines 3 through 5)		75,084,411		75,084,411	1,941,166.90	38.68	6
7	Total overhead cost (see instructions)		16,208,666		16,208,666	564,849.00	28.70	7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	1,805,938	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)	6,809,797	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	529,033	10
11	Life Insurance (If employee is owner or beneficiary)	50,731	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	49,583	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	777,886	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	3,190,427	17
18	Medicare Taxes - Employers Portion Only	773,845	18
19	Unemployment Insurance	939	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)	13,988,179	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	1,069,886	13,988,179	1
2	Hospital	1,069,886	13,988,179	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

KPMG LLP Compu-Max 2552-10

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.229415	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	40,208,329	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	12,209,868	5
6	Medicaid charges	188,792,390	6
7	Medicaid cost (line 1 times line 6)	43,311,806	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

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

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

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

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)	13,150	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)	56,614	14
15	State or local indigent care program cost (line 1 times line 14)	12,988	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	13,326,587	1,175,054	14,501,641	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,057,319	1,175,054	4,232,373	21
22	Payments received from patients for amounts previously written off as charity care	25,133		25,133	22
23	Cost of charity care (line 21 minus line 22)	3,032,186	1,175,054	4,207,240	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	5,930,273	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	846,035	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,301,592	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	4,628,681	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,517,446	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	5,724,686	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,724,686	31

KPMG LLP Compu-Max 2552-10

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				2,393,005	2,393,005	232,134	2,625,139	1
2	00200	Cap Rel Costs-Mvble Equip				3,092,938	3,092,938	714,233	3,807,171	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	146,554	-1,865,165	-1,718,611	9,995,287	8,276,676	-79,326	8,197,350	4
4.01	00401	MAINTENANCE OF PERSONNEL	315,977	963,679	1,279,656	-826,523	453,133	-191	452,942	4.01
5.01	00540	NONPATIENT TELEPHONES						603,475	603,475	5.01
5.02	00560	PURCHASING RECEIVING & STORES	308,473	149,766	458,239	-58,403	399,836	-1,096	398,740	5.02
5.03	00570	ADMITTING	1,016,463	350,610	1,367,073	-193,813	1,173,260		1,173,260	5.03
5.04	00580	CASHIERING ACCOUNTS RECEIVABLE						2,300,186	2,300,186	5.04
5.05	00590	OTHER ADMIN & GENERAL	4,376,088	59,869,473	64,245,561	-1,053,037	63,192,524	-44,294,179	18,898,345	5.05
6	00600	Maintenance & Repairs	1,272,192	6,070,938	7,343,130	-1,155,695	6,187,435	-12,694	6,174,741	6
7	00700	Operation of Plant	850,766	2,230,324	3,081,090	-280,133	2,800,957	-80,303	2,720,654	7
8	00800	Laundry & Linen Service	117,377	651,903	769,280	-44,013	725,267	-40,744	684,523	8
9	00900	Housekeeping	1,888,826	1,126,396	3,015,222	-553,361	2,461,861		2,461,861	9
10	01000	Dietary	1,729,692	2,150,338	3,880,030	-2,744,953	1,135,077		1,135,077	10
11	01100	Cafeteria				2,227,137	2,227,137	-899,344	1,327,793	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,026,833	561,937	1,588,770	-278,919	1,309,851	-573	1,309,278	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	1,810,946	5,782,005	7,592,951	-2,666,960	4,925,991		4,925,991	15
16	01600	Medical Records & Library	62,606	99,000	161,606	-6,693	154,913	1,998,668	2,153,581	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	13,312,149	5,992,117	19,304,266	-4,762,972	14,541,294	-8,417	14,532,877	30
31	03100	Intensive Care Unit	2,200,478	1,145,907	3,346,385	-577,319	2,769,066	-4,208	2,764,858	31
40	04000	Subprovider - IPF	1,411,106	769,652	2,180,758	-449,922	1,730,836		1,730,836	40
41	04100	Subprovider - IRF	1,860,267	1,432,412	3,292,679	-432,474	2,860,205	-14	2,860,191	41
43	04300	Nursery				561,542	561,542		561,542	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	3,432,735	8,960,673	12,393,408	-4,561,597	7,831,811	-415,026	7,416,785	50
51	05100	Recovery Room	366,719	121,663	488,382	-57,699	430,683		430,683	51
52	05200	Delivery Room & Labor Room				1,270,434	1,270,434		1,270,434	52
53	05300	Anesthesiology	2,170,909	735,269	2,906,178	-203,461	2,702,717	-2,464,286	238,431	53
54	05400	Radiology-Diagnostic	1,860,196	1,524,467	3,384,663	-817,386	2,567,277	-42,169	2,525,108	54
54.01	05401	ULTRASOUND	386,617	318,065	704,682	-158,837	545,845		545,845	54.01
54.02	03040	AUDIOLOGY								54.02
56	05600	Radioisotope	563,011	685,114	1,248,125	-73,227	1,174,898		1,174,898	56
57	05700	CT Scan	442,089	532,253	974,342	-249,578	724,764		724,764	57
59	05900	Cardiac Catheterization	1,134,109	4,641,053	5,775,162	-4,057,373	1,717,789	-15,746	1,702,043	59
60	06000	Laboratory	2,605,920	3,528,957	6,134,877	-638,923	5,495,954	-16,340	5,479,614	60
62	06200	Whole Blood & Packed Red Blood Cells	165,659	732,371	898,030	-83,851	814,179		814,179	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	06301	NONINVASIVE LAB	755,928	497,348	1,253,276	-258,853	994,423	-118,251	876,172	63.02
65	06500	Respiratory Therapy	1,162,169	545,952	1,708,121	-237,240	1,470,881	-1,764	1,469,117	65
66	06600	Physical Therapy	1,918,159	1,631,712	3,549,871	-340,821	3,209,050	-107,737	3,101,313	66
67	06700	Occupational Therapy	696,748	759,854	1,456,602	-88,611	1,367,991		1,367,991	67
68	06800	Speech Pathology	303,420	271,508	574,928	-50,205	524,723		524,723	68
70	07000	Electroencephalography	161,651	133,128	294,779	-58,143	236,636	-530	236,106	70
71	07100	Medical Supplies Charged to Patients				3,667,298	3,667,298		3,667,298	71
72	07200	Impl. Dev. Charged to Patients				3,468,624	3,468,624		3,468,624	72
73	07300	Drugs Charged to Patients				2,354,641	2,354,641		2,354,641	73
74	07400	Renal Dialysis		879,916	879,916	-7,351	872,565		872,565	74
75.01	03480	ONCOLOGY	333,503	677,247	1,010,750	-93,212	917,538	-495,898	421,640	75.01
76.97	07697	CARDIAC REHABILITATION	534,661	187,071	721,732	-88,995	632,737	-38,312	594,425	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	134,126	58,597	192,723	-28,993	163,730	-3,622	160,108	90
90.01	09001	OP PSYCH	86,923	61,420	148,343	-12,239	136,104		136,104	90.01
91	09100	Emergency	2,944,189	1,726,438	4,670,627	-610,227	4,060,400	-183,702	3,876,698	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency		2,121	2,121		2,121	-2,121		101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	55,866,234	116,693,489	172,559,723	168,894	172,728,617	-43,477,897	129,250,720	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices		155,618	155,618	-61,614	94,004		94,004	192
194	07950	OTHER NON REIM COST CENTER								194
194.01	07954	RETAIL PHARMACY	383,654	3,935,358	4,319,012	-106,987	4,212,025		4,212,025	194.01

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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	4,195	490,921	495,116	-206	494,910		494,910	194.03
194.04	07952	REGENCY HOSPITAL		22,379	22,379	-87	22,292		22,292	194.04
194.05	07953	UNUSED SPACE								194.05
200		TOTAL (sum of lines 118-199)	56,254,083	121,297,765	177,551,848		177,551,848	-43,477,897	134,073,951	200

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1	MEDICAL SUPPLIES CHARGED TO PATIENT	A	Medical Supplies Charged to P	71		279,148	1
2							2
3							3
4							4
5			Medical Supplies Charged to P	71		3,388,150	5
6			Impl. Dev. Charged to Patient	72		3,468,624	6
7							7
8							8
500	Total reclassifications					7,135,922	500
	Code Letter - A						
1	RECLASS DRUGS	B	Drugs Charged to Patients	73		2,354,641	1
500	Total reclassifications					2,354,641	500
	Code Letter - B						
1	CAFETERIA RECLASS	C	Cafeteria	11	992,843	1,234,294	1
500	Total reclassifications				992,843	1,234,294	500
	Code Letter - C						
1	BUILDING DEPR RECLASS	D	Cap Rel Costs-Bldg & Fixt	1		2,291,927	1
2	BUILDING DEPR RECLASS	D					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					2,291,927	500
	Code Letter - D						
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Nursery	43	374,958	186,584	1
2			Delivery Room & Labor Room	52	848,305	422,129	2
500	Total reclassifications				1,223,263	608,713	500
	Code Letter - F						
1							1
2	RECLASS RENTAL EQUIPMENT	G	Cap Rel Costs-Mvble Equip	2		669,998	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

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
21						21
22						22
23						23
24						24
25						25
26						26
500	Total reclassifications					669,998
	Code Letter -					
1	RECLASS EQUIPMENT DEPR	H	Cap Rel Costs-Mvble Equip	2		2,417,991
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38						38
500	Total reclassifications					2,417,991
	Code Letter - H					
1	RECLASS PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		101,078
2			Cap Rel Costs-Mvble Equip	2		4,949
500	Total reclassifications					106,027
	Code Letter - J					
1	RECLASS FRINGE BENEFITS	L	Employee Benefits Department	4		7,953,586
2	257	L	Employee Benefits Department	4		2,042,060
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

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			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
500	Total reclassifications					9,995,646	500
	Code Letter - L						
	GRAND TOTAL (Increases)				2,216,106	26,815,159	

(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.

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	MEDICAL SUPPLIES CHARGED TO PATIENT	A	Adults & Pediatrics	30		176,888		1
2			Intensive Care Unit	31		44,298		2
3			Subprovider - IRF	41		23,040		3
4			Emergency	91		34,922		4
5			Operating Room	50		3,261,601		5
6			Anesthesiology	53		32,899		6
7			Cardiac Catheterization	59		3,546,889		7
8			Physical Therapy	66		15,385		8
500	Total reclassifications					7,135,922		500
	Code letter - A							
1	RECLASS DRUGS	B	Pharmacy	15		2,354,641		1
500	Total reclassifications					2,354,641		500
	Code letter - B							
1	CAFETERIA RECLASS	C	Dietary	10	992,843	1,234,294		1
500	Total reclassifications				992,843	1,234,294		500
	Code letter - C							
1	BUILDING DEPR RECLASS	D	PURCHASING RECEIVING & STORES	5.02		1,740	9	1
2	BUILDING DEPR RECLASS	D	OTHER ADMIN & GENERAL	5.05		228,512		2
3			Maintenance & Repairs	6		792,276		3
4			Operation of Plant	7		59,724		4
5			Housekeeping	9		650		5
6			Dietary	10		53,840		6
7			Nursing Administration	13		9,169		7
8			Pharmacy	15		6,588		8
9			Adults & Pediatrics	30		311,305		9
10			Intensive Care Unit	31		144,439		10
11			Subprovider - IPF	40		198,896		11
12			Subprovider - IRF	41		83,614		12
13			Operating Room	50		14,110		13
14			Radiology-Diagnostic	54		88,465		14
15			ULTRASOUND	54.01		1,856		15
16			Radioisotope	56		8,639		16
17			CT Scan	57		35,604		17
18			Cardiac Catheterization	59		68,910		18
19			Laboratory	60		25,228		19
20			Physical Therapy	66		650		20
21			Electroencephalography	70		2,899		21
22			Renal Dialysis	74		7,351		22
23			ONCOLOGY	75.01		26,174		23
24			CARDIAC REHABILITATION	76.97		7,093		24
25			Clinic	90		24,308		25
26			Emergency	91		22,433		26
27			Physicians' Private Offices	192		60,693		27
28			REGENCY HOSPITAL	194.04		87		28
29			RETAIL PHARMACY	194.01		6,674		29
500	Total reclassifications					2,291,927		500
	Code letter - D							
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Adults & Pediatrics	30	374,958	186,584		1
2			Adults & Pediatrics	30	848,305	422,129		2
500	Total reclassifications				1,223,263	608,713		500
	Code letter - F							
1								1
2	RECLASS RENTAL EQUIPMENT	G	MAINTENANCE OF PERSONNEL	4.01		465	10	2
3			OTHER ADMIN & GENERAL	5.05		45,545		3
4			Maintenance & Repairs	6		1,679		4
5			Operation of Plant	7		16,584		5
6			Laundry & Linen Service	8		15,249		6
7			Housekeeping	9		137		7
8			Dietary	10		22,250		8
9			Nursing Administration	13		39,891		9
10			Adults & Pediatrics	30		4,044		10
11			Intensive Care Unit	31		130		11
12			Subprovider - IRF	41		5,192		12
13			Operating Room	50		263,531		13
14			Radiology-Diagnostic	54		117,776		14
15			ULTRASOUND	54.01		37,940		15
16			Radioisotope	56		2,819		16
17			CT Scan	57		34,766		17
18			Cardiac Catheterization	59		6,051		18
19			Laboratory	60		7,171		19

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
20			NONINVASIVE LAB	63.02		6,678		20
21			Respiratory Therapy	65		3,124		21
22			Physical Therapy	66		32,914		22
23			Occupational Therapy	67		1,232		23
24			Electroencephalography	70		4,572		24
25			CARDIAC REHABILITATION	76.97		130		25
26			Emergency	91		128		26
500	Total reclassifications					669,998		500
	Code letter -							
1	RECLASS EQUIPMENT DEPR	H	Employee Benefits Department	4		359	9	1
2			ADMITTING	5.03		543		2
3			OTHER ADMIN & GENERAL	5.05		71,340		3
4			Maintenance & Repairs	6		114,943		4
5			Operation of Plant	7		25,749		5
6			Laundry & Linen Service	8		1,069		6
7			Housekeeping	9		14,189		7
8			Dietary	10		60,878		8
9			Nursing Administration	13		84,220		9
10			PURCHASING RECEIVING & STORES	5.02		787		10
11			Pharmacy	15		98,341		11
12			Medical Records & Library	16		957		12
13			Adults & Pediatrics	30		141,530		13
14			Intensive Care Unit	31		66,370		14
15			Subprovider - IPF	40		29,396		15
16			Subprovider - IRF	41		41,414		16
17			Operating Room	50		433,632		17
18			Recovery Room	51		654		18
19			Anesthesiology	53		46,962		19
20			Radiology-Diagnostic	54		288,697		20
21			ULTRASOUND	54.01		78,927		21
22			Radioisotope	56		4,952		22
23			CT Scan	57		103,113		23
24			Cardiac Catheterization	59		253,368		24
25			Laboratory	60		137,706		25
26			Whole Blood & Packed Red Bloo	62		34,225		26
27			NONINVASIVE LAB	63.02		115,034		27
28			Respiratory Therapy	65		37,314		28
29			Physical Therapy	66		17,907		29
30			Occupational Therapy	67		3,484		30
31			Speech Pathology	68		7,870		31
32			Electroencephalography	70		25,470		32
33			ONCOLOGY	75.01		1,272		33
34			CARDIAC REHABILITATION	76.97		13,133		34
35			Clinic	90		280		35
36			Emergency	91		43,471		36
37			RETAIL PHARMACY	194.01		17,514		37
38			Physicians' Private Offices	192		921		38
500	Total reclassifications					2,417,991		500
	Code letter - H							
1	RECLASS PROPERTY INSURANCE	J	OTHER ADMIN & GENERAL	5.05		106,027	12	1
2							12	2
500	Total reclassifications					106,027		500
	Code letter - J							
1	RECLASS FRINGE BENEFITS	L						1
2	257	L	MAINTENANCE OF PERSONNEL	4.01		826,058		2
3			PURCHASING RECEIVING & STORES	5.02		55,876		3
4			ADMITTING	5.03		193,270		4
5			OTHER ADMIN & GENERAL	5.05		601,613		5
6			Maintenance & Repairs	6		246,797		6
7			Operation of Plant	7		178,076		7
8			Laundry & Linen Service	8		27,695		8
9			Housekeeping	9		538,385		9
10			Dietary	10		380,848		10
11			Nursing Administration	13		145,639		11
12			Pharmacy	15		207,390		12
13			Medical Records & Library	16		5,736		13
14			Adults & Pediatrics	30		2,297,229		14
15			Intensive Care Unit	31		322,082		15
16			Subprovider - IPF	40		221,630		16
17			Subprovider - IRF	41		279,214		17
18			Operating Room	50		588,723		18
19			Recovery Room	51		57,045		19

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref. 10	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9		
20			Anesthesiology	53		123,600		20
21			Radiology-Diagnostic	54		322,448		21
22			ULTRASOUND	54.01		40,114		22
23			Radioisotope	56		56,817		23
24			CT Scan	57		76,095		24
25			Cardiac Catheterization	59		182,155		25
26			Laboratory	60		468,818		26
27			Whole Blood & Packed Red Bloo	62		49,626		27
28			NONINVASIVE LAB	63.02		137,141		28
29			Respiratory Therapy	65		196,802		29
30			Physical Therapy	66		273,965		30
31			Occupational Therapy	67		83,895		31
32			Speech Pathology	68		42,335		32
33			Electroencephalography	70		25,202		33
34			ONCOLOGY	75.01		65,766		34
35			CARDIAC REHABILITATION	76.97		68,639		35
36			Clinic	90		4,405		36
37			OP PSYCH	90.01		12,239		37
38			Emergency	91		509,273		38
39			RETAIL PHARMACY	194.01		82,799		39
40			ADVERTISING EXPENSE	194.03		206		40
500	Total reclassifications					9,995,646		500
	Code letter - L							
	GRAND TOTAL (Decreases)				2,216,106	26,815,159		

(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.

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	Purchases 2	Donation 3	Total 4	5	6	7	
1	Land								1
2	Land Improvements	2,638,270					2,638,270		2
3	Buildings and Fixtures	77,000,150	3,223,147		3,223,147	31,318	80,191,979		3
4	Building Improvements	36,426					36,426		4
5	Fixed Equipment								5
6	Movable Equipment	107,443,649	2,670,524		2,670,524	518,687	109,595,486		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	187,118,495	5,893,671		5,893,671	550,005	192,462,161		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	187,118,495	5,893,671		5,893,671	550,005	192,462,161		10

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

	Description	SUMMARY OF CAPITAL							
		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 line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		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	82,866,675		82,866,675	0.430561					1
2	Cap Rel Costs-Mvble Equ	109,595,486		109,595,486	0.569439					2
3	Total (sum of lines 1-2)	192,462,161		192,462,161	1.000000					3

	Description	SUMMARY OF CAPITAL							
		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	2,524,061			101,078			2,625,139	1
2	Cap Rel Costs-Mvble Equip	3,132,224	669,998		4,949			3,807,171	2
3	Total (sum of lines 1-2)	5,656,285	669,998		106,027			6,432,310	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.)

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	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	-33,735	NONPATIENT TELEPHONES	5.01	7
8	Television and radio service (chapter 21)	A	-469	Cap Rel Costs-Mvble Equip	2	9 8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-1,772,443			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-5,900,836			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	148,484	Cap Rel Costs-Bldg & Fixt	1	9 26
27	Depreciation--movable equipment	A	3,066	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	-38,312	CARDIAC REHABILITATION	76.97	33
33.07	LAB REVENUE	B	-1,550	Laboratory	60	33.07
33.12	OFFSET OTHER REVENUE	B	-255	Employee Benefits Department	4	33.12
33.13	OTHER OPERATING REVENUE	B	-191	MAINTENANCE OF PERSONNEL	4.01	33.13
33.14	OTHER INCOME	B	-1,263	Clinic	90	33.14
33.15	OTHER INCOME	B	-1,764	Respiratory Therapy	65	33.15
33.16	OFFSET INTERCO REVENUE	B	-118,251	NONINVASIVE LAB	63.02	33.16
33.19	OTHER OPERATING REVENUE	B	-50,839	OTHER ADMIN & GENERAL	5.05	33.19
33.20	OTHER INCOME	B	-10	Cardiac Catheterization	59	33.20
33.21	OTHER INCOME	B	-5,462	Physical Therapy	66	33.21
33.23	OTHER OPER REV	B	-1,096	PURCHASING RECEIVING & STORES	5.02	33.23
33.26	CAFETERIA REVENUE	B	-899,344	Cafeteria	11	33.26
33.28	OTHER OPER REVENUE	B	-80,303	Operation of Plant	7	33.28
33.29	OTHER OPERATING REVENUE	B	-12,694	Maintenance & Repairs	6	33.29
33.30	OTHER OPERATING REVENUE	B	-40,744	Laundry & Linen Service	8	33.30
33.31	OFFSET OTHER REVENUE	B	-14	Subprovider - IRF	41	33.31
33.33	OFFSET OTHER REVENUE	B	-58	Adults & Pediatrics	30	33.33
33.34	RELEASED TEMP REST OP	B	-6,427	Medical Records & Library	16	33.34
33.37	RELEASED TEMP REST INCOME	B	-8,359	Adults & Pediatrics	30	33.37
33.38	RELEASED TEMP REST INCOME	B	-530	Electroencephalography	70	33.38
33.39	RELEASED TEMP REST INCOME	B	-812	Physical Therapy	66	33.39
34	OFFSET TELEPHONE DEPRECIATION	A	-189	Cap Rel Costs-Mvble Equip	2	9 34
34.01	OFFSET CONTRIBUTIONS	A	-50	Physical Therapy	66	34.01
34.03	OFFSET CAPITATION EXPENSE	A	-34,742,092	OTHER ADMIN & GENERAL	5.05	34.03
35	CRNA SALARIES	A	-631,109	Anesthesiology	53	35
35.01	OFFSET BENEFITS CRNA/ANEST	A	-79,071	Employee Benefits Department	4	35.01
35.02	OFFSET BENEFITS FOR ANEST/CRNA	A	-105,295	Anesthesiology	53	35.02
35.03	OFFSET ANESTHESIA OTHER REVENUE	B	-2,339	Anesthesiology	53	35.03
36	OFFSET HHA COSTS	A	-2,121	Home Health Agency	101	36
37	OFFSET WOUND CLINIC NP	A	-101,413	Physical Therapy	66	37
38	OFFSET MEDICAL STAFF FEES	B	-10,250	OTHER ADMIN & GENERAL	5.05	38
38.01	OFFSET OTHER ANEST PHYS COSTS	A	-185,742	Anesthesiology	53	38.01
39	OFFSET FEES FOR ON CALL SURGEONS	A	-415,000	Operating Room	50	39

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
40	MDWISE ADD BACK	A	5,279,596	OTHER ADMIN & GENERAL	5.05	40
41						41
42						42
43	OFFSET INTEREST EXPENSE	A	-14,990	OTHER ADMIN & GENERAL	5.05	43
44	OFFSET OTHER INCOME	B	-30,895	Radiology-Diagnostic	54	44
45	OFFSET OTHER INCOME	B	-26	Operating Room	50	45
46	ELIMINATE PHYSICIAN COSTS	A	-3,116,802	OTHER ADMIN & GENERAL	5.05	46
46.04	OFFSET ONCOLOGY PHYSICIAN COSTS	A	-495,898	ONCOLOGY	75.01	46.04
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-43,477,897			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.

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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	83,650		83,650	9	1
2	2	Cap Rel Costs-Mvble Equip	DEPRECIATION EQUIP	711,825		711,825	9	2
3	5.05	OTHER ADMIN & GENERAL	A&G OTHER	11,442,073	23,080,875	-11,638,802		3
3.01	5.01	NONPATIENT TELEPHONES	TELECOMMUNICATIONS	637,210		637,210		3.01
3.02	16	Medical Records & Library	MEDICAL RECORDS	2,005,095		2,005,095		3.02
3.03	5.04	CASHIERING ACCOUNTS RECEIVABLE	PATIENT ACCOUNTING	2,300,186		2,300,186		3.03
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			17,180,039	23,080,875	-5,900,836		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.

	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:

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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	31,583		31,583	211,500	316	32,132	1,607	1
2	13	Nursing Administrati	44,500		44,500	211,500	432	43,927	2,196	2
3	16	Medical Records & Li	16,300		16,300	211,500	163	16,574	829	3
4	30	Adults & Pediatrics	27,950		27,950	211,500	280	28,471	1,424	4
5	31	Intensive Care Unit	24,443		24,443	211,500	199	20,235	1,012	5
6	53	Anesthesiology AGGREGATE	1,539,801	1,539,801		239,400				6
7	54	Radiology-Diagnostic	25,000		25,000	271,900	105	13,726	686	7
8	59	Cardiac Catheterizat	28,040		28,040	211,500	121	12,304	615	8
9	60	Laboratory	41,070		41,070	260,300	210	26,280	1,314	9
10	90	Clinic	9,782		9,782	211,500	73	7,423	371	10
11	91	Emergency AGGREGATE	253,050	116,667	136,383	211,500	682	69,348	3,467	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,041,519	1,656,468	385,051		2,581	270,420	13,521	200

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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					32,132			1
2	13	Nursing Administrati					43,927	573	573	2
3	16	Medical Records & Li					16,574			3
4	30	Adults & Pediatrics					28,471			4
5	31	Intensive Care Unit					20,235	4,208	4,208	5
6	53	Anesthesiology AGGREGATE							1,539,801	6
7	54	Radiology-Diagnostic					13,726	11,274	11,274	7
8	59	Cardiac Catheterizat					12,304	15,736	15,736	8
9	60	Laboratory					26,280	14,790	14,790	9
10	90	Clinic					7,423	2,359	2,359	10
11	91	Emergency AGGREGATE					69,348	67,035	183,702	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					270,420	115,975	1,772,443	200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,625,139	2,625,139					1
2	Cap Rel Costs-Mvble Equip	3,807,171		3,807,171				2
4	Employee Benefits Department	8,197,350	2,205	565	8,200,120			4
4.01	MAINTENANCE OF PERSONNEL	452,942	12,094		48,129	513,165		4.01
5.01	NONPATIENT TELEPHONES	603,475	5,044				608,519	5.01
5.02	PURCHASING RECEIVING & STORES	398,740	49,715	1,239	46,986	5,016	9,295	5.02
5.03	ADMITTING	1,173,260	21,548	855	154,827	16,615	9,295	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE	2,300,186						5.04
5.05	OTHER ADMIN & GENERAL	18,898,345	278,169	112,326	666,561	29,115	115,362	5.05
6	Maintenance & Repairs	6,174,741	369,920	180,980	193,779	11,025	3,827	6
7	Operation of Plant	2,720,654	108,859	40,542	129,588	8,610	9,841	7
8	Laundry & Linen Service	684,523	10,176	1,683	17,879	1,875	1,093	8
9	Housekeeping	2,461,861	39,869	22,341	287,704	32,853	6,561	9
10	Dietary	1,135,077	69,475	59,937	112,236	11,866	13,122	10
11	Cafeteria	1,327,793	22,650	35,916	151,229	15,988		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,309,278	13,321	132,606	156,406	6,636	1,640	13
14	Central Services & Supply							14
15	Pharmacy	4,925,991	26,716	154,840	275,841	11,594	18,042	15
16	Medical Records & Library	2,153,581	17,643	1,507	9,536	395	9,841	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,532,877	401,949	222,842	1,841,363	122,514	120,831	30
31	Intensive Care Unit	2,764,858	57,487	104,501	335,175	17,544	15,855	31
40	Subprovider - IPF	1,730,836	46,763	46,285	214,938	14,804	7,654	40
41	Subprovider - IRF	2,860,191	90,163	65,207	283,354	19,855	31,164	41
43	Nursery	561,542	12,985		57,113	2,961		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,416,785	195,074	682,760	522,871	29,097	38,818	50
51	Recovery Room	430,683	7,560	1,030	55,858	2,502	2,187	51
52	Delivery Room & Labor Room	1,270,434	29,376		129,213	6,705		52
53	Anesthesiology	238,431	1,993	73,943		3,919	3,280	53
54	Radiology-Diagnostic	2,525,108	55,245	454,559	283,343	19,048	15,309	54
54.01	ULTRASOUND	545,845	6,769	124,272	58,889	2,078	4,374	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,174,898	10,631	7,797	85,757	2,903	4,921	56
57	CT Scan	724,764	7,554	162,353	67,339	3,443	2,187	57
59	Cardiac Catheterization	1,702,043	39,763	398,932	172,746	8,197	29,524	59
60	Laboratory	5,479,614	61,548	216,821	396,931	26,868	31,711	60
62	Whole Blood & Packed Red Blood Cells	814,179	4,584	53,888	25,233	1,329	3,827	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	876,172	13,165	181,123	115,142	6,769	4,374	63.02
65	Respiratory Therapy	1,469,117	10,687	58,752	177,020	10,427	5,467	65
66	Physical Therapy	3,101,313	57,269	28,195	276,725	14,473	19,683	66
67	Occupational Therapy	1,367,991	15,214	5,486	106,128	5,463		67
68	Speech Pathology	524,723	4,932	12,391	46,217	1,852	1,093	68
70	Electroencephalography	236,106	15,880	40,103	24,623	1,527	3,827	70
71	Medical Supplies Charged to Patients	3,667,298						71
72	Impl. Dev. Charged to Patients	3,468,624						72
73	Drugs Charged to Patients	2,354,641						73
74	Renal Dialysis	872,565	5,244					74
75.01	ONCOLOGY	421,640	7,498	2,003	50,799	3,315	1,093	75.01
76.97	CARDIAC REHABILITATION	594,425	34,563	20,678	81,439	4,435	3,280	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	160,108	29,338	441	20,430	493		90
90.01	OP PSYCH	136,104	5,898		13,240	778		90.01
91	Emergency	3,876,698	62,550	68,446	448,456	25,387	22,963	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)	129,250,720	2,339,086	3,778,145	8,141,043	510,274	571,341	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		6,956					190
192	Physicians' Private Offices	94,004	161,532				1,093	192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY	4,212,025	6,682	27,576	58,438	2,862		194.01
194.03	ADVERTISING EXPENSE	494,910	7,841		639	29	2,734	194.03
194.04	REGENCY HOSPITAL	22,292	103,042	1,450			33,351	194.04

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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)	134,073,951	2,625,139	3,807,171	8,200,120	513,165	608,519	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	
	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	510,991						5.02
5.03	ADMITTING	1,197	1,377,597					5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE			2,300,186				5.04
5.05	OTHER ADMIN & GENERAL	1,015			20,100,893	20,100,893		5.05
6	Maintenance & Repairs	511			6,934,783	1,223,053	8,157,836	6
7	Operation of Plant	91			3,018,185	532,302	470,754	7
8	Laundry & Linen Service	470			717,699	126,577	44,005	8
9	Housekeeping	1,596			2,852,785	503,131	172,412	9
10	Dietary	8,216			1,409,929	248,662	300,442	10
11	Cafeteria				1,553,576	273,996	97,948	11
12	Maintenance of Personnel							12
13	Nursing Administration	528			1,620,415	285,784	57,605	13
14	Central Services & Supply							14
15	Pharmacy	7,580			5,420,604	956,005	115,534	15
16	Medical Records & Library	34			2,192,537	386,687	76,296	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	78,839	168,692	281,688	17,771,595	3,134,325	1,738,211	30
31	Intensive Care Unit	19,777	14,601	24,382	3,354,180	591,560	248,600	31
40	Subprovider - IPF	2,828	31,729	52,982	2,148,819	378,976	202,225	40
41	Subprovider - IRF	12,109	19,191	32,046	3,413,280	601,983	389,907	41
43	Nursery		4,668	7,795	647,064	114,119	56,151	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	95,778	131,675	219,877	9,332,735	1,645,968	843,587	50
51	Recovery Room	988	7,631	12,743	521,182	91,918	32,694	51
52	Delivery Room & Labor Room		10,561	17,635	1,463,924	258,185	127,034	52
53	Anesthesiology	11,436	17,067	28,499	378,568	66,766	8,618	53
54	Radiology-Diagnostic	6,034	62,579	104,497	3,525,722	621,814	238,905	54
54.01	ULTRASOUND	6,842	19,454	32,484	801,007	141,270	29,274	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,302	34,256	57,202	1,379,667	243,325	45,971	56
57	CT Scan	6,410	79,927	133,465	1,187,442	209,423	32,667	57
59	Cardiac Catheterization	42,800	70,813	118,246	2,583,064	455,562	171,955	59
60	Laboratory	123,577	169,792	283,345	6,790,207	1,197,555	266,159	60
62	Whole Blood & Packed Red Blood Cells	10,394	7,185	11,998	932,617	164,481	19,821	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,012	42,047	70,211	1,311,015	231,217	56,932	63.02
65	Respiratory Therapy	8,321	27,026	45,129	1,811,946	319,564	46,214	65
66	Physical Therapy	12,433	30,812	51,451	3,592,354	633,566	247,658	66
67	Occupational Therapy	1,103	14,930	24,931	1,541,246	271,822	65,792	67
68	Speech Pathology	220	4,161	6,948	602,537	106,266	21,329	68
70	Electroencephalography	3,386	11,492	19,189	356,133	62,809	68,674	70
71	Medical Supplies Charged to Patients		25,776	43,041	3,736,115	658,920		71
72	Impl. Dev. Charged to Patients		22,118	36,934	3,527,676	622,159		72
73	Drugs Charged to Patients		160,470	267,960	2,783,071	490,836		73
74	Renal Dialysis	599	9,001	15,030	902,439	159,159	22,676	74
75.01	ONCOLOGY	2,855	6,430	10,738	506,371	89,306	32,425	75.01
76.97	CARDIAC REHABILITATION	741	1,981	3,308	744,850	131,365	149,467	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	629	1,115	1,862	214,416	37,815	126,872	90
90.01	OP PSYCH	14	2,426	4,051	162,511	28,661	25,504	90.01
91	Emergency	37,564	167,991	280,519	4,990,574	880,163	270,495	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)	510,229	1,377,597	2,300,186	128,835,733	19,177,055	6,920,813	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				6,956	1,227	30,082	190
192	Physicians' Private Offices				256,629	45,260	698,537	192
194	OTHER NON REIM COST CENTER	85			85	15		194
194.01	RETAIL PHARMACY	660			4,308,243	759,823	28,897	194.01
194.03	ADVERTISING EXPENSE	17			506,170	89,271	33,906	194.03
194.04	REGENCY HOSPITAL				160,135	28,242	445,601	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

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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)	510,991	1,377,597	2,300,186	134,073,951	20,100,893	8,157,836	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	4,021,241						7
8	Laundry & Linen Service	23,020	911,301					8
9	Housekeeping	90,192		3,618,520				9
10	Dietary	157,166			2,221,570			10
11	Cafeteria	51,238		49,579		2,026,337		11
12	Maintenance of Personnel							12
13	Nursing Administration	30,134		12,695		35,366	2,041,999	13
14	Central Services & Supply							14
15	Pharmacy	60,438		7,461		61,790		15
16	Medical Records & Library	39,911		17,261		2,104		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	909,288	267,376	929,199	1,502,510	652,950	982,996	30
31	Intensive Care Unit	130,047	38,260	153,469	70,443	93,504	140,782	31
40	Subprovider - IPF	105,787	43,039	156,732	163,094	78,900	118,800	40
41	Subprovider - IRF	203,967	58,184	185,285	290,153	105,819	159,298	41
43	Nursery	29,374	10,697	5,457		15,780	23,774	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	441,295	145,326	535,042		155,077	233,439	50
51	Recovery Room	17,103	25,899	23,898		13,336	20,099	51
52	Delivery Room & Labor Room	66,453	28,784			35,737	53,785	52
53	Anesthesiology	4,508				20,885		53
54	Radiology-Diagnostic	124,975	33,156	160,875		101,518		54
54.01	ULTRASOUND	15,314	29,151	13,152		11,077		54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	24,048	8,178	13,519		15,471		56
57	CT Scan	17,089				18,348		57
59	Cardiac Catheterization	89,952	25,660	111,318		43,689	65,770	59
60	Laboratory	139,232		101,006		143,196		60
62	Whole Blood & Packed Red Blood Cells	10,369				7,086		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	29,782	3,725	10,591		36,077		63.02
65	Respiratory Therapy	24,175		16,148		55,570		65
66	Physical Therapy	129,554	27,614	122,521		77,136		66
67	Occupational Therapy	34,417				29,116		67
68	Speech Pathology	11,158				9,870		68
70	Electroencephalography	35,925	7,562	15,569		8,138		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	11,862		4,455				74
75.01	ONCOLOGY	16,962				17,667		75.01
76.97	CARDIAC REHABILITATION	78,189	11,603	47,363		23,639	35,582	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	66,369	13,028	10,023		2,630	3,966	90
90.01	OP PSYCH	13,341				4,146		90.01
91	Emergency	141,501	72,877	472,857		135,306	203,708	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)	3,374,135	850,119	3,280,846	2,026,200	2,010,928	2,041,999	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	15,736		10,914				190
192	Physicians' Private Offices	365,416		11,136				192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY	15,116		9,020		15,254		194.01
194.03	ADVERTISING EXPENSE	17,737		5,011		155		194.03
194.04	REGENCY HOSPITAL	233,101	61,182	301,593	195,370			194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

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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)	4,021,241	911,301	3,618,520	2,221,570	2,026,337	2,041,999	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	6,621,832					15
16	Medical Records & Library		2,714,796				16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		332,429	28,220,879		28,220,879	30
31	Intensive Care Unit		28,774	4,849,619		4,849,619	31
40	Subprovider - IPF		62,526	3,458,898		3,458,898	40
41	Subprovider - IRF		37,818	5,445,694		5,445,694	41
43	Nursery		9,199	911,615		911,615	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		259,484	13,591,953		13,591,953	50
51	Recovery Room		15,038	761,167		761,167	51
52	Delivery Room & Labor Room		20,811	2,054,713		2,054,713	52
53	Anesthesiology		33,633	512,978		512,978	53
54	Radiology-Diagnostic		123,320	4,930,285		4,930,285	54
54.01	ULTRASOUND		38,336	1,078,581		1,078,581	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope		67,506	1,797,685		1,797,685	56
57	CT Scan		157,506	1,622,475		1,622,475	57
59	Cardiac Catheterization		139,547	3,686,517		3,686,517	59
60	Laboratory		334,659	8,972,014		8,972,014	60
62	Whole Blood & Packed Red Blood Cells		14,159	1,148,533		1,148,533	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB		82,858	1,762,197		1,762,197	63.02
65	Respiratory Therapy		53,258	2,326,875		2,326,875	65
66	Physical Therapy		60,719	4,891,122		4,891,122	66
67	Occupational Therapy		29,422	1,971,815		1,971,815	67
68	Speech Pathology		8,200	759,360		759,360	68
70	Electroencephalography		22,646	577,456		577,456	70
71	Medical Supplies Charged to Patients		50,794	4,445,829		4,445,829	71
72	Impl. Dev. Charged to Patients		43,587	4,193,422		4,193,422	72
73	Drugs Charged to Patients	6,621,832	316,228	10,211,967		10,211,967	73
74	Renal Dialysis		17,737	1,118,328		1,118,328	74
75.01	ONCOLOGY		12,672	675,403		675,403	75.01
76.97	CARDIAC REHABILITATION		3,904	1,225,962		1,225,962	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		2,197	477,316		477,316	90
90.01	OP PSYCH		4,780	238,943		238,943	90.01
91	Emergency		331,049	7,498,530		7,498,530	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)	6,621,832	2,714,796	125,418,131		125,418,131	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			64,915		64,915	190
192	Physicians' Private Offices			1,376,978		1,376,978	192
194	OTHER NON REIM COST CENTER			100		100	194
194.01	RETAIL PHARMACY			5,136,353		5,136,353	194.01
194.03	ADVERTISING EXPENSE			652,250		652,250	194.03
194.04	REGENCY HOSPITAL			1,425,224		1,425,224	194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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)	6,621,832	2,714,796	134,073,951		134,073,951		202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		2,205	565	2,770	2,770		4
4.01	MAINTENANCE OF PERSONNEL		12,094		12,094	16	12,110	4.01
5.01	NONPATIENT TELEPHONES		5,044		5,044			5.01
5.02	PURCHASING RECEIVING & STORES		49,715	1,239	50,954	16	118	5.02
5.03	ADMITTING		21,548	855	22,403	52	392	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL		278,169	112,326	390,495	223	687	5.05
6	Maintenance & Repairs		369,920	180,980	550,900	65	260	6
7	Operation of Plant		108,859	40,542	149,401	43	203	7
8	Laundry & Linen Service		10,176	1,683	11,859	6	44	8
9	Housekeeping		39,869	22,341	62,210	96	775	9
10	Dietary		69,475	59,937	129,412	38	280	10
11	Cafeteria		22,650	35,916	58,566	51	377	11
12	Maintenance of Personnel							12
13	Nursing Administration		13,321	132,606	145,927	52	157	13
14	Central Services & Supply							14
15	Pharmacy		26,716	154,840	181,556	92	274	15
16	Medical Records & Library		17,643	1,507	19,150	3	9	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		401,949	222,842	624,791	641	2,891	30
31	Intensive Care Unit		57,487	104,501	161,988	112	414	31
40	Subprovider - IPF		46,763	46,285	93,048	72	349	40
41	Subprovider - IRF		90,163	65,207	155,370	95	469	41
43	Nursery		12,985		12,985	19	70	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		195,074	682,760	877,834	175	687	50
51	Recovery Room		7,560	1,030	8,590	19	59	51
52	Delivery Room & Labor Room		29,376		29,376	43	158	52
53	Anesthesiology		1,993	73,943	75,936		92	53
54	Radiology-Diagnostic		55,245	454,559	509,804	95	450	54
54.01	ULTRASOUND		6,769	124,272	131,041	20	49	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		10,631	7,797	18,428	29	69	56
57	CT Scan		7,554	162,353	169,907	23	81	57
59	Cardiac Catheterization		39,763	398,932	438,695	58	193	59
60	Laboratory		61,548	216,821	278,369	133	634	60
62	Whole Blood & Packed Red Blood Cells		4,584	53,888	58,472	8	31	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		13,165	181,123	194,288	39	160	63.02
65	Respiratory Therapy		10,687	58,752	69,439	59	246	65
66	Physical Therapy		57,269	28,195	85,464	93	342	66
67	Occupational Therapy		15,214	5,486	20,700	36	129	67
68	Speech Pathology		4,932	12,391	17,323	15	44	68
70	Electroencephalography		15,880	40,103	55,983	8	36	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis		5,244		5,244			74
75.01	ONCOLOGY		7,498	2,003	9,501	17	78	75.01
76.97	CARDIAC REHABILITATION		34,563	20,678	55,241	27	105	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		29,338	441	29,779	7	12	90
90.01	OP PSYCH		5,898		5,898	4	18	90.01
91	Emergency		62,550	68,446	130,996	150	599	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)		2,339,086	3,778,145	6,117,231	2,750	12,041	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		6,956		6,956			190
192	Physicians' Private Offices		161,532		161,532			192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		6,682	27,576	34,258	20	68	194.01
194.03	ADVERTISING EXPENSE		7,841		7,841		1	194.03
194.04	REGENCY HOSPITAL		103,042	1,450	104,492			194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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)		2,625,139	3,807,171	6,432,310	2,770	12,110	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	OTHER ADMIN GENERAL	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
	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	5,044						5.01
5.02	PURCHASING RECEIVING & STORES	77	51,165					5.02
5.03	ADMITTING	77	120	23,044				5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	956	102		392,463			5.05
6	Maintenance & Repairs	32	51		23,876	575,184		6
7	Operation of Plant	82	9		10,392	33,191	193,321	7
8	Laundry & Linen Service	9	47		2,471	3,103	1,107	8
9	Housekeeping	54	160		9,822	12,156	4,336	9
10	Dietary	109	823		4,854	21,183	7,556	10
11	Cafeteria				5,349	6,906	2,463	11
12	Maintenance of Personnel							12
13	Nursing Administration	14	53		5,579	4,062	1,449	13
14	Central Services & Supply							14
15	Pharmacy	150	759		18,663	8,146	2,906	15
16	Medical Records & Library	82	3		7,549	5,379	1,919	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,002	7,894	2,812	61,243	122,557	43,713	30
31	Intensive Care Unit	131	1,980	243	11,548	17,528	6,252	31
40	Subprovider - IPF	63	283	529	7,398	14,258	5,086	40
41	Subprovider - IRF	258	1,212	320	11,752	27,491	9,806	41
43	Nursery			78	2,228	3,959	1,412	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	322	9,590	2,195	32,133	59,479	21,215	50
51	Recovery Room	18	99	127	1,794	2,305	822	51
52	Delivery Room & Labor Room			176	5,040	8,957	3,195	52
53	Anesthesiology	27	1,145	284	1,303	608	217	53
54	Radiology-Diagnostic	127	604	1,043	12,139	16,844	6,008	54
54.01	ULTRASOUND	36	685	324	2,758	2,064	736	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	41	130	571	4,750	3,241	1,156	56
57	CT Scan	18	642	1,332	4,088	2,303	822	57
59	Cardiac Catheterization	245	4,286	1,180	8,893	12,124	4,324	59
60	Laboratory	263	12,375	2,912	23,379	18,766	6,694	60
62	Whole Blood & Packed Red Blood Cells	32	1,041	120	3,211	1,398	498	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	36	202	701	4,514	4,014	1,432	63.02
65	Respiratory Therapy	45	833	450	6,239	3,258	1,162	65
66	Physical Therapy	163	1,245	514	12,368	17,462	6,228	66
67	Occupational Therapy		110	249	5,307	4,639	1,655	67
68	Speech Pathology	9	22	69	2,075	1,504	536	68
70	Electroencephalography	32	339	192	1,226	4,842	1,727	70
71	Medical Supplies Charged to Patients			430	12,863			71
72	Impl. Dev. Charged to Patients			369	12,146			72
73	Drugs Charged to Patients			2,675	9,582			73
74	Renal Dialysis		60	150	3,107	1,599	570	74
75.01	ONCOLOGY	9	286	107	1,743	2,286	815	75.01
76.97	CARDIAC REHABILITATION	27	74	33	2,565	10,538	3,759	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		63	19	738	8,945	3,191	90
90.01	OP PSYCH		1	40	560	1,798	641	90.01
91	Emergency	190	3,761	2,800	17,183	19,072	6,803	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)	4,736	51,089	23,044	374,428	487,965	162,211	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				24	2,121	757	190
192	Physicians' Private Offices	9			884	49,252	17,567	192
194	OTHER NON REIM COST CENTER		8					194
194.01	RETAIL PHARMACY		66		14,833	2,037	727	194.01
194.03	ADVERTISING EXPENSE	23	2		1,743	2,391	853	194.03
194.04	REGENCY HOSPITAL	276			551	31,418	11,206	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	OTHER ADMIN GENERAL	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,044	51,165	23,044	392,463	575,184	193,321	202

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	
		8	9	10	11	13	15	
	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	18,646						8
9	Housekeeping		89,609					9
10	Dietary		2,609	166,864				10
11	Cafeteria		1,228		74,940			11
12	Maintenance of Personnel							12
13	Nursing Administration		314		1,308	158,915		13
14	Central Services & Supply							14
15	Pharmacy		185		2,285		215,016	15
16	Medical Records & Library		427		78			16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,470	23,011	112,855	24,149	76,501		30
31	Intensive Care Unit	783	3,801	5,291	3,458	10,956		31
40	Subprovider - IPF	881	3,881	12,250	2,918	9,245		40
41	Subprovider - IRF	1,191	4,588	21,794	3,913	12,397		41
43	Nursery	219	135		584	1,850		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,974	13,250		5,735	18,167		50
51	Recovery Room	530	592		493	1,564		51
52	Delivery Room & Labor Room	589			1,322	4,186		52
53	Anesthesiology				772			53
54	Radiology-Diagnostic	678	3,984		3,754			54
54.01	ULTRASOUND	596	326		410			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	167	335		572			56
57	CT Scan				679			57
59	Cardiac Catheterization	525	2,757		1,616	5,118		59
60	Laboratory		2,501		5,296			60
62	Whole Blood & Packed Red Blood Cells				262			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	76	262		1,334			63.02
65	Respiratory Therapy		400		2,055			65
66	Physical Therapy	565	3,034		2,853			66
67	Occupational Therapy				1,077			67
68	Speech Pathology				365			68
70	Electroencephalography	155	386		301			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						215,016	73
74	Renal Dialysis		110					74
75.01	ONCOLOGY				653			75.01
76.97	CARDIAC REHABILITATION	237	1,173		874	2,769		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	267	248		97	309		90
90.01	OP PSYCH				153			90.01
91	Emergency	1,491	11,710		5,004	15,853		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)	17,394	81,247	152,190	74,370	158,915	215,016	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		270					190
192	Physicians' Private Offices		276					192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		223		564			194.01
194.03	ADVERTISING EXPENSE		124		6			194.03
194.04	REGENCY HOSPITAL	1,252	7,469	14,674				194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	
		8	9	10	11	13	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	18,646	89,609	166,864	74,940	158,915	215,016	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	24	25	26		
	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	34,599					16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	4,217	1,113,747		1,113,747		30
31	Intensive Care Unit	365	224,850		224,850		31
40	Subprovider - IPF	793	151,054		151,054		40
41	Subprovider - IRF	480	251,136		251,136		41
43	Nursery	117	23,656		23,656		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,292	1,047,048		1,047,048		50
51	Recovery Room	191	17,203		17,203		51
52	Delivery Room & Labor Room	264	53,306		53,306		52
53	Anesthesiology	427	80,811		80,811		53
54	Radiology-Diagnostic	1,564	557,094		557,094		54
54.01	ULTRASOUND	486	139,531		139,531		54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	856	30,345		30,345		56
57	CT Scan	1,998	181,893		181,893		57
59	Cardiac Catheterization	1,770	481,784		481,784		59
60	Laboratory	4,404	355,726		355,726		60
62	Whole Blood & Packed Red Blood Cells	180	65,253		65,253		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,051	208,109		208,109		63.02
65	Respiratory Therapy	676	84,862		84,862		65
66	Physical Therapy	770	131,101		131,101		66
67	Occupational Therapy	373	34,275		34,275		67
68	Speech Pathology	104	22,066		22,066		68
70	Electroencephalography	287	65,514		65,514		70
71	Medical Supplies Charged to Patients	644	13,937		13,937		71
72	Impl. Dev. Charged to Patients	553	13,068		13,068		72
73	Drugs Charged to Patients	4,012	231,285		231,285		73
74	Renal Dialysis	225	11,065		11,065		74
75.01	ONCOLOGY	161	15,656		15,656		75.01
76.97	CARDIAC REHABILITATION	50	77,472		77,472		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	28	43,703		43,703		90
90.01	OP PSYCH	61	9,174		9,174		90.01
91	Emergency	4,200	219,812		219,812		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)	34,599	5,955,536		5,955,536		118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		10,128		10,128		190
192	Physicians' Private Offices		229,520		229,520		192
194	OTHER NON REIM COST CENTER		8		8		194
194.01	RETAIL PHARMACY		52,796		52,796		194.01
194.03	ADVERTISING EXPENSE		12,984		12,984		194.03
194.04	REGENCY HOSPITAL		171,338		171,338		194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		16	24	25	26			
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	34,599	6,432,310		6,432,310			202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	421,532						1
2	Cap Rel Costs-Mvble Equip		2,417,991					2
4	Employee Benefits Department	354	359	53,835,207				4
4.01	MAINTENANCE OF PERSONNEL	1,942		315,977	88,393			4.01
5.01	NONPATIENT TELEPHONES	810				1,113		5.01
5.02	PURCHASING RECEIVING & STORES	7,983	787	308,473	864	17	151,076	5.02
5.03	ADMITTING	3,460	543	1,016,463	2,862	17	354	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	44,667	71,340	4,376,088	5,015	211	300	5.05
6	Maintenance & Repairs	59,400	114,943	1,272,192	1,899	7	151	6
7	Operation of Plant	17,480	25,749	850,766	1,483	18	27	7
8	Laundry & Linen Service	1,634	1,069	117,377	323	2	139	8
9	Housekeeping	6,402	14,189	1,888,826	5,659	12	472	9
10	Dietary	11,156	38,067	736,849	2,044	24	2,429	10
11	Cafeteria	3,637	22,811	992,843	2,754			11
12	Maintenance of Personnel							12
13	Nursing Administration	2,139	84,220	1,026,833	1,143	3	156	13
14	Central Services & Supply							14
15	Pharmacy	4,290	98,341	1,810,946	1,997	33	2,241	15
16	Medical Records & Library	2,833	957	62,606	68	18	10	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,543	141,530	12,088,886	21,103	221	23,309	30
31	Intensive Care Unit	9,231	66,370	2,200,478	3,022	29	5,847	31
40	Subprovider - IPF	7,509	29,396	1,411,106	2,550	14	836	40
41	Subprovider - IRF	14,478	41,414	1,860,267	3,420	57	3,580	41
43	Nursery	2,085		374,958	510			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,324	433,632	3,432,735	5,012	71	28,317	50
51	Recovery Room	1,214	654	366,719	431	4	292	51
52	Delivery Room & Labor Room	4,717		848,305	1,155			52
53	Anesthesiology	320	46,962		675	6	3,381	53
54	Radiology-Diagnostic	8,871	288,697	1,860,196	3,281	28	1,784	54
54.01	ULTRASOUND	1,087	78,927	386,617	358	8	2,023	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,707	4,952	563,011	500	9	385	56
57	CT Scan	1,213	103,113	442,089	593	4	1,895	57
59	Cardiac Catheterization	6,385	253,368	1,134,109	1,412	54	12,654	59
60	Laboratory	9,883	137,706	2,605,920	4,628	58	36,537	60
62	Whole Blood & Packed Red Blood Cells	736	34,225	165,659	229	7	3,073	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,114	115,034	755,928	1,166	8	595	63.02
65	Respiratory Therapy	1,716	37,314	1,162,169	1,796	10	2,460	65
66	Physical Therapy	9,196	17,907	1,816,746	2,493	36	3,676	66
67	Occupational Therapy	2,443	3,484	696,748	941		326	67
68	Speech Pathology	792	7,870	303,420	319	2	65	68
70	Electroencephalography	2,550	25,470	161,651	263	7	1,001	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	842					177	74
75.01	ONCOLOGY	1,204	1,272	333,503	571	2	844	75.01
76.97	CARDIAC REHABILITATION	5,550	13,133	534,661	764	6	219	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,711	280	134,126	85		186	90
90.01	OP PSYCH	947		86,923	134	4		90.01
91	Emergency	10,044	43,471	2,944,189	4,373	42	11,106	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)	375,599	2,399,556	53,447,358	87,895	1,045	150,851	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,117						190
192	Physicians' Private Offices	25,938				2		192
194	OTHER NON REIM COST CENTER						25	194
194.01	RETAIL PHARMACY	1,073	17,514	383,654	493		195	194.01
194.03	ADVERTISING EXPENSE	1,259		4,195	5	5	5	194.03
194.04	REGENCY HOSPITAL	16,546	921			61		194.04
194.05	UNUSED SPACE							194.05

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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)	2,625,139	3,807,171	8,200,120	513,165	608,519	510,991	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.227615	1.574518	0.152319	5.805494	546.737646	3.382344	203
204	Cost to be allocated (Per Wkst. B, Part II)			2,770	12,110	5,044	51,165	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000051	0.137002	4.531896	0.338671	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	
	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	546,685,717						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE		546,685,717					5.04
5.05	OTHER ADMIN & GENERAL			-20,100,893	113,973,058			5.05
6	Maintenance & Repairs				6,934,783	302,916		6
7	Operation of Plant				3,018,185	17,480	285,436	7
8	Laundry & Linen Service				717,699	1,634	1,634	8
9	Housekeeping				2,852,785	6,402	6,402	9
10	Dietary				1,409,929	11,156	11,156	10
11	Cafeteria				1,553,576	3,637	3,637	11
12	Maintenance of Personnel							12
13	Nursing Administration				1,620,415	2,139	2,139	13
14	Central Services & Supply							14
15	Pharmacy				5,420,604	4,290	4,290	15
16	Medical Records & Library				2,192,537	2,833	2,833	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	66,941,099	66,941,099		17,771,595	64,543	64,543	30
31	Intensive Care Unit	5,794,140	5,794,140		3,354,180	9,231	9,231	31
40	Subprovider - IPF	12,590,777	12,590,777		2,148,819	7,509	7,509	40
41	Subprovider - IRF	7,615,388	7,615,388		3,413,280	14,478	14,478	41
43	Nursery	1,852,339	1,852,339		647,064	2,085	2,085	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	52,252,155	52,252,155		9,332,735	31,324	31,324	50
51	Recovery Room	3,028,231	3,028,231		521,182	1,214	1,214	51
52	Delivery Room & Labor Room	4,190,734	4,190,734		1,463,924	4,717	4,717	52
53	Anesthesiology	6,772,648	6,772,648		378,568	320	320	53
54	Radiology-Diagnostic	24,832,860	24,832,860		3,525,722	8,871	8,871	54
54.01	ULTRASOUND	7,719,664	7,719,664		801,007	1,087	1,087	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	13,593,546	13,593,546		1,379,667	1,707	1,707	56
57	CT Scan	31,716,887	31,716,887		1,187,442	1,213	1,213	57
59	Cardiac Catheterization	28,100,386	28,100,386		2,583,064	6,385	6,385	59
60	Laboratory	67,399,137	67,399,137		6,790,207	9,883	9,883	60
62	Whole Blood & Packed Red Blood Cells	2,851,171	2,851,171		932,617	736	736	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	16,685,153	16,685,153		1,311,015	2,114	2,114	63.02
65	Respiratory Therapy	10,724,497	10,724,497		1,811,946	1,716	1,716	65
66	Physical Therapy	12,226,882	12,226,882		3,592,354	9,196	9,196	66
67	Occupational Therapy	5,924,637	5,924,637		1,541,246	2,443	2,443	67
68	Speech Pathology	1,651,255	1,651,255		602,537	792	792	68
70	Electroencephalography	4,560,231	4,560,231		356,133	2,550	2,550	70
71	Medical Supplies Charged to Patients	10,228,402	10,228,402		3,736,115			71
72	Impl. Dev. Charged to Patients	8,777,017	8,777,017		3,527,676			72
73	Drugs Charged to Patients	63,678,672	63,678,672		2,783,071			73
74	Renal Dialysis	3,571,775	3,571,775		902,439	842	842	74
75.01	ONCOLOGY	2,551,729	2,551,729		506,371	1,204	1,204	75.01
76.97	CARDIAC REHABILITATION	786,116	786,116		744,850	5,550	5,550	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	442,424	442,424		214,416	4,711	4,711	90
90.01	OP PSYCH	962,576	962,576		162,511	947	947	90.01
91	Emergency	66,663,189	66,663,189		4,990,574	10,044	10,044	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)	546,685,717	546,685,717	-20,100,893	108,734,840	256,983	239,503	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				6,956	1,117	1,117	190
192	Physicians' Private Offices				256,629	25,938	25,938	192
194	OTHER NON REIM COST CENTER				85			194
194.01	RETAIL PHARMACY				4,308,243	1,073	1,073	194.01
194.03	ADVERTISING EXPENSE				506,170	1,259	1,259	194.03
194.04	REGENCY HOSPITAL				160,135	16,546	16,546	194.04
194.05	UNUSED SPACE							194.05

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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)	1,377,597	2,300,186		20,100,893	8,157,836	4,021,241	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.002520	0.004208		0.176365	26.931017	14.088065	203
204	Cost to be allocated (Per Wkst. B, Part II)	23,044			392,463	575,184	193,321	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000042			0.003443	1.898823	0.677283	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING HOUSEKEEP HOURS	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	179,067						8
9	Housekeeping		324,931					9
10	Dietary		9,462	150,053				10
11	Cafeteria		4,452		65,490			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,140		1,143	911,835		13
14	Central Services & Supply							14
15	Pharmacy		670		1,997		10,000	15
16	Medical Records & Library		1,550		68			16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	52,538	83,439	101,485	21,103	438,947		30
31	Intensive Care Unit	7,518	13,781	4,758	3,022	62,865		31
40	Subprovider - IPF	8,457	14,074	11,016	2,550	53,049		40
41	Subprovider - IRF	11,433	16,638	19,598	3,420	71,133		41
43	Nursery	2,102	490		510	10,616		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,556	48,045		5,012	104,240		50
51	Recovery Room	5,089	2,146		431	8,975		51
52	Delivery Room & Labor Room	5,656			1,155	24,017		52
53	Anesthesiology				675			53
54	Radiology-Diagnostic	6,515	14,446		3,281			54
54.01	ULTRASOUND	5,728	1,181		358			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,607	1,214		500			56
57	CT Scan				593			57
59	Cardiac Catheterization	5,042	9,996		1,412	29,369		59
60	Laboratory		9,070		4,628			60
62	Whole Blood & Packed Red Blood Cells				229			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	732	951		1,166			63.02
65	Respiratory Therapy		1,450		1,796			65
66	Physical Therapy	5,426	11,002		2,493			66
67	Occupational Therapy				941			67
68	Speech Pathology				319			68
70	Electroencephalography	1,486	1,398		263			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		400					74
75.01	ONCOLOGY				571			75.01
76.97	CARDIAC REHABILITATION	2,280	4,253		764	15,889		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,560	900		85	1,771		90
90.01	OP PSYCH				134			90.01
91	Emergency	14,320	42,461		4,373	90,964		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)	167,045	294,609	136,857	64,992	911,835	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		980					190
192	Physicians' Private Offices		1,000					192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		810		493			194.01
194.03	ADVERTISING EXPENSE		450		5			194.03
194.04	REGENCY HOSPITAL	12,022	27,082	13,196				194.04
194.05	UNUSED SPACE							194.05

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING HOUSEKEEP HOURS	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)	911,301	3,618,520	2,221,570	2,026,337	2,041,999	6,621,832	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.089162	11.136272	14.805235	30.941167	2.239439	662.183200	203
204	Cost to be allocated (Per Wkst. B, Part II)	18,646	89,609	166,864	74,940	158,915	215,016	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.104129	0.275779	1.112034	1.144297	0.174280	21.501600	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

KPMG LLP Compu-Max 2552-10

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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	546,685,717						16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	66,941,099						30
31	Intensive Care Unit	5,794,140						31
40	Subprovider - IPF	12,590,777						40
41	Subprovider - IRF	7,615,388						41
43	Nursery	1,852,339						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	52,252,155						50
51	Recovery Room	3,028,231						51
52	Delivery Room & Labor Room	4,190,734						52
53	Anesthesiology	6,772,648						53
54	Radiology-Diagnostic	24,832,860						54
54.01	ULTRASOUND	7,719,664						54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	13,593,546						56
57	CT Scan	31,716,887						57
59	Cardiac Catheterization	28,100,386						59
60	Laboratory	67,399,137						60
62	Whole Blood & Packed Red Blood Cells	2,851,171						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	16,685,153						63.02
65	Respiratory Therapy	10,724,497						65
66	Physical Therapy	12,226,882						66
67	Occupational Therapy	5,924,637						67
68	Speech Pathology	1,651,255						68
70	Electroencephalography	4,560,231						70
71	Medical Supplies Charged to Patients	10,228,402						71
72	Impl. Dev. Charged to Patients	8,777,017						72
73	Drugs Charged to Patients	63,678,672						73
74	Renal Dialysis	3,571,775						74
75.01	ONCOLOGY	2,551,729						75.01
76.97	CARDIAC REHABILITATION	786,116						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	442,424						90
90.01	OP PSYCH	962,576						90.01
91	Emergency	66,663,189						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)	546,685,717						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

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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)	2,714,796						202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.004966						203
204	Cost to be allocated (Per Wkst. B, Part II)	34,599						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000063						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

KPMG LLP Compu-Max 2552-10

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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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	28,220,879		28,220,879		28,220,879	30
31	Intensive Care Unit	4,849,619		4,849,619	4,208	4,853,827	31
40	Subprovider - IPF	3,458,898		3,458,898		3,458,898	40
41	Subprovider - IRF	5,445,694		5,445,694		5,445,694	41
43	Nursery	911,615		911,615		911,615	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	13,591,953		13,591,953		13,591,953	50
51	Recovery Room	761,167		761,167		761,167	51
52	Delivery Room & Labor Room	2,054,713		2,054,713		2,054,713	52
53	Anesthesiology	512,978		512,978		512,978	53
54	Radiology-Diagnostic	4,930,285		4,930,285	11,274	4,941,559	54
54.01	ULTRASOUND	1,078,581		1,078,581		1,078,581	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,797,685		1,797,685		1,797,685	56
57	CT Scan	1,622,475		1,622,475		1,622,475	57
59	Cardiac Catheterization	3,686,517		3,686,517	15,736	3,702,253	59
60	Laboratory	8,972,014		8,972,014	14,790	8,986,804	60
62	Whole Blood & Packed Red Blood Cells	1,148,533		1,148,533		1,148,533	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,762,197		1,762,197		1,762,197	63.02
65	Respiratory Therapy	2,326,875		2,326,875		2,326,875	65
66	Physical Therapy	4,891,122		4,891,122		4,891,122	66
67	Occupational Therapy	1,971,815		1,971,815		1,971,815	67
68	Speech Pathology	759,360		759,360		759,360	68
70	Electroencephalography	577,456		577,456		577,456	70
71	Medical Supplies Charged to Patients	4,445,829		4,445,829		4,445,829	71
72	Impl. Dev. Charged to Patients	4,193,422		4,193,422		4,193,422	72
73	Drugs Charged to Patients	10,211,967		10,211,967		10,211,967	73
74	Renal Dialysis	1,118,328		1,118,328		1,118,328	74
75.01	ONCOLOGY	675,403		675,403		675,403	75.01
76.97	CARDIAC REHABILITATION	1,225,962		1,225,962		1,225,962	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	477,316		477,316	2,359	479,675	90
90.01	OP PSYCH	238,943		238,943		238,943	90.01
91	Emergency	7,498,530		7,498,530	67,035	7,565,565	91
92	Observation Beds (Non-Distinct Part)	4,722,118		4,722,118		4,722,118	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
200	Subtotal (sum of lines 30 thru 199)	130,140,249		130,140,249	115,402	130,255,651	200
201	Less Observation Beds	4,722,118		4,722,118		4,722,118	201
202	Total (line 200 minus line 201)	125,418,131		125,418,131		125,533,533	202

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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	54,285,490		54,285,490				30
31	Intensive Care Unit	5,794,140		5,794,140				31
40	Subprovider - IPF	12,590,777		12,590,777				40
41	Subprovider - IRF	7,615,388		7,615,388				41
43	Nursery	1,852,339		1,852,339				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,798,537	39,453,618	52,252,155	0.260122	0.260122	0.260122	50
51	Recovery Room	944,545	2,083,686	3,028,231	0.251357	0.251357	0.251357	51
52	Delivery Room & Labor Room	2,810,177	1,380,557	4,190,734	0.490299	0.490299	0.490299	52
53	Anesthesiology	2,004,036	4,768,612	6,772,648	0.075743	0.075743	0.075743	53
54	Radiology-Diagnostic	5,937,216	18,895,644	24,832,860	0.198539	0.198539	0.198993	54
54.01	ULTRASOUND	1,055,635	6,664,029	7,719,664	0.139719	0.139719	0.139719	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	2,473,053	11,120,493	13,593,546	0.132245	0.132245	0.132245	56
57	CT Scan	8,912,494	22,804,393	31,716,887	0.051155	0.051155	0.051155	57
59	Cardiac Catheterization	12,277,154	15,823,232	28,100,386	0.131191	0.131191	0.131751	59
60	Laboratory	21,902,248	45,496,889	67,399,137	0.133118	0.133118	0.133337	60
62	Whole Blood & Packed Red Blood Cells	1,770,571	1,080,600	2,851,171	0.402829	0.402829	0.402829	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	6,071,905	10,613,248	16,685,153	0.105615	0.105615	0.105615	63.02
65	Respiratory Therapy	8,696,139	2,028,358	10,724,497	0.216968	0.216968	0.216968	65
66	Physical Therapy	5,776,850	6,450,032	12,226,882	0.400030	0.400030	0.400030	66
67	Occupational Therapy	4,568,243	1,356,394	5,924,637	0.332816	0.332816	0.332816	67
68	Speech Pathology	895,537	755,718	1,651,255	0.459868	0.459868	0.459868	68
70	Electroencephalography	499,849	4,060,382	4,560,231	0.126629	0.126629	0.126629	70
71	Medical Supplies Charged to Patients	4,648,944	5,579,458	10,228,402	0.434655	0.434655	0.434655	71
72	Impl. Dev. Charged to Patients	4,045,564	4,731,453	8,777,017	0.477773	0.477773	0.477773	72
73	Drugs Charged to Patients	27,631,268	36,047,404	63,678,672	0.160367	0.160367	0.160367	73
74	Renal Dialysis	3,068,216	503,559	3,571,775	0.313101	0.313101	0.313101	74
75.01	ONCOLOGY	6,256	2,545,473	2,551,729	0.264684	0.264684	0.264684	75.01
76.97	CARDIAC REHABILITATION	145,555	640,561	786,116	1.559518	1.559518	1.559518	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,062	441,362	442,424	1.078866	1.078866	1.084198	90
90.01	OP PSYCH	2,441	960,135	962,576	0.248233	0.248233	0.248233	90.01
91	Emergency	15,025,569	51,637,620	66,663,189	0.112484	0.112484	0.113489	91
92	Observation Beds (Non-Distinct Part)	2,353,490	10,302,119	12,655,609	0.373125	0.373125	0.373125	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
200	Subtotal (sum of lines 30 thru 199)	238,460,688	308,225,029	546,685,717				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	238,460,688	308,225,029	546,685,717				202

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

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	28,220,879		28,220,879		28,220,879	30
31	Intensive Care Unit	4,849,619		4,849,619		4,849,619	31
40	Subprovider - IPF	3,458,898		3,458,898		3,458,898	40
41	Subprovider - IRF	5,445,694		5,445,694		5,445,694	41
43	Nursery	911,615		911,615		911,615	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	13,591,953		13,591,953		13,591,953	50
51	Recovery Room	761,167		761,167		761,167	51
52	Delivery Room & Labor Room	2,054,713		2,054,713		2,054,713	52
53	Anesthesiology	512,978		512,978		512,978	53
54	Radiology-Diagnostic	4,930,285		4,930,285		4,930,285	54
54.01	ULTRASOUND	1,078,581		1,078,581		1,078,581	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,797,685		1,797,685		1,797,685	56
57	CT Scan	1,622,475		1,622,475		1,622,475	57
59	Cardiac Catheterization	3,686,517		3,686,517		3,686,517	59
60	Laboratory	8,972,014		8,972,014		8,972,014	60
62	Whole Blood & Packed Red Blood Cells	1,148,533		1,148,533		1,148,533	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,762,197		1,762,197		1,762,197	63.02
65	Respiratory Therapy	2,326,875		2,326,875		2,326,875	65
66	Physical Therapy	4,891,122		4,891,122		4,891,122	66
67	Occupational Therapy	1,971,815		1,971,815		1,971,815	67
68	Speech Pathology	759,360		759,360		759,360	68
70	Electroencephalography	577,456		577,456		577,456	70
71	Medical Supplies Charged to Patients	4,445,829		4,445,829		4,445,829	71
72	Impl. Dev. Charged to Patients	4,193,422		4,193,422		4,193,422	72
73	Drugs Charged to Patients	10,211,967		10,211,967		10,211,967	73
74	Renal Dialysis	1,118,328		1,118,328		1,118,328	74
75.01	ONCOLOGY	675,403		675,403		675,403	75.01
76.97	CARDIAC REHABILITATION	1,225,962		1,225,962		1,225,962	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	477,316		477,316		477,316	90
90.01	OP PSYCH	238,943		238,943		238,943	90.01
91	Emergency	7,498,530		7,498,530		7,498,530	91
92	Observation Beds (Non-Distinct Part)	4,722,118		4,722,118		4,722,118	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
200	Subtotal (sum of lines 30 thru 199)	130,140,249		130,140,249		130,140,249	200
201	Less Observation Beds	4,722,118		4,722,118		4,722,118	201
202	Total (line 200 minus line 201)	125,418,131		125,418,131		125,418,131	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	54,285,490		54,285,490				30
31	Intensive Care Unit	5,794,140		5,794,140				31
40	Subprovider - IPF	12,590,777		12,590,777				40
41	Subprovider - IRF	7,615,388		7,615,388				41
43	Nursery	1,852,339		1,852,339				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,798,537	39,453,618	52,252,155	0.260122	0.260122	0.260122	50
51	Recovery Room	944,545	2,083,686	3,028,231	0.251357	0.251357	0.251357	51
52	Delivery Room & Labor Room	2,810,177	1,380,557	4,190,734	0.490299	0.490299	0.490299	52
53	Anesthesiology	2,004,036	4,768,612	6,772,648	0.075743	0.075743	0.075743	53
54	Radiology-Diagnostic	5,937,216	18,895,644	24,832,860	0.198539	0.198539	0.198539	54
54.01	ULTRASOUND	1,055,635	6,664,029	7,719,664	0.139719	0.139719	0.139719	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	2,473,053	11,120,493	13,593,546	0.132245	0.132245	0.132245	56
57	CT Scan	8,912,494	22,804,393	31,716,887	0.051155	0.051155	0.051155	57
59	Cardiac Catheterization	12,277,154	15,823,232	28,100,386	0.131191	0.131191	0.131191	59
60	Laboratory	21,902,248	45,496,889	67,399,137	0.133118	0.133118	0.133118	60
62	Whole Blood & Packed Red Blood Cells	1,770,571	1,080,600	2,851,171	0.402829	0.402829	0.402829	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	6,071,905	10,613,248	16,685,153	0.105615	0.105615	0.105615	63.02
65	Respiratory Therapy	8,696,139	2,028,358	10,724,497	0.216968	0.216968	0.216968	65
66	Physical Therapy	5,776,850	6,450,032	12,226,882	0.400030	0.400030	0.400030	66
67	Occupational Therapy	4,568,243	1,356,394	5,924,637	0.332816	0.332816	0.332816	67
68	Speech Pathology	895,537	755,718	1,651,255	0.459868	0.459868	0.459868	68
70	Electroencephalography	499,849	4,060,382	4,560,231	0.126629	0.126629	0.126629	70
71	Medical Supplies Charged to Patients	4,648,944	5,579,458	10,228,402	0.434655	0.434655	0.434655	71
72	Impl. Dev. Charged to Patients	4,045,564	4,731,453	8,777,017	0.477773	0.477773	0.477773	72
73	Drugs Charged to Patients	27,631,268	36,047,404	63,678,672	0.160367	0.160367	0.160367	73
74	Renal Dialysis	3,068,216	503,559	3,571,775	0.313101	0.313101	0.313101	74
75.01	ONCOLOGY	6,256	2,545,473	2,551,729	0.264684	0.264684	0.264684	75.01
76.97	CARDIAC REHABILITATION	145,555	640,561	786,116	1.559518	1.559518	1.559518	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,062	441,362	442,424	1.078866	1.078866	1.078866	90
90.01	OP PSYCH	2,441	960,135	962,576	0.248233	0.248233	0.248233	90.01
91	Emergency	15,025,569	51,637,620	66,663,189	0.112484	0.112484	0.112484	91
92	Observation Beds (Non-Distinct Part)	2,353,490	10,302,119	12,655,609	0.373125	0.373125	0.373125	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
200	Subtotal (sum of lines 30 thru 199)	238,460,688	308,225,029	546,685,717				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	238,460,688	308,225,029	546,685,717				202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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	13,591,953	1,047,048	12,544,905		50
51	Recovery Room	761,167	17,203	743,964		51
52	Delivery Room & Labor Room	2,054,713	53,306	2,001,407		52
53	Anesthesiology	512,978	80,811	432,167		53
54	Radiology-Diagnostic	4,930,285	557,094	4,373,191		54
54.01	ULTRASOUND	1,078,581	139,531	939,050		54.01
54.02	AUDIOLOGY					54.02
56	Radioisotope	1,797,685	30,345	1,767,340		56
57	CT Scan	1,622,475	181,893	1,440,582		57
59	Cardiac Catheterization	3,686,517	481,784	3,204,733		59
60	Laboratory	8,972,014	355,726	8,616,288		60
62	Whole Blood & Packed Red Blood Cells	1,148,533	65,253	1,083,280		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63.02	NONINVASIVE LAB	1,762,197	208,109	1,554,088		63.02
65	Respiratory Therapy	2,326,875	84,862	2,242,013		65
66	Physical Therapy	4,891,122	131,101	4,760,021		66
67	Occupational Therapy	1,971,815	34,275	1,937,540		67
68	Speech Pathology	759,360	22,066	737,294		68
70	Electroencephalography	577,456	65,514	511,942		70
71	Medical Supplies Charged to Patients	4,445,829	13,937	4,431,892		71
72	Impl. Dev. Charged to Patients	4,193,422	13,068	4,180,354		72
73	Drugs Charged to Patients	10,211,967	231,285	9,980,682		73
74	Renal Dialysis	1,118,328	11,065	1,107,263		74
75.01	ONCOLOGY	675,403	15,656	659,747		75.01
76.97	CARDIAC REHABILITATION	1,225,962	77,472	1,148,490		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	477,316	43,703	433,613		90
90.01	OP PSYCH	238,943	9,174	229,769		90.01
91	Emergency	7,498,530	219,812	7,278,718		91
92	Observation Beds (Non-Distinct Part)	4,722,118	186,358	4,535,760		92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
200	Subtotal	87,253,544	4,377,451	82,876,093		200
201	Less Observation Beds	4,722,118	186,358	4,535,760		201
202	Total	82,531,426	4,191,093	78,340,333		202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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		13,591,953	52,252,155	0.260122	50
51	Recovery Room		761,167	3,028,231	0.251357	51
52	Delivery Room & Labor Room		2,054,713	4,190,734	0.490299	52
53	Anesthesiology		512,978	6,772,648	0.075743	53
54	Radiology-Diagnostic		4,930,285	24,832,860	0.198539	54
54.01	ULTRASOUND		1,078,581	7,719,664	0.139719	54.01
54.02	AUDIOLOGY					54.02
56	Radioisotope		1,797,685	13,593,546	0.132245	56
57	CT Scan		1,622,475	31,716,887	0.051155	57
59	Cardiac Catheterization		3,686,517	28,100,386	0.131191	59
60	Laboratory		8,972,014	67,399,137	0.133118	60
62	Whole Blood & Packed Red Blood Cells		1,148,533	2,851,171	0.402829	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63.02	NONINVASIVE LAB		1,762,197	16,685,153	0.105615	63.02
65	Respiratory Therapy		2,326,875	10,724,497	0.216968	65
66	Physical Therapy		4,891,122	12,226,882	0.400030	66
67	Occupational Therapy		1,971,815	5,924,637	0.332816	67
68	Speech Pathology		759,360	1,651,255	0.459868	68
70	Electroencephalography		577,456	4,560,231	0.126629	70
71	Medical Supplies Charged to Patients		4,445,829	10,228,402	0.434655	71
72	Impl. Dev. Charged to Patients		4,193,422	8,777,017	0.477773	72
73	Drugs Charged to Patients		10,211,967	63,678,672	0.160367	73
74	Renal Dialysis		1,118,328	3,571,775	0.313101	74
75.01	ONCOLOGY		675,403	2,551,729	0.264684	75.01
76.97	CARDIAC REHABILITATION		1,225,962	786,116	1.559518	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		477,316	442,424	1.078866	90
90.01	OP PSYCH		238,943	962,576	0.248233	90.01
91	Emergency		7,498,530	66,663,189	0.112484	91
92	Observation Beds (Non-Distinct Part)		4,722,118	12,655,609	0.373125	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
200	Subtotal		87,253,544	464,547,583		200
201	Less Observation Beds		4,722,118	12,655,609		201
202	Total		82,531,426	451,891,974		202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ 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)	1,113,747		1,113,747	31,549	35.30	7,290	257,337	30
31	Intensive Care Unit	224,850		224,850	2,410	93.30	741	69,135	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	151,054		151,054	3,567	42.35	1,819	77,035	40
41	Subprovider - IRF	251,136		251,136	6,617	37.95	4,155	157,682	41
42	Subprovider I								42
43	Nursery	23,656		23,656	1,129	20.95			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,764,443		1,764,443	45,272		14,005	561,189	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0008

WORKSHEET D PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,047,048	52,252,155	0.020038	3,458,471	69,301	50
51	Recovery Room	17,203	3,028,231	0.005681	219,321	1,246	51
52	Delivery Room & Labor Room	53,306	4,190,734	0.012720	21,919	279	52
53	Anesthesiology	80,811	6,772,648	0.011932	480,190	5,730	53
54	Radiology-Diagnostic	557,094	24,832,860	0.022434	2,010,301	45,099	54
54.01	ULTRASOUND	139,531	7,719,664	0.018075	195,274	3,530	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	30,345	13,593,546	0.002232	930,565	2,077	56
57	CT Scan	181,893	31,716,887	0.005735	2,963,558	16,996	57
59	Cardiac Catheterization	481,784	28,100,386	0.017145	4,610,692	79,050	59
60	Laboratory	355,726	67,399,137	0.005278	6,473,233	34,166	60
62	Whole Blood & Packed Red Blood	65,253	2,851,171	0.022886	422,430	9,668	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,109	16,685,153	0.012473	2,361,447	29,454	63.02
65	Respiratory Therapy	84,862	10,724,497	0.007913	2,703,466	21,393	65
66	Physical Therapy	131,101	12,226,882	0.010722	818,301	8,774	66
67	Occupational Therapy	34,275	5,924,637	0.005785	504,315	2,917	67
68	Speech Pathology	22,066	1,651,255	0.013363	170,810	2,283	68
70	Electroencephalography	65,514	4,560,231	0.014366	152,729	2,194	70
71	Medical Supplies Charged to Pat	13,937	10,228,402	0.001363	1,567,425	2,136	71
72	Impl. Dev. Charged to Patients	13,068	8,777,017	0.001489	1,427,597	2,126	72
73	Drugs Charged to Patients	231,285	63,678,672	0.003632	7,057,766	25,634	73
74	Renal Dialysis	11,065	3,571,775	0.003098	1,101,726	3,413	74
75.01	ONCOLOGY	15,656	2,551,729	0.006135			75.01
76.97	CARDIAC REHABILITATION	77,472	786,116	0.098550	51,582	5,083	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	43,703	442,424	0.098781			90
90.01	OP PSYCH	9,174	962,576	0.009531	525	5	90.01
91	Emergency	219,812	66,663,189	0.003297	4,798,996	15,822	91
92	Observation Beds (Non-Distinct	186,358	12,655,609	0.014725	861,805	12,690	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,377,451	464,547,583		45,364,444	401,066	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	31,549		7,290		30
31	Intensive Care Unit	2,410		741		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	3,567		1,819		40
41	Subprovider - IRF	6,617		4,155		41
42	Subprovider I					42
43	Nursery	1,129				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	45,272		14,005		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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	52,252,155			3,458,471		9,660,392		50
51	Recovery Room	3,028,231			219,321		365,332		51
52	Delivery Room & Labor Room	4,190,734			21,919				52
53	Anesthesiology	6,772,648			480,190		905,095		53
54	Radiology-Diagnostic	24,832,860			2,010,301		3,074,244		54
54.01	ULTRASOUND	7,719,664			195,274		532,309		54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	13,593,546			930,565		3,548,588		56
57	CT Scan	31,716,887			2,963,558		4,016,607		57
59	Cardiac Catheterization	28,100,386			4,610,692		5,924,661		59
60	Laboratory	67,399,137			6,473,233		3,229,953		60
62	Whole Blood & Packed Red Blood	2,851,171			422,430		33,768		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	16,685,153			2,361,447		2,723,336		63.02
65	Respiratory Therapy	10,724,497			2,703,466		528,927		65
66	Physical Therapy	12,226,882			818,301		400,678		66
67	Occupational Therapy	5,924,637			504,315		17,138		67
68	Speech Pathology	1,651,255			170,810		40,219		68
70	Electroencephalography	4,560,231			152,729		687,991		70
71	Medical Supplies Charged to Pat	10,228,402			1,567,425		1,835,010		71
72	Impl. Dev. Charged to Patients	8,777,017			1,427,597		974,137		72
73	Drugs Charged to Patients	63,678,672			7,057,766		10,103,132		73
74	Renal Dialysis	3,571,775			1,101,726		171,117		74
75.01	ONCOLOGY	2,551,729					858,177		75.01
76.97	CARDIAC REHABILITATION	786,116			51,582		201,312		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	442,424					128,882		90
90.01	OP PSYCH	962,576			525		54,750		90.01
91	Emergency	66,663,189			4,798,996		5,312,539		91
92	Observation Beds (Non-Distinct	12,655,609			861,805		1,215,028		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	464,547,583			45,364,444		56,543,322		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.260122	9,660,392		265,294	2,512,880		69,009	50
51	Recovery Room	0.251357	365,332			91,829			51
52	Delivery Room & Labor Room	0.490299							52
53	Anesthesiology	0.075743	905,095			68,555			53
54	Radiology-Diagnostic	0.198539	3,074,244			610,357			54
54.01	ULTRASOUND	0.139719	532,309			74,374			54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.132245	3,548,588			469,283			56
57	CT Scan	0.051155	4,016,607			205,470			57
59	Cardiac Catheterization	0.131191	5,924,661			777,262			59
60	Laboratory	0.133118	3,229,953			429,965			60
62	Whole Blood & Packed Red Blood	0.402829	33,768			13,603			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.105615	2,723,336			287,625			63.02
65	Respiratory Therapy	0.216968	528,927			114,760			65
66	Physical Therapy	0.400030	400,678			160,283			66
67	Occupational Therapy	0.332816	17,138			5,704			67
68	Speech Pathology	0.459868	40,219			18,495			68
70	Electroencephalography	0.126629	687,991			87,120			70
71	Medical Supplies Charged to Pat	0.434655	1,835,010			797,596			71
72	Impl. Dev. Charged to Patients	0.477773	974,137			465,416			72
73	Drugs Charged to Patients	0.160367	10,103,132		21,191	1,620,209		3,398	73
74	Renal Dialysis	0.313101	171,117			53,577			74
75.01	ONCOLOGY	0.264684	858,177			227,146			75.01
76.97	CARDIAC REHABILITATION	1.559518	201,312			313,950			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.078866	128,882			139,046			90
90.01	OP PSYCH	0.248233	54,750			13,591			90.01
91	Emergency	0.112484	5,312,539			597,576			91
92	Observation Beds (Non-Distinct	0.373125	1,215,028			453,357			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		56,543,322		286,485	10,609,029		72,407	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		56,543,322		286,485	10,609,029		72,407	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-S008

WORKSHEET D PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☒ IPF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,047,048	52,252,155	0.020038	45,316	908	50
51	Recovery Room	17,203	3,028,231	0.005681	34,518	196	51
52	Delivery Room & Labor Room	53,306	4,190,734	0.012720			52
53	Anesthesiology	80,811	6,772,648	0.011932	44,604	532	53
54	Radiology-Diagnostic	557,094	24,832,860	0.022434	54,377	1,220	54
54.01	ULTRASOUND	139,531	7,719,664	0.018075	4,654	84	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	30,345	13,593,546	0.002232			56
57	CT Scan	181,893	31,716,887	0.005735	62,628	359	57
59	Cardiac Catheterization	481,784	28,100,386	0.017145			59
60	Laboratory	355,726	67,399,137	0.005278	454,714	2,400	60
62	Whole Blood & Packed Red Blood	65,253	2,851,171	0.022886	2,058	47	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,109	16,685,153	0.012473	62,439	779	63.02
65	Respiratory Therapy	84,862	10,724,497	0.007913	63,311	501	65
66	Physical Therapy	131,101	12,226,882	0.010722	78,421	841	66
67	Occupational Therapy	34,275	5,924,637	0.005785	57,618	333	67
68	Speech Pathology	22,066	1,651,255	0.013363	8,247	110	68
70	Electroencephalography	65,514	4,560,231	0.014366	4,545	65	70
71	Medical Supplies Charged to Pat	13,937	10,228,402	0.001363	42,024	57	71
72	Impl. Dev. Charged to Patients	13,068	8,777,017	0.001489			72
73	Drugs Charged to Patients	231,285	63,678,672	0.003632	870,096	3,160	73
74	Renal Dialysis	11,065	3,571,775	0.003098	32,415	100	74
75.01	ONCOLOGY	15,656	2,551,729	0.006135			75.01
76.97	CARDIAC REHABILITATION	77,472	786,116	0.098550			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	43,703	442,424	0.098781	525	52	90
90.01	OP PSYCH	9,174	962,576	0.009531			90.01
91	Emergency	219,812	66,663,189	0.003297	192,131	633	91
92	Observation Beds (Non-Distinct		12,655,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,191,093	464,547,583		2,114,641	12,377	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-S008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-S008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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	52,252,155			45,316				50
51	Recovery Room	3,028,231			34,518				51
52	Delivery Room & Labor Room	4,190,734							52
53	Anesthesiology	6,772,648			44,604				53
54	Radiology-Diagnostic	24,832,860			54,377		188		54
54.01	ULTRASOUND	7,719,664			4,654				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	13,593,546							56
57	CT Scan	31,716,887			62,628		1,424		57
59	Cardiac Catheterization	28,100,386					331		59
60	Laboratory	67,399,137			454,714				60
62	Whole Blood & Packed Red Blood	2,851,171			2,058				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	16,685,153			62,439				63.02
65	Respiratory Therapy	10,724,497			63,311				65
66	Physical Therapy	12,226,882			78,421				66
67	Occupational Therapy	5,924,637			57,618				67
68	Speech Pathology	1,651,255			8,247				68
70	Electroencephalography	4,560,231			4,545				70
71	Medical Supplies Charged to Pat	10,228,402			42,024				71
72	Impl. Dev. Charged to Patients	8,777,017							72
73	Drugs Charged to Patients	63,678,672			870,096		422		73
74	Renal Dialysis	3,571,775			32,415				74
75.01	ONCOLOGY	2,551,729							75.01
76.97	CARDIAC REHABILITATION	786,116							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	442,424			525				90
90.01	OP PSYCH	962,576							90.01
91	Emergency	66,663,189			192,131				91
92	Observation Beds (Non-Distinct	12,655,609							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	464,547,583			2,114,641		2,365		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-S008

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☒ Title XVIII, Part B

☐ Title XIX - O/P

☐ 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	0.260122							50
51	Recovery Room	0.251357							51
52	Delivery Room & Labor Room	0.490299							52
53	Anesthesiology	0.075743							53
54	Radiology-Diagnostic	0.198539	188			37			54
54.01	ULTRASOUND	0.139719							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.132245							56
57	CT Scan	0.051155	1,424			73			57
59	Cardiac Catheterization	0.131191	331			43			59
60	Laboratory	0.133118							60
62	Whole Blood & Packed Red Blood	0.402829							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.105615							63.02
65	Respiratory Therapy	0.216968							65
66	Physical Therapy	0.400030							66
67	Occupational Therapy	0.332816							67
68	Speech Pathology	0.459868							68
70	Electroencephalography	0.126629							70
71	Medical Supplies Charged to Pat	0.434655							71
72	Impl. Dev. Charged to Patients	0.477773							72
73	Drugs Charged to Patients	0.160367	422			68			73
74	Renal Dialysis	0.313101							74
75.01	ONCOLOGY	0.264684							75.01
76.97	CARDIAC REHABILITATION	1.559518							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.078866							90
90.01	OP PSYCH	0.248233							90.01
91	Emergency	0.112484							91
92	Observation Beds (Non-Distinct	0.373125							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		2,365			221			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,365			221			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T008

WORKSHEET D PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
Boxes: ☐ Title XIX ☒ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,047,048	52,252,155	0.020038	145,045	2,906	50
51	Recovery Room	17,203	3,028,231	0.005681	3,715	21	51
52	Delivery Room & Labor Room	53,306	4,190,734	0.012720			52
53	Anesthesiology	80,811	6,772,648	0.011932	18,228	217	53
54	Radiology-Diagnostic	557,094	24,832,860	0.022434	136,217	3,056	54
54.01	ULTRASOUND	139,531	7,719,664	0.018075	14,332	259	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	30,345	13,593,546	0.002232	16,193	36	56
57	CT Scan	181,893	31,716,887	0.005735	90,946	522	57
59	Cardiac Catheterization	481,784	28,100,386	0.017145			59
60	Laboratory	355,726	67,399,137	0.005278	806,090	4,255	60
62	Whole Blood & Packed Red Blood	65,253	2,851,171	0.022886	36,074	826	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,109	16,685,153	0.012473	85,259	1,063	63.02
65	Respiratory Therapy	84,862	10,724,497	0.007913	394,883	3,125	65
66	Physical Therapy	131,101	12,226,882	0.010722	2,176,039	23,331	66
67	Occupational Therapy	34,275	5,924,637	0.005785	1,948,775	11,274	67
68	Speech Pathology	22,066	1,651,255	0.013363	285,456	3,815	68
70	Electroencephalography	65,514	4,560,231	0.014366	13,653	196	70
71	Medical Supplies Charged to Pat	13,937	10,228,402	0.001363	328,953	448	71
72	Impl. Dev. Charged to Patients	13,068	8,777,017	0.001489	4,864	7	72
73	Drugs Charged to Patients	231,285	63,678,672	0.003632	2,099,086	7,624	73
74	Renal Dialysis	11,065	3,571,775	0.003098	472,224	1,463	74
75.01	ONCOLOGY	15,656	2,551,729	0.006135			75.01
76.97	CARDIAC REHABILITATION	77,472	786,116	0.098550			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	43,703	442,424	0.098781			90
90.01	OP PSYCH	9,174	962,576	0.009531			90.01
91	Emergency	219,812	66,663,189	0.003297	2,710	9	91
92	Observation Beds (Non-Distinct		12,655,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,191,093	464,547,583		9,078,742	64,453	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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
☐ Title XIX

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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
☐ Title XIX

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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	52,252,155			145,045				50
51	Recovery Room	3,028,231			3,715				51
52	Delivery Room & Labor Room	4,190,734							52
53	Anesthesiology	6,772,648			18,228				53
54	Radiology-Diagnostic	24,832,860			136,217		518		54
54.01	ULTRASOUND	7,719,664			14,332				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	13,593,546			16,193				56
57	CT Scan	31,716,887			90,946				57
59	Cardiac Catheterization	28,100,386					945		59
60	Laboratory	67,399,137			806,090		904		60
62	Whole Blood & Packed Red Blood	2,851,171			36,074				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	16,685,153			85,259				63.02
65	Respiratory Therapy	10,724,497			394,883				65
66	Physical Therapy	12,226,882			2,176,039				66
67	Occupational Therapy	5,924,637			1,948,775				67
68	Speech Pathology	1,651,255			285,456				68
70	Electroencephalography	4,560,231			13,653		158		70
71	Medical Supplies Charged to Pat	10,228,402			328,953		5,925		71
72	Impl. Dev. Charged to Patients	8,777,017			4,864				72
73	Drugs Charged to Patients	63,678,672			2,099,086		5,240		73
74	Renal Dialysis	3,571,775			472,224		5,670		74
75.01	ONCOLOGY	2,551,729							75.01
76.97	CARDIAC REHABILITATION	786,116							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	442,424							90
90.01	OP PSYCH	962,576							90.01
91	Emergency	66,663,189			2,710				91
92	Observation Beds (Non-Distinct	12,655,609							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	464,547,583			9,078,742		19,360		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T008

WORKSHEET D
PART V

Check
Applicable
Boxes:

[] Title V - O/P

[XX] Title XVIII, Part B

[] Title XIX - o/P

[] Hospital

[] IPF

[XX] 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	0.260122							50
51	Recovery Room	0.251357							51
52	Delivery Room & Labor Room	0.490299							52
53	Anesthesiology	0.075743							53
54	Radiology-Diagnostic	0.198539	518			103			54
54.01	ULTRASOUND	0.139719							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.132245							56
57	CT Scan	0.051155							57
59	Cardiac Catheterization	0.131191	945			124			59
60	Laboratory	0.133118	904			120			60
62	Whole Blood & Packed Red Blood	0.402829							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.105615							63.02
65	Respiratory Therapy	0.216968							65
66	Physical Therapy	0.400030							66
67	Occupational Therapy	0.332816							67
68	Speech Pathology	0.459868							68
70	Electroencephalography	0.126629	158			20			70
71	Medical Supplies Charged to Pat	0.434655	5,925			2,575			71
72	Impl. Dev. Charged to Patients	0.477773							72
73	Drugs Charged to Patients	0.160367	5,240		3,474	840		557	73
74	Renal Dialysis	0.313101	5,670			1,775			74
75.01	ONCOLOGY	0.264684							75.01
76.97	CARDIAC REHABILITATION	1.559518							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.078866							90
90.01	OP PSYCH	0.248233							90.01
91	Emergency	0.112484							91
92	Observation Beds (Non-Distinct	0.373125							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		19,360		3,474	5,557		557	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		19,360		3,474	5,557		557	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ 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)	1,113,747		1,113,747	31,549	35.30	1,740	61,422	30
31	Intensive Care Unit	224,850		224,850	2,410	93.30	135	12,596	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	151,054		151,054	3,567	42.35	271	11,477	40
41	Subprovider - IRF	251,136		251,136	6,617	37.95	24	911	41
42	Subprovider I								42
43	Nursery	23,656		23,656	1,129	20.95	176	3,687	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,764,443		1,764,443	45,272		2,346	90,093	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0008

WORKSHEET D PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,047,048	52,252,155	0.020038	422,598	8,468	50
51	Recovery Room	17,203	3,028,231	0.005681	58,527	332	51
52	Delivery Room & Labor Room	53,306	4,190,734	0.012720	218,338	2,777	52
53	Anesthesiology	80,811	6,772,648	0.011932	127,139	1,517	53
54	Radiology-Diagnostic	557,094	24,832,860	0.022434	196,805	4,415	54
54.01	ULTRASOUND	139,531	7,719,664	0.018075	50,739	917	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	30,345	13,593,546	0.002232	63,394	141	56
57	CT Scan	181,893	31,716,887	0.005735	315,466	1,809	57
59	Cardiac Catheterization	481,784	28,100,386	0.017145	288,150	4,940	59
60	Laboratory	355,726	67,399,137	0.005278	886,016	4,676	60
62	Whole Blood & Packed Red Blood	65,253	2,851,171	0.022886	30,552	699	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,109	16,685,153	0.012473	162,039	2,021	63.02
65	Respiratory Therapy	84,862	10,724,497	0.007913	147,132	1,164	65
66	Physical Therapy	131,101	12,226,882	0.010722	71,749	769	66
67	Occupational Therapy	34,275	5,924,637	0.005785	36,894	213	67
68	Speech Pathology	22,066	1,651,255	0.013363	37,993	508	68
70	Electroencephalography	65,514	4,560,231	0.014366	13,132	189	70
71	Medical Supplies Charged to Pat	13,937	10,228,402	0.001363	238,102	325	71
72	Impl. Dev. Charged to Patients	13,068	8,777,017	0.001489	43,680	65	72
73	Drugs Charged to Patients	231,285	63,678,672	0.003632	1,073,558	3,899	73
74	Renal Dialysis	11,065	3,571,775	0.003098	53,261	165	74
75.01	ONCOLOGY	15,656	2,551,729	0.006135			75.01
76.97	CARDIAC REHABILITATION	77,472	786,116	0.098550	668	66	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	43,703	442,424	0.098781	537	53	90
90.01	OP PSYCH	9,174	962,576	0.009531			90.01
91	Emergency	219,812	66,663,189	0.003297	435,655	1,436	91
92	Observation Beds (Non-Distinct	186,358	12,655,609	0.014725			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,377,451	464,547,583		4,972,124	41,564	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	31,549		1,740		30
31	Intensive Care Unit	2,410		135		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	3,567		271		40
41	Subprovider - IRF	6,617		24		41
42	Subprovider I					42
43	Nursery	1,129		176		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	45,272		2,346		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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	52,252,155			422,598				50
51	Recovery Room	3,028,231			58,527				51
52	Delivery Room & Labor Room	4,190,734			218,338				52
53	Anesthesiology	6,772,648			127,139				53
54	Radiology-Diagnostic	24,832,860			196,805				54
54.01	ULTRASOUND	7,719,664			50,739				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	13,593,546			63,394				56
57	CT Scan	31,716,887			315,466				57
59	Cardiac Catheterization	28,100,386			288,150				59
60	Laboratory	67,399,137			886,016				60
62	Whole Blood & Packed Red Blood	2,851,171			30,552				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	16,685,153			162,039				63.02
65	Respiratory Therapy	10,724,497			147,132				65
66	Physical Therapy	12,226,882			71,749				66
67	Occupational Therapy	5,924,637			36,894				67
68	Speech Pathology	1,651,255			37,993				68
70	Electroencephalography	4,560,231			13,132				70
71	Medical Supplies Charged to Pat	10,228,402			238,102				71
72	Impl. Dev. Charged to Patients	8,777,017			43,680				72
73	Drugs Charged to Patients	63,678,672			1,073,558				73
74	Renal Dialysis	3,571,775			53,261				74
75.01	ONCOLOGY	2,551,729							75.01
76.97	CARDIAC REHABILITATION	786,116			668				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	442,424			537				90
90.01	OP PSYCH	962,576							90.01
91	Emergency	66,663,189			435,655				91
92	Observation Beds (Non-Distinct	12,655,609							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	464,547,583			4,972,124				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART V

Check
Applicable
Boxes:

[] Title V - O/P

[] Title XVIII, Part B

[XX] Title XIX - o/P

[XX] Hospital

[] IPF

[] IRF

[] SUB (Other)

[] SNF

[] NF

[] Swing Bed SNF

[] Swing Bed NF

[] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room	0.260122							50
51	Recovery Room	0.251357							51
52	Delivery Room & Labor Room	0.490299							52
53	Anesthesiology	0.075743							53
54	Radiology-Diagnostic	0.198539							54
54.01	ULTRASOUND	0.139719							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.132245							56
57	CT Scan	0.051155							57
59	Cardiac Catheterization	0.131191							59
60	Laboratory	0.133118							60
62	Whole Blood & Packed Red Blood	0.402829							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.105615							63.02
65	Respiratory Therapy	0.216968							65
66	Physical Therapy	0.400030							66
67	Occupational Therapy	0.332816							67
68	Speech Pathology	0.459868							68
70	Electroencephalography	0.126629							70
71	Medical Supplies Charged to Pat	0.434655							71
72	Impl. Dev. Charged to Patients	0.477773							72
73	Drugs Charged to Patients	0.160367							73
74	Renal Dialysis	0.313101							74
75.01	ONCOLOGY	0.264684							75.01
76.97	CARDIAC REHABILITATION	1.559518							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.078866							90
90.01	OP PSYCH	0.248233							90.01
91	Emergency	0.112484							91
92	Observation Beds (Non-Distinct	0.373125							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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-S008

WORKSHEET D PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☐ Title XVIII, Part A ☒ IPF ☐ TEFRA
Boxes: ☒ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,047,048	52,252,155	0.020038			50
51	Recovery Room	17,203	3,028,231	0.005681			51
52	Delivery Room & Labor Room	53,306	4,190,734	0.012720			52
53	Anesthesiology	80,811	6,772,648	0.011932			53
54	Radiology-Diagnostic	557,094	24,832,860	0.022434	4,865	109	54
54.01	ULTRASOUND	139,531	7,719,664	0.018075			54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	30,345	13,593,546	0.002232			56
57	CT Scan	181,893	31,716,887	0.005735	4,668	27	57
59	Cardiac Catheterization	481,784	28,100,386	0.017145			59
60	Laboratory	355,726	67,399,137	0.005278	69,477	367	60
62	Whole Blood & Packed Red Blood	65,253	2,851,171	0.022886			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,109	16,685,153	0.012473	7,707	96	63.02
65	Respiratory Therapy	84,862	10,724,497	0.007913	11,253	89	65
66	Physical Therapy	131,101	12,226,882	0.010722	12,330	132	66
67	Occupational Therapy	34,275	5,924,637	0.005785	10,733	62	67
68	Speech Pathology	22,066	1,651,255	0.013363	531	7	68
70	Electroencephalography	65,514	4,560,231	0.014366			70
71	Medical Supplies Charged to Pat	13,937	10,228,402	0.001363	3,210	4	71
72	Impl. Dev. Charged to Patients	13,068	8,777,017	0.001489			72
73	Drugs Charged to Patients	231,285	63,678,672	0.003632	125,725	457	73
74	Renal Dialysis	11,065	3,571,775	0.003098			74
75.01	ONCOLOGY	15,656	2,551,729	0.006135			75.01
76.97	CARDIAC REHABILITATION	77,472	786,116	0.098550			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	43,703	442,424	0.098781			90
90.01	OP PSYCH	9,174	962,576	0.009531			90.01
91	Emergency	219,812	66,663,189	0.003297	39,731	131	91
92	Observation Beds (Non-Distinct		12,655,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,191,093	464,547,583		290,230	1,481	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-S008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-S008

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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	52,252,155							50
51	Recovery Room	3,028,231							51
52	Delivery Room & Labor Room	4,190,734							52
53	Anesthesiology	6,772,648							53
54	Radiology-Diagnostic	24,832,860			4,865				54
54.01	ULTRASOUND	7,719,664							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	13,593,546							56
57	CT Scan	31,716,887			4,668				57
59	Cardiac Catheterization	28,100,386							59
60	Laboratory	67,399,137			69,477				60
62	Whole Blood & Packed Red Blood	2,851,171							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	16,685,153			7,707				63.02
65	Respiratory Therapy	10,724,497			11,253				65
66	Physical Therapy	12,226,882			12,330				66
67	Occupational Therapy	5,924,637			10,733				67
68	Speech Pathology	1,651,255			531				68
70	Electroencephalography	4,560,231							70
71	Medical Supplies Charged to Pat	10,228,402			3,210				71
72	Impl. Dev. Charged to Patients	8,777,017							72
73	Drugs Charged to Patients	63,678,672			125,725				73
74	Renal Dialysis	3,571,775							74
75.01	ONCOLOGY	2,551,729							75.01
76.97	CARDIAC REHABILITATION	786,116							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	442,424							90
90.01	OP PSYCH	962,576							90.01
91	Emergency	66,663,189			39,731				91
92	Observation Beds (Non-Distinct	12,655,609							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	464,547,583			290,230				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-S008

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P
☐ Title XVIII, Part B
☒ Title XIX - o/P

☐ 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	0.260122							50
51	Recovery Room	0.251357							51
52	Delivery Room & Labor Room	0.490299							52
53	Anesthesiology	0.075743							53
54	Radiology-Diagnostic	0.198539							54
54.01	ULTRASOUND	0.139719							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.132245							56
57	CT Scan	0.051155							57
59	Cardiac Catheterization	0.131191							59
60	Laboratory	0.133118							60
62	Whole Blood & Packed Red Blood	0.402829							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.105615							63.02
65	Respiratory Therapy	0.216968							65
66	Physical Therapy	0.400030							66
67	Occupational Therapy	0.332816							67
68	Speech Pathology	0.459868							68
70	Electroencephalography	0.126629							70
71	Medical Supplies Charged to Pat	0.434655							71
72	Impl. Dev. Charged to Patients	0.477773							72
73	Drugs Charged to Patients	0.160367							73
74	Renal Dialysis	0.313101							74
75.01	ONCOLOGY	0.264684							75.01
76.97	CARDIAC REHABILITATION	1.559518							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.078866							90
90.01	OP PSYCH	0.248233							90.01
91	Emergency	0.112484							91
92	Observation Beds (Non-Distinct	0.373125							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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T008

WORKSHEET D PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ Title XIX ☒ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,047,048	52,252,155	0.020038			50
51	Recovery Room	17,203	3,028,231	0.005681			51
52	Delivery Room & Labor Room	53,306	4,190,734	0.012720			52
53	Anesthesiology	80,811	6,772,648	0.011932			53
54	Radiology-Diagnostic	557,094	24,832,860	0.022434			54
54.01	ULTRASOUND	139,531	7,719,664	0.018075			54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	30,345	13,593,546	0.002232			56
57	CT Scan	181,893	31,716,887	0.005735			57
59	Cardiac Catheterization	481,784	28,100,386	0.017145			59
60	Laboratory	355,726	67,399,137	0.005278	1,826	10	60
62	Whole Blood & Packed Red Blood	65,253	2,851,171	0.022886			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,109	16,685,153	0.012473			63.02
65	Respiratory Therapy	84,862	10,724,497	0.007913	4,214	33	65
66	Physical Therapy	131,101	12,226,882	0.010722	11,553	124	66
67	Occupational Therapy	34,275	5,924,637	0.005785	12,714	74	67
68	Speech Pathology	22,066	1,651,255	0.013363	2,251	30	68
70	Electroencephalography	65,514	4,560,231	0.014366			70
71	Medical Supplies Charged to Pat	13,937	10,228,402	0.001363	4,995	7	71
72	Impl. Dev. Charged to Patients	13,068	8,777,017	0.001489			72
73	Drugs Charged to Patients	231,285	63,678,672	0.003632	13,672	50	73
74	Renal Dialysis	11,065	3,571,775	0.003098			74
75.01	ONCOLOGY	15,656	2,551,729	0.006135			75.01
76.97	CARDIAC REHABILITATION	77,472	786,116	0.098550			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	43,703	442,424	0.098781			90
90.01	OP PSYCH	9,174	962,576	0.009531			90.01
91	Emergency	219,812	66,663,189	0.003297			91
92	Observation Beds (Non-Distinct		12,655,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,191,093	464,547,583		51,225	328	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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
☒ Title XIX

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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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
☒ Title XIX

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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	52,252,155							50
51	Recovery Room	3,028,231							51
52	Delivery Room & Labor Room	4,190,734							52
53	Anesthesiology	6,772,648							53
54	Radiology-Diagnostic	24,832,860							54
54.01	ULTRASOUND	7,719,664							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	13,593,546							56
57	CT Scan	31,716,887							57
59	Cardiac Catheterization	28,100,386							59
60	Laboratory	67,399,137			1,826				60
62	Whole Blood & Packed Red Blood	2,851,171							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	16,685,153							63.02
65	Respiratory Therapy	10,724,497			4,214				65
66	Physical Therapy	12,226,882			11,553				66
67	Occupational Therapy	5,924,637			12,714				67
68	Speech Pathology	1,651,255			2,251				68
70	Electroencephalography	4,560,231							70
71	Medical Supplies Charged to Pat	10,228,402			4,995				71
72	Impl. Dev. Charged to Patients	8,777,017							72
73	Drugs Charged to Patients	63,678,672			13,672				73
74	Renal Dialysis	3,571,775							74
75.01	ONCOLOGY	2,551,729							75.01
76.97	CARDIAC REHABILITATION	786,116							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	442,424							90
90.01	OP PSYCH	962,576							90.01
91	Emergency	66,663,189							91
92	Observation Beds (Non-Distinct	12,655,609							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	464,547,583			51,225				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T008

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☐ Title XVIII, Part B

☒ Title XIX - o/P

☐ 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	0.260122							50
51	Recovery Room	0.251357							51
52	Delivery Room & Labor Room	0.490299							52
53	Anesthesiology	0.075743							53
54	Radiology-Diagnostic	0.198539							54
54.01	ULTRASOUND	0.139719							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.132245							56
57	CT Scan	0.051155							57
59	Cardiac Catheterization	0.131191							59
60	Laboratory	0.133118							60
62	Whole Blood & Packed Red Blood	0.402829							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.105615							63.02
65	Respiratory Therapy	0.216968							65
66	Physical Therapy	0.400030							66
67	Occupational Therapy	0.332816							67
68	Speech Pathology	0.459868							68
70	Electroencephalography	0.126629							70
71	Medical Supplies Charged to Pat	0.434655							71
72	Impl. Dev. Charged to Patients	0.477773							72
73	Drugs Charged to Patients	0.160367							73
74	Renal Dialysis	0.313101							74
75.01	ONCOLOGY	0.264684							75.01
76.97	CARDIAC REHABILITATION	1.559518							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.078866							90
90.01	OP PSYCH	0.248233							90.01
91	Emergency	0.112484							91
92	Observation Beds (Non-Distinct	0.373125							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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0008****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **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)	31,549	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	31,549	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)	26,270	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,290	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)	28,220,879	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)	28,220,879	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)	28,220,879	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0008****WORKSHEET D-1
PART II**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **TEFRA**
Boxes: ☐ **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)						894.51	38
39	Program general inpatient routine service cost (line 9 x line 38)						6,520,978	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)						6,520,978	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	4,853,827	2,410	2,014.04	741	1,492,404	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)						8,560,561	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						16,573,943	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						326,472	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						401,066	51
52	Total Program excludable cost (sum of lines 50 and 51)						727,538	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						15,846,405	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 enter 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					5,279	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					894.51	88
89	Observation bed cost (line 87 x line 88) (see instructions)					4,722,118	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	1,113,747	28,220,879	0.039465	4,722,118	186,358	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-S008****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☒ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **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)	3,567	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,567	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)	3,567	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)	1,819	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)	3,458,898	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)	3,458,898	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)	3,458,898	37

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS			1
38	Adjusted general inpatient routine service cost per diem (see instructions)		969.69 38
39	Program general inpatient routine service cost (line 9 x line 38)	1,763,866	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)	1,763,866	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	365,546	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,129,412	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	77,035	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,377	51
52	Total Program excludable cost (sum of lines 50 and 51)	89,412	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,040,000	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 enter 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T008****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **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)	6,617	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,617	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)	6,617	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)	4,155	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)	5,445,694	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)	5,445,694	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)	5,445,694	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T008****WORKSHEET D-1
PART II**

Check	☐ Title V - I/P	☐ Hospital	☐ SUB (Other)	☒ PPS
Applicable	☒ Title XVIII, Part A	☐ IPF		☐ TEFRA
Boxes:	☐ 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)	822.99	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,419,523	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)	3,419,523	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,574,798	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,994,321	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	157,682	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	64,453	51
52	Total Program excludable cost (sum of lines 50 and 51)	222,135	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	5,772,186	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 enter 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0008****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☒ **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)	31,549	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	31,549	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)	26,270	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,740	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)	1,129	15
16	Nursery days (title V or XIX only)	176	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)	28,220,879	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)	28,220,879	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)	28,220,879	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-0008****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ 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)						894.51 38
39	Program general inpatient routine service cost (line 9 x line 38)						1,556,447 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)						1,556,447 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)	911,615	1,129	807.45	176	142,111	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,849,619	2,410	2,012.29	135	271,659	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)					953,036	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,923,253	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					77,705	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					41,564	51
52	Total Program excludable cost (sum of lines 50 and 51)					119,269	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,803,984	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 enter 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					5,279	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-S008****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☐ **Title XVIII, Part A** ☒ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☒ **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)	3,567	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,567	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)	3,567	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)	271	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)	3,458,898	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)	3,458,898	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)	3,458,898	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-S008****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☐ Title XVIII, Part A ☒ IPF ☐ TEFRA
 Boxes: ☒ 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)	969.69	38
39	Program general inpatient routine service cost (line 9 x line 38)	262,786	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)	262,786	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	48,484	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	311,270	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	11,477	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,481	51
52	Total Program excludable cost (sum of lines 50 and 51)	12,958	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	298,312	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 enter 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T008****WORKSHEET D-1
PART I**

Check	☐ Title V - I/P	☐ Hospital	☐ SUB (Other)	☐ ICF/IID	☒ PPS
Applicable	☐ Title XVIII, Part A	☐ IPF	☐ SNF		☐ TEFRA
Boxes:	☒ 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)	6,617	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,617	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)	6,617	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)	24	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)	5,445,694	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)	5,445,694	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)	5,445,694	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-T008****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ 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)	822.99	38
39	Program general inpatient routine service cost (line 9 x line 38)	19,752	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)	19,752	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	15,409	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	35,161	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	911	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	328	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,239	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	33,922	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 enter 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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**COMPONENT CCN: 15-0008****WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		13,000,853		30
31	Intensive Care Unit		1,871,541		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.260122	3,458,471	899,624	50
51	Recovery Room	0.251357	219,321	55,128	51
52	Delivery Room & Labor Room	0.490299	21,919	10,747	52
53	Anesthesiology	0.075743	480,190	36,371	53
54	Radiology-Diagnostic	0.198993	2,010,301	400,036	54
54.01	ULTRASOUND	0.139719	195,274	27,283	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.132245	930,565	123,063	56
57	CT Scan	0.051155	2,963,558	151,601	57
59	Cardiac Catheterization	0.131751	4,610,692	607,463	59
60	Laboratory	0.133337	6,473,233	863,121	60
62	Whole Blood & Packed Red Blood Cells	0.402829	422,430	170,167	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.105615	2,361,447	249,404	63.02
65	Respiratory Therapy	0.216968	2,703,466	586,566	65
66	Physical Therapy	0.400030	818,301	327,345	66
67	Occupational Therapy	0.332816	504,315	167,844	67
68	Speech Pathology	0.459868	170,810	78,550	68
70	Electroencephalography	0.126629	152,729	19,340	70
71	Medical Supplies Charged to Patients	0.434655	1,567,425	681,289	71
72	Impl. Dev. Charged to Patients	0.477773	1,427,597	682,067	72
73	Drugs Charged to Patients	0.160367	7,057,766	1,131,833	73
74	Renal Dialysis	0.313101	1,101,726	344,952	74
75.01	ONCOLOGY	0.264684			75.01
76.97	CARDIAC REHABILITATION	1.559518	51,582	80,443	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.084198			90
90.01	OP PSYCH	0.248233	525	130	90.01
91	Emergency	0.113489	4,798,996	544,633	91
92	Observation Beds (Non-Distinct Part)	0.373125	861,805	321,561	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		45,364,444	8,560,561	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		45,364,444		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-S008

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		6,410,627		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.260122	45,316	11,788	50
51	Recovery Room	0.251357	34,518	8,676	51
52	Delivery Room & Labor Room	0.490299			52
53	Anesthesiology	0.075743	44,604	3,378	53
54	Radiology-Diagnostic	0.198993	54,377	10,821	54
54.01	ULTRASOUND	0.139719	4,654	650	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.132245			56
57	CT Scan	0.051155	62,628	3,204	57
59	Cardiac Catheterization	0.131751			59
60	Laboratory	0.133337	454,714	60,630	60
62	Whole Blood & Packed Red Blood Cells	0.402829	2,058	829	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.105615	62,439	6,594	63.02
65	Respiratory Therapy	0.216968	63,311	13,736	65
66	Physical Therapy	0.400030	78,421	31,371	66
67	Occupational Therapy	0.332816	57,618	19,176	67
68	Speech Pathology	0.459868	8,247	3,793	68
70	Electroencephalography	0.126629	4,545	576	70
71	Medical Supplies Charged to Patients	0.434655	42,024	18,266	71
72	Impl. Dev. Charged to Patients	0.477773			72
73	Drugs Charged to Patients	0.160367	870,096	139,535	73
74	Renal Dialysis	0.313101	32,415	10,149	74
75.01	ONCOLOGY	0.264684			75.01
76.97	CARDIAC REHABILITATION	1.559518			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.084198	525	569	90
90.01	OP PSYCH	0.248233			90.01
91	Emergency	0.113489	192,131	21,805	91
92	Observation Beds (Non-Distinct Part)	0.373125			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,114,641	365,546	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,114,641		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT**COMPONENT CCN: 15-T008****WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF		4,737,528		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.260122	145,045	37,729	50
51	Recovery Room	0.251357	3,715	934	51
52	Delivery Room & Labor Room	0.490299			52
53	Anesthesiology	0.075743	18,228	1,381	53
54	Radiology-Diagnostic	0.198993	136,217	27,106	54
54.01	ULTRASOUND	0.139719	14,332	2,002	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.132245	16,193	2,141	56
57	CT Scan	0.051155	90,946	4,652	57
59	Cardiac Catheterization	0.131751			59
60	Laboratory	0.133337	806,090	107,482	60
62	Whole Blood & Packed Red Blood Cells	0.402829	36,074	14,532	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.105615	85,259	9,005	63.02
65	Respiratory Therapy	0.216968	394,883	85,677	65
66	Physical Therapy	0.400030	2,176,039	870,481	66
67	Occupational Therapy	0.332816	1,948,775	648,584	67
68	Speech Pathology	0.459868	285,456	131,272	68
70	Electroencephalography	0.126629	13,653	1,729	70
71	Medical Supplies Charged to Patients	0.434655	328,953	142,981	71
72	Impl. Dev. Charged to Patients	0.477773	4,864	2,324	72
73	Drugs Charged to Patients	0.160367	2,099,086	336,624	73
74	Renal Dialysis	0.313101	472,224	147,854	74
75.01	ONCOLOGY	0.264684			75.01
76.97	CARDIAC REHABILITATION	1.559518			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.084198			90
90.01	OP PSYCH	0.248233			90.01
91	Emergency	0.113489	2,710	308	91
92	Observation Beds (Non-Distinct Part)	0.373125			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		9,078,742	2,574,798	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,078,742		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0008

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		2,665,739		30
31	Intensive Care Unit		188,555		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery		265,530		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.260122	422,598	109,927	50
51	Recovery Room	0.251357	58,527	14,711	51
52	Delivery Room & Labor Room	0.490299	218,338	107,051	52
53	Anesthesiology	0.075743	127,139	9,630	53
54	Radiology-Diagnostic	0.198539	196,805	39,073	54
54.01	ULTRASOUND	0.139719	50,739	7,089	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.132245	63,394	8,384	56
57	CT Scan	0.051155	315,466	16,138	57
59	Cardiac Catheterization	0.131191	288,150	37,803	59
60	Laboratory	0.133118	886,016	117,945	60
62	Whole Blood & Packed Red Blood Cells	0.402829	30,552	12,307	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.105615	162,039	17,114	63.02
65	Respiratory Therapy	0.216968	147,132	31,923	65
66	Physical Therapy	0.400030	71,749	28,702	66
67	Occupational Therapy	0.332816	36,894	12,279	67
68	Speech Pathology	0.459868	37,993	17,472	68
70	Electroencephalography	0.126629	13,132	1,663	70
71	Medical Supplies Charged to Patients	0.434655	238,102	103,492	71
72	Impl. Dev. Charged to Patients	0.477773	43,680	20,869	72
73	Drugs Charged to Patients	0.160367	1,073,558	172,163	73
74	Renal Dialysis	0.313101	53,261	16,676	74
75.01	ONCOLOGY	0.264684			75.01
76.97	CARDIAC REHABILITATION	1.559518	668	1,042	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.078866	537	579	90
90.01	OP PSYCH	0.248233			90.01
91	Emergency	0.112484	435,655	49,004	91
92	Observation Beds (Non-Distinct Part)	0.373125			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,972,124	953,036	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,972,124		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-S008

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		969,194		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.260122			50
51	Recovery Room	0.251357			51
52	Delivery Room & Labor Room	0.490299			52
53	Anesthesiology	0.075743			53
54	Radiology-Diagnostic	0.198539	4,865	966	54
54.01	ULTRASOUND	0.139719			54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.132245			56
57	CT Scan	0.051155	4,668	239	57
59	Cardiac Catheterization	0.131191			59
60	Laboratory	0.133118	69,477	9,249	60
62	Whole Blood & Packed Red Blood Cells	0.402829			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.105615	7,707	814	63.02
65	Respiratory Therapy	0.216968	11,253	2,442	65
66	Physical Therapy	0.400030	12,330	4,932	66
67	Occupational Therapy	0.332816	10,733	3,572	67
68	Speech Pathology	0.459868	531	244	68
70	Electroencephalography	0.126629			70
71	Medical Supplies Charged to Patients	0.434655	3,210	1,395	71
72	Impl. Dev. Charged to Patients	0.477773			72
73	Drugs Charged to Patients	0.160367	125,725	20,162	73
74	Renal Dialysis	0.313101			74
75.01	ONCOLOGY	0.264684			75.01
76.97	CARDIAC REHABILITATION	1.559518			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.078866			90
90.01	OP PSYCH	0.248233			90.01
91	Emergency	0.112484	39,731	4,469	91
92	Observation Beds (Non-Distinct Part)	0.373125			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		290,230	48,484	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		290,230		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T008

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF		25,920		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.260122			50
51	Recovery Room	0.251357			51
52	Delivery Room & Labor Room	0.490299			52
53	Anesthesiology	0.075743			53
54	Radiology-Diagnostic	0.198539			54
54.01	ULTRASOUND	0.139719			54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.132245			56
57	CT Scan	0.051155			57
59	Cardiac Catheterization	0.131191			59
60	Laboratory	0.133118	1,826	243	60
62	Whole Blood & Packed Red Blood Cells	0.402829			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.105615			63.02
65	Respiratory Therapy	0.216968	4,214	914	65
66	Physical Therapy	0.400030	11,553	4,622	66
67	Occupational Therapy	0.332816	12,714	4,231	67
68	Speech Pathology	0.459868	2,251	1,035	68
70	Electroencephalography	0.126629			70
71	Medical Supplies Charged to Patients	0.434655	4,995	2,171	71
72	Impl. Dev. Charged to Patients	0.477773			72
73	Drugs Charged to Patients	0.160367	13,672	2,193	73
74	Renal Dialysis	0.313101			74
75.01	ONCOLOGY	0.264684			75.01
76.97	CARDIAC REHABILITATION	1.559518			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.078866			90
90.01	OP PSYCH	0.248233			90.01
91	Emergency	0.112484			91
92	Observation Beds (Non-Distinct Part)	0.373125			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		51,225	15,409	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		51,225		202

(A) Worksheet A line numbers

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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)	3,505,981			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,478,945			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)	43,155			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	150.38			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)	0.1027			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4099			31
32	Sum of lines 30 and 31	0.5126			32
33	Allowable disproportionate share percentage (see instructions)	0.3150			33
34	Disproportionate share adjustment (see instructions)	1,180,063			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		8,272,872,447	35
35.01	Factor 3 (see instructions)	0.000300872		0.000277445	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,035,909		2,295,264	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	513,161		1,716,731	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,229,892			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)	2,619			40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	271			41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	271			41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	10.35			42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	1,332			43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)	0.702161			44

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
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)	77,151			46
47	Subtotal (see instructions)	18,515,187			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)	18,515,187			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,353,868			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				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)	19,869,055			59
60	Primary payer payments	7,182			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	19,861,873			61
62	Deductibles billed to program beneficiaries	1,429,936			62
63	Coinurance billed to program beneficiaries	119,628			63
64	Allowable bad debts (see instructions)	567,240			64
65	Adjusted reimbursable bad debts (see instructions)	368,706			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	188,301			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,681,015			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)	97,876			70.93
70.94	HRR adjustment amount (see instructions)	-21,234			70.94
71	Amount due provider (see instructions)	18,757,657			71
71.01	Sequestration adjustment (see instructions)	375,153			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	17,863,744			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	518,760			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	462,960			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

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

Check applicable box: ☒ Hospital ☐ IPF ☐ IRF ☐ SUB (Other) ☐ SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	72,407			1
2	Medical and other services reimbursed under OPPS (see instructions)	10,609,029			2
3	OPPS payments	9,070,516			3
4	Outlier payment (see instructions)	19,785			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)	72,407			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	286,485			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)	286,485			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)	286,485			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	214,078			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)	72,407			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)	9,090,301			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	53,059			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,736,108			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)	7,373,541			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)	7,373,541			30
31	Primary payer payments	1,098			31
32	Subtotal (line 30 minus line 31)	7,372,443			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)	686,212			34
35	Adjusted reimbursable bad debts (see instructions)	446,038			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	345,715			36
37	Subtotal (see instructions)	7,818,481			37
38	MSP-LCC reconciliation amount from PS&R	-9			38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	7,818,490			40
40.01	Sequestration adjustment (see instructions)	156,370			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	7,672,401			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-10,281			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 (see 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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 15-S008****WORKSHEET E
PART B**

Check applicable box: ☐ Hospital ☒ IPF ☐ IRF ☐ SUB (Other) ☐ SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	221			2
3	OPPS payments	170			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 reasonable 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)	170			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	34			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)	136			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)	136			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	136			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)	136			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)	136			40
40.01	Sequestration adjustment (see instructions)	3			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	133			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 (see 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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 15-T008****WORKSHEET E
PART B**

Check applicable box: ☐ Hospital ☐ IPF ☒ IRF ☐ SUB (Other) ☐ SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	557			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,557			2
3	OPPS payments	2,336			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)	557			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	3,474			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)	3,474			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)	3,474			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	2,917			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)	557			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)	2,336			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	379			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)	2,514			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)	2,514			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,514			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)	2,514			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)	2,514			40
40.01	Sequestration adjustment (see instructions)	50			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,598			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-134			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 (see 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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
COMPONENT CCN: 15-0008
**WORKSHEET E-1
PART I**

Check ☒ **Hospital** ☐ **SUB (Other)**
Applicable ☐ **IPF** ☐ **SNF**
Boxes: ☐ **IRF** ☐ **Swing Bed SNF**

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			17,467,918		7,222,439
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			357,026		385,062
3	List separately each retroactive lump sum adjustment	.01	01/18/2019	38,800	01/18/2019	64,900
	amount based on subsequent revision of the interim	.02				
	rate for the cost reporting period. Also show date of	Program				
	each payment. If none, write 'NONE' or enter a zero. (1)	to				
		Provider				
		.03				
		.04				
		.05				
		.06				
		.07				
		.08				
		.09				
		.10				
		.50				
		.51				
		Provider				
		to				
		Program				
		.52				
		.53				
		.54				
		.55				
		.56				
		.57				
		.58				
		.59				
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		38,800		64,900
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)			17,863,744		7,672,401
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				
	after desk review. Also show date of each payment.	.02				
	If none, write 'NONE' or enter a zero. (1)	Program				
		to				
		Provider				
		.03				
		.04				
		.05				
		.06				
		.07				
		.08				
		.09				
		.10				
		.50				
		.51				
		Provider				
		to				
		Program				
		.52				
		.53				
		.54				
		.55				
		.56				
		.57				
		.58				
		.59				
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				
6	Determined net settlement amount (balance due)	.01				
	based on the cost report (1)	.02				
7	Total Medicare program liability (see instructions)					
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
COMPONENT CCN: 15-S008
**WORKSHEET E-1
PART I**

Check ☐ Hospital ☐ SUB (Other)
 Applicable ☒ IPF ☐ SNF
 Boxes: ☐ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			1,511,231		133
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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	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)			1,511,231		133
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	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) based on the cost report (1)	.01				6.01
		.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.

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
COMPONENT CCN: 15-T008
**WORKSHEET E-1
PART I**

Check ☐ Hospital ☐ SUB (Other)
 Applicable ☐ IPF ☐ SNF
 Boxes: ☒ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			7,400,511		2,598
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					
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	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)			7,400,511		2,598
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	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) based on the cost report (1)	.01				6.01
		.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.

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 15-S008****WORKSHEET E-3
PART II**

Check ☐ Hospital
Applicable ☒ Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,727,083	1
2	Net IPF PPS Outlier payment	23,805	2
3	Net IPF PPS ECT payment	10,464	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)	9.772603	9
10	Teaching adjustment factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$		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)	1,761,352	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)	1,761,352	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,761,352	18
19	Deductibles	110,864	19
20	Subtotal (line 18 minus line 19)	1,650,488	20
21	Coinsurance	108,412	21
22	Subtotal (line 20 minus line 21)	1,542,076	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,273	23
24	Adjusted reimbursable bad debts (see instructions)	11,877	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,203	25
26	Subtotal (sum of lines 22 and 24)	1,553,953	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)	1,553,953	31
31.01	Sequestration adjustment (see instructions)	31,079	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	1,511,231	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)	11,643	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 15-T008****WORKSHEET E-3
PART III**

Check ☐ Hospital
Applicable ☒ Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	7,155,154		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.069900		2
3	Inpatient Rehabilitation LIP payments (see instructions)	462,938		3
4	Outlier payments	40,941		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)	18,128,767		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	7,659,033		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)	7,659,033		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	7,659,033		19
20	Deductibles	44,604		20
21	Subtotal (line 19 minus line 20)	7,614,429		21
22	Coinsurance	104,529		22
23	Subtotal (line 21 minus line 22)	7,509,900		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,867		24
25	Adjusted reimbursable bad debts (see instructions)	19,414		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,563		26
27	Subtotal (sum of lines 23 and 25)	7,529,314		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)	7,529,314		32
32.01	Sequestration adjustment (see instructions)	150,586		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	7,400,511		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)	-21,783		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0008

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☒ PPS
 Applicable ☒ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☐ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	2,665,739		8
9	Ancillary service charges	4,972,124		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)	7,637,863		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)	7,637,863		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,637,863		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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-S008

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☒ PPS
 Applicable ☒ Title XIX ☒ Subprovider IPF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☐ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	969,194		8
9	Ancillary service charges	290,230		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)	1,259,424		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)	1,259,424		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,259,424		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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T008

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☒ PPS
 Applicable ☒ Title XIX ☒ Subprovider IRF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☐ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	25,920		8
9	Ancillary service charges	51,225		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)	77,145		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)	77,145		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	77,145		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

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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	3,585				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	16,890,884				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	6,570,430				7
8	Prepaid expenses	2,141,555				8
9	Other current assets	7,463,932				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	33,070,386				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	32,930,900				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)	32,930,900				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,442,513				34
35	Total other assets (sum of lines 31-34)	1,442,513				35
36	Total assets (sum of lines 11, 30 and 35)	67,443,799				36
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	498,005				37
38	Salaries, wages and fees payable	5,178,508				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	5,447,355				43
44	Other current liabilities	14,163,656				44
45	Total current liabilities (sum of lines 37 thru 44)	25,287,524				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	1,922,558				49
50	Total long term liabilities (sum of lines 46 thru 49)	1,922,558				50
51	Total liabilities (sum of lines 45 and 50)	27,210,082				51
	CAPITAL ACCOUNTS					
52	General fund balance	40,233,717				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)	40,233,717				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	67,443,799				60

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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		45,815,000		1
2	Net income (loss) (from Worksheet G-3, line 29)		3,140,739		2
3	Total (sum of line 1 and line 2)		48,955,739		3
4	Additions (credit adjustments) (specify)				4
5	NET ASSETS RELEASED FROM RESTRICTIO				5
6	NET ASSETS TRANSFERRED	73,000			6
7	CONTRIBUTIONS	102,000			7
8	INVESTMENT INCOME	9,000			8
9	OTHER	375,000			9
10	Total additions (sum of lines 4-9)		559,000		10
11	Subtotal (line 3 plus line 10)		49,514,739		11
12	Deductions (debit adjustments) (specify)				12
13	TRANSFERS	9,090,000			13
14	ASSET TRANSFERS	191,000			14
15	ROUNDING	22			15
16					16
17					17
18	Total deductions (sum of lines 12-17)		9,281,022		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,233,717		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	INVESTMENT INCOME				8
9	OTHER				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	ASSET TRANSFERS				14
15	ROUNDING				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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	54,745,704		54,745,704	1
2	Subprovider IPF	12,590,777		12,590,777	2
3	Subprovider IRF	21,914,888		21,914,888	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)	89,251,369		89,251,369	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	5,995,183		5,995,183	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)	5,995,183		5,995,183	16
17	Total inpatient routine care services (sum of lines 10 and 16)	95,246,552		95,246,552	17
18	Ancillary services	143,213,143		143,213,143	18
19	Outpatient services		303,635,058	303,635,058	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN REVENUE	2,476,426	4,804,969	7,281,395	27
27.01	CAPITATION		-5,279,596	-5,279,596	27.01
27.02	REGENCY		4,596,220	4,596,220	27.02
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	240,936,121	307,756,651	548,692,772	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		177,551,848	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)		177,551,848	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	548,692,772	1
2	Less contractual allowances and discounts on patients' accounts	410,732,313	2
3	Net patient revenues (line 1 minus line 2)	137,960,459	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	177,551,848	4
5	Net income from service to patients (line 3 minus line 4)	-39,591,389	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	5,000	6
7	Income from investments	120,522	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	54	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	799,492	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	509,129	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	1,833	21
22	Rental of hosptial space	826,841	22
23	Governmental appropriations		23
24	Other (GAIN ON SALE OF ASSETS)		24
24.01	Other (CAPITATION REVENUE)	33,699,107	24.01
24.02	Other (GRANT INCOME)		24.02
24.03	Other (OTHER INCOME)	800,891	24.03
24.04	Other (PHARMACY INCOME)	5,815,397	24.04
24.05	Other (CLASSES)	36,175	24.05
24.06	Other (TEMP RESTRICTED)	117,687	24.06
25	Total other income (sum of lines 6-24)	42,732,128	25
26	Total (line 5 plus line 25)	3,140,739	26
29	Net income (or loss) for the period (line 26 minus line 28)	3,140,739	29

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/25/2019 Run Time: 15:09 Version: 2018.12 (10/24/2019)
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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 15-0008****WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,219,549	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	900	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)	79.08	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)	0.1027	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4099	8
9	Sum of lines 7 and 8	0.5126	9
10	Allowable disproportionate share percentage (see instructions)	0.1094	10
11	Disproportionate share adjustment (see instructions)	133,419	11
12	Total prospective capital payments (see instructions)	1,353,868	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

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

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 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

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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