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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11/25/2014 TIME: 22:49 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED	6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN
		10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		412,454	58,603	-183,940		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		-18,526	223			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		393,928	58,826	-183,940		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 OMD 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.

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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 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. CATHERINE HOSPITAL	15-0008	23844	1	07/01/1966	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF	ST. CATHERINE HOSPITAL - REHAB	15-T008	23844	5	01/01/2002	N	P	P	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	ST. CATHERINES HHA	15-7453	23844		01/01/1996	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	
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)	N	N	22.01
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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	5,154	321	241	134	3,229		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	496	201	43	14	38		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 in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	Y	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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 Facilty 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.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.			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
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

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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 appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: 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. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'		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
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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WORKSHEET S-2
PART I

All Providers

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

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

141	Name: NAME: COMMUNITY FOUNDATION OF	Contractor's Name: WPS	Contractor's Number: 15H05	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 Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		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, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	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.		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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.75			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2012	09/30/2013	170

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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 ON 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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT 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

BAD DEBTS		Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14

BED COMPLEMENT			
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	11/18/2014	Y	11/18/2014	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)	N		N		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 COSTS			
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 CAPITALIZED 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	WERE 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 REORT PREPARER INFORMATION				
41	FIRST NAME: JANE	LAST NAME: BACHMANN	TITLE: CONSULTANT	41
42	EMPLOYER: BACHMANN ASSOCIATES			42
43	PHONE NUMBER: 3122852828	E-MAIL ADDRESS: JBOPIL@ATT.NET		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA 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	151	55,115			10,449	4,268	25,223	1
2	HMO AND OTHER (see instructions)						1,522	3,604		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER						76	296		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)		151	55,115			10,449	4,268	25,223	7
8	INTENSIVE CARE UNIT	31	10	3,650			1,066	394	2,352	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						204	981	13
14	TOTAL (see instructions)		161	58,765			11,515	4,866	28,556	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	30	10,950			7,058	496	8,806	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					17,567		22,100	22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		191							27
28	OBSERVATION BED DAYS								3,498	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							609	1,315	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,447	1,246	6,980	1
2	HMO AND OTHER (see instructions)					260	1,184		2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		814.77			2,447	1,246	6,980	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF		39.29			693	78	862	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		15.62						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)		869.68						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	51,334,448	3,997	51,338,445	1,808,930.00	28.38	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B		818,512		818,512	8,577.00	95.43	3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		1,978,736		1,978,736	11,716.00	168.89	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 PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		3,178,034	160,485	3,338,519	118,463.00	28.18	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		856,771		856,771	8,751.00	97.91	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		644,981		644,981	3,638.00	177.29	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		7,721,460		7,721,460	196,760.00	39.24	14
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)		12,401,359		12,401,359			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		886,616		886,616			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B		215,481		215,481			21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		340,432		340,432			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		462,423		462,423	12,881.00	35.90	26
27	ADMINISTRATIVE & GENERAL		5,411,523	3,997	5,415,520	176,024.00	30.77	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		1,282,954		1,282,954	9,176.00	139.82	28
29	MAINTENANCE & REPAIRS		1,196,817		1,196,817	41,662.00	28.73	29
30	OPERATION OF PLANT		433,444		433,444	16,712.00	25.94	30
31	LAUNDRY & LINEN SERVICE		89,742		89,742	6,382.00	14.06	31
32	HOUSEKEEPING		1,613,129		1,613,129	107,350.00	15.03	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		1,510,553	-867,189	643,364	39,873.00	16.14	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			867,189	867,189	53,748.00	16.13	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,124,519		1,124,519	28,138.00	39.96	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		1,706,122	-160,485	1,545,637	37,006.00	41.77	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		103,639		103,639	3,687.00	28.11	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		49,820,154	3,997	49,824,151	1,797,813.00	27.71	1
2	EXCLUDED AREA SALARIES (see instructions)		3,178,034	160,485	3,338,519	118,463.00	28.18	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		46,642,120	-156,488	46,485,632	1,679,350.00	27.68	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		9,223,212		9,223,212	209,149.00	44.10	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		12,401,359		12,401,359		26.68%	5
6	TOTAL (sum of lines 3 through 5)		68,266,691	-156,488	68,110,203	1,888,499.00	36.07	6
7	TOTAL OVERHEAD COST (see instructions)		14,934,865	-156,488	14,778,377	532,639.00	27.75	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	972,062	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,462,574	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	7,048,349	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	53,231	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	113,063	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	633,654	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	2,789,402	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	686,775	18
19	UNEMPLOYMENT INSURANCE	43,770	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	41,007	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	13,843,887	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	856,771		1
2	HOSPITAL	856,771		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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

HOME HEALTH AGENCY STATISTICAL DATA COUNTY: LAKE

		TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
	DESCRIPTION	1	2	3	4	5	
1	HOME HEALTH AIDE HOURS		3,485		616	4,101	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		336.00		163.00	499.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF	CONTRACT	TOTAL	
		1	2	3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.03		1.03	3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	6.15		6.15	5
6	DIRECT NURSING SERVICE	6.27		6.27	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE		1.77	1.77	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE		0.43	0.43	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE		0.01	0.01	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE		0.01	0.01	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	2.17		2.17	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	23844	20

PPS ACTIVITY

		FULL EPISODES					
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES	TOTAL (columns 1 through 4)	
		1	2	3	4	5	
21	SKILLED NURSING VISITS	8,918	1,116	142	124	10,300	21
22	SKILLED NURSING VISIT CHARGES	1,348,483	173,310	16,218	17,967	1,555,978	22
23	PHYSICAL THERAPY VISITS	2,668	170	10	43	2,891	23
24	PHYSICAL THERAPY VISIT CHARGES	490,250	31,450	1,665	7,955	531,320	24
25	OCCUPATIONAL THERAPY VISITS	609	80	6	27	722	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	111,925	14,800	740	4,995	132,460	26
27	SPEECH PATHOLOGY VISITS						27
28	SPEECH PATHOLOGY VISIT CHARGES						28
29	MEDICAL SOCIAL SERVICE VISITS	7	2			9	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	1,477	422			1,899	30
31	HOME HEALTH AIDE VISITS	2,913	657		75	3,645	31
32	HOME HEALTH AIDE VISIT CHARGES	338,199	76,993		8,925	424,117	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	15,115	2,025	158	269	17,567	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,290,334	296,975	18,623	39,842	2,645,774	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	621		44	10	675	36
37	TOTAL NUMBER OF OUTLIER EPISODES		46		1	47	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	227,360	12,759	2,445	2,880	245,444	38

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COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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)	0.312105	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	26,537,485	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	97,883,560	6
7	MEDICAID COST (line 1 times line 6)	30,549,948	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.	4,012,463	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE	13,498	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)	4,012,463	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	22,439,406		22,439,406	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	7,003,451		7,003,451	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	82,450		82,450	22
23	COST OF CHARITY CARE (line 21 minus line 22)	6,921,001		6,921,001	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?		24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	8,731,916	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	568,012	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	8,163,904	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	2,547,995	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	9,468,996	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	13,481,459	31

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COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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				1,755,122	1,755,122	905,669	2,660,791	1
2	00200	CAP REL COSTS-MVBLE EQUIP				4,103,587	4,103,587	2,210,808	6,314,395	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	71,386	14,284	85,670	12,802,881	12,888,551		12,888,551	4
4.01	00401	MAINTENANCE OF PERSONNEL	391,037	225,447	616,484	-333	616,151	-220	615,931	4.01
5.01	00540	NONPATIENT TELEPHONES	-3,997		-3,997		-3,997	473,318	469,321	5.01
5.02	00560	PURCHASING RECEIVING & STORES	301,564	108,374	409,938		409,938	-12,127	397,811	5.02
5.03	00570	ADMITTING	900,283	51,992	952,275		952,275		952,275	5.03
5.04	00580	CASHIERING ACCOUNTS RECEIVABLE		8,391	8,391		8,391		8,391	5.04
5.05	00590	OTHER ADMIN & GENERAL	4,213,673	72,760,114	76,973,787	-18,073,772	58,900,015	-39,873,069	19,026,946	5.05
6	00600	MAINTENANCE & REPAIRS	1,196,817	6,121,778	7,318,595	-26,856	7,291,739	-8,248	7,283,491	6
7	00700	OPERATION OF PLANT	433,444	1,361,764	1,795,208	-99	1,795,109	-38,737	1,756,372	7
8	00800	LAUNDRY & LINEN SERVICE	89,742	453,092	542,834	-13,455	529,379	-29,640	499,739	8
9	00900	HOUSEKEEPING	1,613,129	319,590	1,932,719		1,932,719		1,932,719	9
10	01000	DIETARY	1,510,553	1,327,819	2,838,372	-1,646,019	1,192,353		1,192,353	10
11	01100	CAFETERIA				1,629,473	1,629,473	-717,380	912,093	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,124,519	75,381	1,199,900		1,199,900	-15,693	1,184,207	13
14	01400	CENTRAL SERVICES & SUPPLY		19,856	19,856	-19,113	743		743	14
15	01500	PHARMACY	1,706,122	3,848,096	5,554,218	-3,767,974	1,786,244	-265,817	1,520,427	15
16	01600	MEDICAL RECORDS & LIBRARY	103,639	113,784	217,423		217,423	1,421,554	1,638,977	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	11,513,669	1,876,530	13,390,199	-1,231,212	12,158,987	-69,178	12,089,809	30
31	03100	INTENSIVE CARE UNIT	1,947,117	368,302	2,315,419	-55,782	2,259,637	-28,657	2,230,980	31
41	04100	SUBPROVIDER - IRF	2,041,849	1,095,350	3,137,199	-25,642	3,111,557		3,111,557	41
43	04300	NURSERY				326,974	326,974		326,974	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	2,966,795	6,094,656	9,061,451	-3,581,835	5,479,616	-632,987	4,846,629	50
51	05100	RECOVERY ROOM	300,667	34,342	335,009	-569	334,440		334,440	51
52	05200	DELIVERY ROOM & LABOR ROOM				721,194	721,194		721,194	52
53	05300	ANESTHESIOLOGY	2,233,053	458,630	2,691,683	-61,344	2,630,339	-2,370,467	259,872	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,600,083	344,237	1,944,320	-149,398	1,794,922	-41,513	1,753,409	54
54.01	05401	ULTRASOUND	352,234	38,668	390,902	-22,988	367,914		367,914	54.01
54.02	03040	AUDIOLOGY								54.02
56	05600	RADIOISOTOPE	468,492	318,944	787,436	-287,581	499,855		499,855	56
57	05700	CT SCAN	383,361	175,145	558,506	-43,712	514,794		514,794	57
59	05900	CARDIAC CATHETERIZATION	1,019,360	4,733,979	5,753,339	-3,629,705	2,123,634	-55,355	2,068,279	59
60	06000	LABORATORY	2,059,892	1,994,541	4,054,433		4,054,433	-14,491	4,039,942	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	132,944	853,197	986,141		986,141		986,141	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	06301	NONINVASIVE LAB	626,337	63,133	689,470	-23,088	666,382		666,382	63.02
65	06500	RESPIRATORY THERAPY	1,174,651	158,744	1,333,395	-49,251	1,284,144	-8,853	1,275,291	65
66	06600	PHYSICAL THERAPY	891,761	1,133,888	2,025,649	-15,105	2,010,544	-85,579	1,924,965	66
67	06700	OCCUPATIONAL THERAPY	408,108	966,961	1,375,069		1,375,069		1,375,069	67
68	06800	SPEECH PATHOLOGY	179,502	241,571	421,073		421,073		421,073	68
70	07000	ELECTROENCEPHALOGRAPHY	157,178	68,347	225,525	-1,308	224,217	-14,258	209,959	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				3,403,714	3,403,714		3,403,714	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				3,859,310	3,859,310		3,859,310	72
73	07300	DRUGS CHARGED TO PATIENTS		265,629	265,629	3,940,934	4,206,563		4,206,563	73
74	07400	RENAL DIALYSIS		558,486	558,486		558,486		558,486	74
75.01	03480	ONCOLOGY	100,684	22,653	123,337	-5,157	118,180		118,180	75.01
76.97	07697	CARDIAC REHABILITATION	439,621	36,792	476,413		476,413	-49,321	427,092	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	2,953,722	909,882	3,863,604	-63,016	3,800,588	-2,678,246	1,122,342	90
91	09100	EMERGENCY	2,595,272	841,022	3,436,294	-53,531	3,382,763	-184,995	3,197,768	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	HOME HEALTH AGENCY	1,130,500	459,690	1,590,190		1,590,190		1,590,190	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	51,328,763	110,923,081	162,251,844	-304,656	161,947,188	-42,183,482	119,763,706	118
		NONREIMBURSABLE COST CENTERS								

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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	
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES		225,030	225,030		225,030		225,030	192
194	07950	OTHER NON REIM COST CENTER		73,078	73,078		73,078		73,078	194
194.01	07954	RETAIL PHARMACY				304,656	304,656		304,656	194.01
194.03	07951	ADVERTISING EXPENSE	5,685	390,504	396,189		396,189		396,189	194.03
194.04	07952	REGENCY HOSPITAL		23,376	23,376		23,376		23,376	194.04
194.05	07953	UNUSED SPACE								194.05
200		TOTAL (sum of lines 118-199)	51,334,448	111,635,069	162,969,517		162,969,517	-42,183,482	120,786,035	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	MEDICAL SUPPLIES CHARGED TO PATIENT	A	MEDICAL SUPPLIES CHARGED TO P	71		251,702	1
2			IMPL. DEV. CHARGED TO PATIENT	72		3,859,310	2
3			MEDICAL SUPPLIES CHARGED TO P	71		3,152,012	3
4							4
5							5
6							6
500	TOTAL RECLASSIFICATIONS					7,263,024	500
	CODE LETTER - A						
1	DRUGS CHARGED TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73		3,940,934	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
500	TOTAL RECLASSIFICATIONS					3,940,934	500
	CODE LETTER - B						
1	CAFETERIA RECLASS	C	CAFETERIA	11	867,189	762,284	1
500	TOTAL RECLASSIFICATIONS				867,189	762,284	500
	CODE LETTER - C						
1	UNASSIGNED DEPRECIATION RECLASS	D	CAP REL COSTS-MVBLE EQUIP	2		3,496,006	1
2			CAP REL COSTS-BLDG & FIXT	1		1,741,581	2
500	TOTAL RECLASSIFICATIONS					5,237,587	500
	CODE LETTER - D						
1	UNASSIGNED INTEREST RECLASS	E	CAP REL COSTS-MVBLE EQUIP	2		173	1
500	TOTAL RECLASSIFICATIONS					173	500
	CODE LETTER - E						
1	RECLASS LABOR AND DELIVERY EXPENSE	F	DELIVERY ROOM & LABOR ROOM	52	628,911	92,283	1
2			NURSERY	43	285,135	41,839	2
500	TOTAL RECLASSIFICATIONS				914,046	134,122	500
	CODE LETTER - F						
1	RECLASS RENTAL EQUIPMENT	G	CAP REL COSTS-MVBLE EQUIP	2		607,408	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
500	TOTAL RECLASSIFICATIONS					607,408	500
	CODE LETTER - G						
1	RECLASS RETAIL PHARMACY COSTS	H	RETAIL PHARMACY	194.01	160,485	144,171	1
500	TOTAL RECLASSIFICATIONS				160,485	144,171	500
	CODE LETTER - H						

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS NEGATIVE SALARIES	I	NONPATIENT TELEPHONES	5.01	3,997		1
500	TOTAL RECLASSIFICATIONS				3,997		500
	CODE LETTER - I						
1	RECLASS PROPERTY INSURANCE	J	CAP REL COSTS-BLDG & FIXT	1		13,541	1
500	TOTAL RECLASSIFICATIONS					13,541	500
	CODE LETTER - J						
1	RECLASS FRINGE BENEFITS	L	EMPLOYEE BENEFITS DEPARTMENT	4		12,802,881	1
500	TOTAL RECLASSIFICATIONS					12,802,881	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				1,945,717	30,906,125	

(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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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	MEDICAL SUPPLIES CHARGED TO PATIENT	A	ADULTS & PEDIATRICS	30		124,978		1
2			SUBPROVIDER - IRF	41		21,870		2
3			CARDIAC CATHETERIZATION	59		3,603,599		3
4			EMERGENCY	91		50,974		4
5			INTENSIVE CARE UNIT	31		53,880		5
6			OPERATING ROOM	50		3,407,723		6
500	TOTAL RECLASSIFICATIONS					7,263,024		500
	CODE LETTER - A							
1	DRUGS CHARGED TO PATIENTS	B	PHARMACY	15		3,461,610		1
2			CARDIAC CATHETERIZATION	59		12,214		2
3			ANESTHESIOLOGY	53		61,344		3
4			RADIOLOGY-DIAGNOSTIC	54		21		4
5			RADIOISOTOPE	56		280,146		5
6			RESPIRATORY THERAPY	65		43,382		6
7			CLINIC	90		51,361		7
8			EMERGENCY	91		2,557		8
9			ONCOLOGY	75.01		5,157		9
10			ADULTS & PEDIATRICS	30		12,341		10
11			INTENSIVE CARE UNIT	31		1,262		11
12			ADULTS & PEDIATRICS	30		2,308		12
13			SUBPROVIDER - IRF	41		2,513		13
14			OPERATING ROOM	50		4,149		14
15			RECOVERY ROOM	51		569		15
500	TOTAL RECLASSIFICATIONS					3,940,934		500
	CODE LETTER - B							
1	CAFETERIA RECLASS	C	DIETARY	10	867,189	762,284		1
500	TOTAL RECLASSIFICATIONS				867,189	762,284		500
	CODE LETTER - C							
1	UNASSIGNED DEPRECIATION RECLASS	D	OTHER ADMIN & GENERAL	5.05		3,496,006	9	1
2			OTHER ADMIN & GENERAL	5.05		1,741,581	9	2
500	TOTAL RECLASSIFICATIONS					5,237,587		500
	CODE LETTER - D							
1	UNASSIGNED INTEREST RECLASS	E	OTHER ADMIN & GENERAL	5.05		173	11	1
500	TOTAL RECLASSIFICATIONS					173		500
	CODE LETTER - E							
1	RECLASS LABOR AND DELIVERY EXPENSE	F	ADULTS & PEDIATRICS	30	628,911	92,283		1
2			ADULTS & PEDIATRICS	30	285,135	41,839		2
500	TOTAL RECLASSIFICATIONS				914,046	134,122		500
	CODE LETTER - F							
1	RECLASS RENTAL EQUIPMENT	G					10	1
2								2
3			MAINTENANCE OF PERSONNEL	4.01		333		3
4			OTHER ADMIN & GENERAL	5.05		19,590		4
5			MAINTENANCE & REPAIRS	6		26,856		5
6			OPERATION OF PLANT	7		99		6
7			LAUNDRY & LINEN SERVICE	8		13,455		7
8			DIETARY	10		16,546		8
9			CENTRAL SERVICES & SUPPLY	14		19,113		9
10			PHARMACY	15		1,708		10
11			ADULTS & PEDIATRICS	30		43,417		11
12			INTENSIVE CARE UNIT	31		640		12
13			SUBPROVIDER - IRF	41		1,259		13
14			OPERATING ROOM	50		169,963		14
15			RADIOLOGY-DIAGNOSTIC	54		149,377		15
16			ULTRASOUND	54.01		22,988		16
17			RADIOISOTOPE	56		7,435		17
18			CT SCAN	57		43,712		18
19			CARDIAC CATHETERIZATION	59		13,892		19
20			NONINVASIVE LAB	63.02		23,088		20
21			RESPIRATORY THERAPY	65		5,869		21
22			PHYSICAL THERAPY	66		15,105		22
23			ELECTROENCEPHALOGRAPHY	70		1,308		23
24			CLINIC	90		11,655		24
500	TOTAL RECLASSIFICATIONS					607,408		500
	CODE LETTER - G							
1	RECLASS RETAIL PHARMACY COSTS	H	PHARMACY	15	160,485	144,171		1
500	TOTAL RECLASSIFICATIONS				160,485	144,171		500
	CODE LETTER - H							

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASS NEGATIVE SALARIES	I	NONPATIENT TELEPHONES	5.01		3,997		1
500	TOTAL RECLASSIFICATIONS					3,997		500
	CODE LETTER - I							
1	RECLASS PROPERTY INSURANCE	J	OTHER ADMIN & GENERAL	5.05		13,541	12	1
500	TOTAL RECLASSIFICATIONS					13,541		500
	CODE LETTER - J							
1	RECLASS FRINGE BENEFITS	L	OTHER ADMIN & GENERAL	5.05		12,802,881		1
500	TOTAL RECLASSIFICATIONS					12,802,881		500
	CODE LETTER - L							
	GRAND TOTAL (DECREASES)				1,941,720	30,910,122		

(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

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	251,413					251,413		1
2	LAND IMPROVEMENTS	1,965,438	93,775		93,775		2,059,213		2
3	BUILDINGS AND FIXTURES	49,187,798				110,538	49,077,260		3
4	BUILDING IMPROVEMENTS	9,194,488	2,354,941		2,354,941	8,532	11,540,897		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	102,327,544	3,624,181		3,624,181	605,693	105,346,032		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	162,926,681	6,072,897		6,072,897	724,763	168,274,815		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	162,926,681	6,072,897		6,072,897	724,763	168,274,815		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT								1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	62,928,783		62,928,783	0.373964					1
2	CAP REL COSTS-MVBLE EQU	105,346,032		105,346,032	0.626036					2
3	TOTAL (sum of lines 1-2)	168,274,815		168,274,815	1.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	2,647,250			13,541			2,660,791	1
2	CAP REL COSTS-MVBLE EQUIP	5,706,987	607,408					6,314,395	2
3	TOTAL (sum of lines 1-2)	8,354,237	607,408		13,541			8,975,186	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)	B	-173	CAP REL COSTS-MVBLE EQUIP	2	11	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	-40,852	NONPATIENT TELEPHONES	5.01		7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-2,368	CAP REL COSTS-MVBLE EQUIP	2	9	8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,105,006				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-1,910,706				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	B	-194	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES	A	783,131	CAP REL COSTS-BLDG & FIXT	1	9	26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	129,805	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 AND						32
33	OTHER OPERATING REVENUE	B	-36,793	CARDIAC REHABILITATION	76.97		33
33.07	LAB REVENUE	B	-2,840	LABORATORY	60		33.07
33.13	OTHER OPERATING REVENUE	B	-220	MAINTENANCE OF PERSONNEL	4.01		33.13
33.14	OTHER INCOME	B	-1,014	CLINIC	90		33.14
33.15	OFFSET OCC HEALTH COSTS FOR BP/US	A	-2,132,190	CLINIC	90		33.15
33.19	OTHER OPERATING REVENUE	B	-120,287	OTHER ADMIN & GENERAL	5.05		33.19
33.23	OTHER OPER REV	B	-12,127	PURCHASING RECEIVING & STORES	5.02		33.23
33.26	CAFETERIA REVENUE	B	-717,380	CAFETERIA	11		33.26
33.28	OTHER OPER REVENUE	B	-38,737	OPERATION OF PLANT	7		33.28
33.29	OTHER OPERATING REVENUE	B	-8,248	MAINTENANCE & REPAIRS	6		33.29
33.30	OTHER OPERATING REVENUE	B	-29,640	LAUNDRY & LINEN SERVICE	8		33.30
34	OFFSET TELEPHONE DEPRECIATION	A	-5,874	CAP REL COSTS-MVBLE EQUIP	2	9	34
34.01	OFFSET CONTRIBUTIONS	A	-19,756	OTHER ADMIN & GENERAL	5.05		34.01
34.03	OFFSET CAPITATION EXPENSE	A	-25,787,832	OTHER ADMIN & GENERAL	5.05		34.03
35	CRNA SALARIES	A	-830,431	ANESTHESIOLOGY	53		35
36							36
37	OFFSET CONTRIBUTIONS	A	-200	CLINIC	90		37
38	OFFSET NONWAGE CRNA/ANEST COSTS	A	-137,413	ANESTHESIOLOGY	53		38
39	OFFSET FEES FOR ON CALL SURGEONS	A	-600,000	OPERATING ROOM	50		39
40	MDWISE ADD BACK	A	3,129,957	OTHER ADMIN & GENERAL	5.05		40
41	OFFSET MEDICAID ASSESSMENT	A	-5,638,411	OTHER ADMIN & GENERAL	5.05		41
42	OFFSET MAMMO READS	A	-2,760	RADIOLOGY-DIAGNOSTIC	54		42
43	OFFSET EKG READS AT CLINIC	A	-7,475	CLINIC	90		43
44	OFFSET OTHER INCOME	B	-13,753	RADIOLOGY-DIAGNOSTIC	54		44
45	OFFSET 340B CONTRACT PHARM COSTS	A	-265,623	PHARMACY	15		45
46	ELIMINATE PHYSICIAN COSTS	B	-4,932,235	OTHER ADMIN & GENERAL	5.05		46
46.01	OFFSET PAIN CLINIC PHYS PART B	A	-168,400	CLINIC	90		46.01
46.02	OFFSET OCC HEALTH PHYS PART B	A	-336,960	CLINIC	90		46.02
46.03	OFFSET ADMIN PHYS PART B	A	-320,477	OTHER ADMIN & GENERAL	5.05		46.03
47							47
48							48

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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	
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-42,183,482				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 ADJUST-MENTS (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	122,538		122,538	9	1
2	2	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION EQUIP	2,089,418		2,089,418	9	2
3	5.05	OTHER ADMIN & GENERAL	A&G OTHER	11,712,009	17,777,925	-6,065,916		3
3.01	5.01	NONPATIENT TELEPHONES	TELECOMMUNICATIONS	514,170		514,170		3.01
3.02	16	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,429,084		1,429,084		3.02
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			15,867,219	17,777,925	-1,910,706		5

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

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

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

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

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	G	CFNI				HEALTHCARE HOME OFFICE	6
7							7
8							8
9							9
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5.05	OTHER ADMIN & GENERA AGGREGATE	181,975	64,561	117,414	171,400	775	63,863	3,193	1
2	13	NURSING ADMINISTRATI AGGREGATE	18,000	14,836	3,164	171,400	28	2,307	115	2
3	16	MEDICAL RECORDS & LI AGGREGATE	25,000	4,907	20,093	171,400	212	17,470	874	3
4	30	ADULTS & PEDIATRICS AGGREGATE	85,000	65,800	19,200	171,400	192	15,822	791	4
5	31	INTENSIVE CARE UNIT AGGREGATE	50,000	15,294	34,706	171,400	259	21,343	1,067	5
6	50	OPERATING ROOM AGGREGATE	48,000	14,008	33,992	204,100	153	15,013	751	6
7	54	RADIOLOGY-DIAGNOSTIC AGGREGATE	25,000	25,000						7
8	59	CARDIAC CATHETERIZAT AGGREGATE	70,600	33,600	37,000	171,400	185	15,245	762	8
9	60	LABORATORY	25,000		25,000	171,400	162	13,349	667	9
10	65	RESPIRATORY THERAPY AGGREGATE	18,000	4,430	13,570	171,400	111	9,147	457	10
11	66	PHYSICAL THERAPY AGGREGATE	100,000	66,944	33,056	171,400	175	14,421	721	11
12	70	ELECTROENCEPHALOGRAP AGGREGATE	15,000	14,145	855	171,400	9	742	37	12
13	76.97	CARDIAC REHABILITATI AGGREGATE	15,000	9,000	6,000	171,400	30	2,472	124	13
14	90	CLINIC AGGREGATE	40,000	27,068	12,932	171,400	97	7,993	400	14
15	53	ANESTHESIOLOGY AGGREGATE	1,402,623	1,402,623						15
16	91	EMERGENCY	288,000		288,000	171,400	1,250	103,005	5,150	16
17										17
18										18
19										19
20										20
200		TOTAL	2,407,198	1,762,216	644,982		3,638	302,192	15,109	200

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	5.05	OTHER ADMIN & GENERA AGGREGATE					63,863	53,551	118,112	1
2	13	NURSING ADMINISTRATI AGGREGATE					2,307	857	15,693	2
3	16	MEDICAL RECORDS & LI AGGREGATE					17,470	2,623	7,530	3
4	30	ADULTS & PEDIATRICS AGGREGATE					15,822	3,378	69,178	4
5	31	INTENSIVE CARE UNIT AGGREGATE					21,343	13,363	28,657	5
6	50	OPERATING ROOM AGGREGATE					15,013	18,979	32,987	6
7	54	RADIOLOGY-DIAGNOSTIC AGGREGATE							25,000	7
8	59	CARDIAC CATHETERIZAT AGGREGATE					15,245	21,755	55,355	8
9	60	LABORATORY					13,349	11,651	11,651	9
10	65	RESPIRATORY THERAPY AGGREGATE					9,147	4,423	8,853	10
11	66	PHYSICAL THERAPY AGGREGATE					14,421	18,635	85,579	11
12	70	ELECTROENCEPHALOGRAP AGGREGATE					742	113	14,258	12
13	76.97	CARDIAC REHABILITATI AGGREGATE					2,472	3,528	12,528	13
14	90	CLINIC AGGREGATE					7,993	4,939	32,007	14
15	53	ANESTHESIOLOGY AGGREGATE							1,402,623	15
16	91	EMERGENCY					103,005	184,995	184,995	16
17										17
18										18
19										19
20										20
200		TOTAL					302,192	342,790	2,105,006	200

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	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	2,660,791	2,660,791					1
2	CAP REL COSTS-MVBLE EQUIP	6,314,395		6,314,395				2
4	EMPLOYEE BENEFITS DEPARTMENT	12,888,551			12,888,551			4
4.01	MAINTENANCE OF PERSONNEL	615,931	15,735		102,488	734,154		4.01
5.01	NONPATIENT TELEPHONES	469,321	4,972	37,938			512,231	5.01
5.02	PURCHASING RECEIVING & STORES	397,811	42,925	2,304	79,038	7,814	3,800	5.02
5.03	ADMITTING	952,275	17,746	1,030	235,958	23,903	7,980	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE	8,391	4,494					5.04
5.05	OTHER ADMIN & GENERAL	19,026,946	459,748	456,558	1,104,374	40,246	139,074	5.05
6	MAINTENANCE & REPAIRS	7,283,491	226,328	250,339	313,677	17,032	2,660	6
7	OPERATION OF PLANT	1,756,372	123,678	110,562	113,603	6,828	6,080	7
8	LAUNDRY & LINEN SERVICE	499,739	12,861	642	23,521	2,610	760	8
9	HOUSEKEEPING	1,932,719	10,438	20,841	422,790	43,885	4,560	9
10	DIETARY	1,192,353	94,581	46,487	168,621	16,301	9,500	10
11	CAFETERIA	912,093	3,260		227,284	21,972		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,184,207	21,696	70,016	294,729	11,505	3,800	13
14	CENTRAL SERVICES & SUPPLY	743	19,930				4,180	14
15	PHARMACY	1,520,427	29,091	243,846	405,101	15,127	9,880	15
16	MEDICAL RECORDS & LIBRARY	1,638,977	26,374	4,438	27,163	1,505	14,060	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	12,089,809	417,772	538,618	2,778,077	170,612	59,659	30
31	INTENSIVE CARE UNIT	2,230,980	31,927	158,308	510,326	24,472	7,600	31
41	SUBPROVIDER - IRF	3,111,557	99,042	79,057	535,154	33,409	12,540	41
43	NURSERY	326,974		2,899	74,732	3,656		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,846,629	178,165	1,299,287	777,576	39,115	31,159	50
51	RECOVERY ROOM	334,440	7,428	7,485	78,803	3,478	1,520	51
52	DELIVERY ROOM & LABOR ROOM	721,194	14,475		164,833	8,044		52
53	ANESTHESIOLOGY	259,872	2,755	116,437	37,090	6,650	2,280	53
54	RADIOLOGY-DIAGNOSTIC	1,753,409	65,544	744,695	419,371	27,159	18,620	54
54.01	ULTRASOUND	367,914	3,999	57,710	92,318	3,656	4,940	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	499,855	13,866	63,649	122,788	3,946	3,420	56
57	CT SCAN	514,794	20,050	556,455	100,476	5,042	3,420	57
59	CARDIAC CATHETERIZATION	2,068,279	39,089	658,906	267,167	11,581	14,060	59
60	LABORATORY	4,039,942	83,002	159,678	539,883	34,591	27,740	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	986,141	6,977	16,481	34,844	1,777	2,660	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	666,382	5,760	184,975	164,159	10,161	7,220	63.02
65	RESPIRATORY THERAPY	1,275,291	12,579	51,898	307,868	16,471	17,860	65
66	PHYSICAL THERAPY	1,924,965	43,669	15,375	233,724	10,629	1,900	66
67	OCCUPATIONAL THERAPY	1,375,069	1,538	1,969	106,962	6,165	760	67
68	SPEECH PATHOLOGY	421,073	3,668	13,634	47,046	1,752		68
70	ELECTROENCEPHALOGRAPHY	209,959	27,809	38,306	41,195	2,662	6,080	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,403,714						71
72	IMPL. DEV. CHARGED TO PATIENTS	3,859,310						72
73	DRUGS CHARGED TO PATIENTS	4,206,563						73
74	RENAL DIALYSIS	558,486	3,010					74
75.01	ONCOLOGY	118,180	5,314	1,443	26,389	1,258		75.01
76.97	CARDIAC REHABILITATION	427,092	32,938	24,790	115,222	5,714	6,840	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,122,342	31,085	8,801	774,150	41,734	7,600	90
91	EMERGENCY	3,197,768	56,633	198,965	680,203	36,726	14,060	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	1,590,190	16,953	276	296,296	13,282	5,700	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	119,763,706	2,338,904	6,245,098	12,844,999	732,470	463,972	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,384					190
192	PHYSICIANS' PRIVATE OFFICES	225,030	203,599	67,344			380	192
194	OTHER NON REIM COST CENTER	73,078		1,953				194

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	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	
194.01	RETAIL PHARMACY	304,656			42,062	1,684		194.01
194.03	ADVERTISING EXPENSE	396,189	4,809		1,490		2,660	194.03
194.04	REGENCY HOSPITAL	23,376	89,235				45,219	194.04
194.05	UNUSED SPACE		17,860					194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	120,786,035	2,660,791	6,314,395	12,888,551	734,154	512,231	202

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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	533,692						5.02
5.03	ADMITTING	9,217	1,248,109					5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE			12,885				5.04
5.05	OTHER ADMIN & GENERAL	65,159			21,292,105	21,292,105		5.05
6	MAINTENANCE & REPAIRS	96,512			8,190,039	1,752,701	9,942,740	6
7	OPERATION OF PLANT	25,422			2,142,545	458,513	770,482	7
8	LAUNDRY & LINEN SERVICE	105			540,238	115,613	80,122	8
9	HOUSEKEEPING	65,645			2,500,878	535,198	65,025	9
10	DIETARY	60,231			1,588,074	339,854	589,218	10
11	CAFETERIA				1,164,609	249,231	20,310	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,997			1,587,950	339,828	135,161	13
14	CENTRAL SERVICES & SUPPLY	50			24,903	5,329	124,160	14
15	PHARMACY	4,417			2,227,889	476,777	181,230	15
16	MEDICAL RECORDS & LIBRARY	671			1,713,188	366,629	164,305	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	36,053	139,252	1,434	16,231,286	3,473,569	2,602,618	30
31	INTENSIVE CARE UNIT	6,617	14,458	149	2,984,837	638,767	198,899	31
41	SUBPROVIDER - IRF	7,467	23,489	242	3,901,957	835,034	617,008	41
43	NURSERY		3,243	33	411,537	88,071		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	77,375	109,490	1,127	7,359,923	1,575,053	1,109,924	50
51	RECOVERY ROOM	190	8,063	83	441,490	94,481	46,272	51
52	DELIVERY ROOM & LABOR ROOM		7,147	74	915,767	195,978	90,175	52
53	ANESTHESIOLOGY	889	16,267	168	442,408	94,677	17,162	53
54	RADIOLOGY-DIAGNOSTIC	6,245	71,997	741	3,107,781	665,078	408,326	54
54.01	ULTRASOUND	528	14,671	151	545,887	116,822	24,913	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	652	28,457	293	736,926	157,705	86,384	56
57	CT SCAN	1,912	93,175	959	1,296,283	277,410	124,905	57
59	CARDIAC CATHETERIZATION	5,364	56,642	583	3,121,671	668,050	243,513	59
60	LABORATORY	10,187	198,716	2,079	5,095,818	1,090,525	517,084	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,299	9,915	102	1,060,196	226,886	43,463	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	1,689	38,627	398	1,079,371	230,990	35,880	63.02
65	RESPIRATORY THERAPY	998	31,722	327	1,715,014	367,020	78,362	65
66	PHYSICAL THERAPY	1,837	30,380	313	2,262,792	484,247	272,048	66
67	OCCUPATIONAL THERAPY	1,247	20,056	207	1,513,973	323,996	9,579	67
68	SPEECH PATHOLOGY	758	4,445	46	492,422	105,380	22,848	68
70	ELECTROENCEPHALOGRAPHY	833	15,106	156	342,106	73,212	173,242	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		32,551	335	3,436,600	735,446		71
72	IMPL. DEV. CHARGED TO PATIENTS		28,831	297	3,888,438	832,141		72
73	DRUGS CHARGED TO PATIENTS		100,152	1,031	4,307,746	921,875		73
74	RENAL DIALYSIS		8,079	83	569,658	121,909	18,753	74
75.01	ONCOLOGY	390	3,068	32	156,074	33,400	33,105	75.01
76.97	CARDIAC REHABILITATION	384	1,684	17	614,681	131,544	205,195	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	12,344	6,137	63	2,004,256	428,919	193,653	90
91	EMERGENCY	9,756	124,295	1,280	4,319,686	924,430	352,813	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	6,772	7,994	82	1,937,545	414,642	105,610	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	521,212	1,248,109	12,885	119,266,547	20,966,930	9,761,747	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				6,384	1,366	39,773	190
192	PHYSICIANS' PRIVATE OFFICES	11,135			507,488	108,604		192
194	OTHER NON REIM COST CENTER	272			75,303	16,115		194

KPMG LLP

COMPU-MAX

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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	
194.01	RETAIL PHARMACY				348,402	74,559		194.01
194.03	ADVERTISING EXPENSE	1,073			406,221	86,933	29,957	194.03
194.04	REGENCY HOSPITAL				157,830	33,776		194.04
194.05	UNUSED SPACE				17,860	3,822	111,263	194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	533,692	1,248,109	12,885	120,786,035	21,292,105	9,942,740	202

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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	3,371,540						7
8	LAUNDRY & LINEN SERVICE	27,768	763,741					8
9	HOUSEKEEPING	22,536		3,123,637				9
10	DIETARY	204,208		192,059	2,913,413			10
11	CAFETERIA	7,039		6,620		1,447,809		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	46,843		44,056		30,090	2,183,928	13
14	CENTRAL SERVICES & SUPPLY	43,031		40,471				14
15	PHARMACY	62,810		59,073		39,565		15
16	MEDICAL RECORDS & LIBRARY	56,944		53,556		3,936		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	902,003	274,497	848,337	1,940,352	446,219	967,307	30
31	INTENSIVE CARE UNIT	68,934	38,024	64,832	183,757	64,006	138,732	31
41	SUBPROVIDER - IRF	213,840	55,297	201,117	546,472	87,380	189,421	41
43	NURSERY					9,563	20,738	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	384,672	76,688	361,786		102,303	221,751	50
51	RECOVERY ROOM	16,037	19,148	15,083		9,096	19,727	51
52	DELIVERY ROOM & LABOR ROOM	31,252		29,393		21,039	83,316	52
53	ANESTHESIOLOGY	5,948		5,594		17,392		53
54	RADIOLOGY-DIAGNOSTIC	141,516	17,786	133,096		71,034		54
54.01	ULTRASOUND	8,634	10,768	8,121		9,563		54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	29,938	5,528	28,157		10,319		56
57	CT SCAN	43,289		40,713		13,188		57
59	CARDIAC CATHETERIZATION	84,396	23,715	79,374		30,291	65,672	59
60	LABORATORY	179,209		168,546		90,471		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	15,063		14,167		4,648		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	12,435	7,403	11,695		26,577		63.02
65	RESPIRATORY THERAPY	27,158		25,542		43,078		65
66	PHYSICAL THERAPY	94,285	16,023	88,676		27,800		66
67	OCCUPATIONAL THERAPY	3,320		3,122		16,124		67
68	SPEECH PATHOLOGY	7,919		7,448		4,581		68
70	ELECTROENCEPHALOGRAPHY	60,041	8,028	56,469		6,961		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	6,499		6,113				74
75.01	ONCOLOGY	11,473		10,791		3,291		75.01
76.97	CARDIAC REHABILITATION	71,116	7,691	66,885		14,945	32,411	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	67,115	3,044	63,122		109,153	236,622	90
91	EMERGENCY	122,276	151,197	115,001	3,975	96,054	208,231	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	36,602		34,424		34,739		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,116,149	714,837	2,883,439	2,674,556	1,443,406	2,183,928	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,784		12,964				190
192	PHYSICIANS' PRIVATE OFFICES							192
194	OTHER NON REIM COST CENTER							194

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COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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	
194.01	RETAIL PHARMACY					4,403		194.01
194.03	ADVERTISING EXPENSE	10,382		9,765				194.03
194.04	REGENCY HOSPITAL	192,664	48,904	181,202	238,857			194.04
194.05	UNUSED SPACE	38,561		36,267				194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,371,540	763,741	3,123,637	2,913,413	1,447,809	2,183,928	202

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	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	237,894						14
15	PHARMACY		3,047,344					15
16	MEDICAL RECORDS & LIBRARY			2,358,558				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			263,154	27,949,342		27,949,342	30
31	INTENSIVE CARE UNIT			27,322	4,408,110		4,408,110	31
41	SUBPROVIDER - IRF			44,388	6,691,914		6,691,914	41
43	NURSERY			6,128	536,037		536,037	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			206,910	11,399,010		11,399,010	50
51	RECOVERY ROOM			15,236	676,570		676,570	51
52	DELIVERY ROOM & LABOR ROOM			13,507	1,380,427		1,380,427	52
53	ANESTHESIOLOGY			30,741	613,922		613,922	53
54	RADIOLOGY-DIAGNOSTIC			136,058	4,680,675		4,680,675	54
54.01	ULTRASOUND			27,725	752,433		752,433	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE			53,778	1,108,735		1,108,735	56
57	CT SCAN			176,079	1,971,867		1,971,867	57
59	CARDIAC CATHETERIZATION			107,040	4,423,722		4,423,722	59
60	LABORATORY			375,451	7,517,104		7,517,104	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			18,737	1,383,160		1,383,160	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB			72,995	1,477,346		1,477,346	63.02
65	RESPIRATORY THERAPY			59,946	2,316,120		2,316,120	65
66	PHYSICAL THERAPY			57,412	3,303,283		3,303,283	66
67	OCCUPATIONAL THERAPY			37,902	1,908,016		1,908,016	67
68	SPEECH PATHOLOGY			8,401	648,999		648,999	68
70	ELECTROENCEPHALOGRAPHY			28,546	748,605		748,605	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,948		61,514	4,340,508		4,340,508	71
72	IMPL. DEV. CHARGED TO PATIENTS	130,946		54,483	4,906,008		4,906,008	72
73	DRUGS CHARGED TO PATIENTS		3,047,344	189,263	8,466,228		8,466,228	73
74	RENAL DIALYSIS			15,268	738,200		738,200	74
75.01	ONCOLOGY			5,798	253,932		253,932	75.01
76.97	CARDIAC REHABILITATION			3,182	1,147,650		1,147,650	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			11,598	3,117,482		3,117,482	90
91	EMERGENCY			234,889	6,528,552		6,528,552	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			15,107	2,578,669		2,578,669	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	237,894	3,047,344	2,358,558	117,972,626		117,972,626	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				74,271		74,271	190
192	PHYSICIANS' PRIVATE OFFICES				616,092		616,092	192
194	OTHER NON REIM COST CENTER				91,418		91,418	194

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
194.01	RETAIL PHARMACY				427,364		427,364	194.01
194.03	ADVERTISING EXPENSE				543,258		543,258	194.03
194.04	REGENCY HOSPITAL				853,233		853,233	194.04
194.05	UNUSED SPACE				207,773		207,773	194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	237,894	3,047,344	2,358,558	120,786,035		120,786,035	202

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	2A	4.01	5.01	
	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		15,735		15,735	15,735		4.01
5.01	NONPATIENT TELEPHONES		4,972	37,938	42,910		42,910	5.01
5.02	PURCHASING RECEIVING & STORES		42,925	2,304	45,229	167	318	5.02
5.03	ADMITTING		17,746	1,030	18,776	512	668	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE		4,494		4,494			5.04
5.05	OTHER ADMIN & GENERAL		459,748	456,558	916,306	863	11,651	5.05
6	MAINTENANCE & REPAIRS		226,328	250,339	476,667	365	223	6
7	OPERATION OF PLANT		123,678	110,562	234,240	146	509	7
8	LAUNDRY & LINEN SERVICE		12,861	642	13,503	56	64	8
9	HOUSEKEEPING		10,438	20,841	31,279	941	382	9
10	DIETARY		94,581	46,487	141,068	349	796	10
11	CAFETERIA		3,260		3,260	471		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		21,696	70,016	91,712	247	318	13
14	CENTRAL SERVICES & SUPPLY		19,930		19,930		350	14
15	PHARMACY		29,091	243,846	272,937	324	828	15
16	MEDICAL RECORDS & LIBRARY		26,374	4,438	30,812	32	1,178	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		417,772	538,618	956,390	3,658	4,998	30
31	INTENSIVE CARE UNIT		31,927	158,308	190,235	525	637	31
41	SUBPROVIDER - IRF		99,042	79,057	178,099	716	1,050	41
43	NURSERY			2,899	2,899	78		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		178,165	1,299,287	1,477,452	838	2,610	50
51	RECOVERY ROOM		7,428	7,485	14,913	75	127	51
52	DELIVERY ROOM & LABOR ROOM		14,475		14,475	172		52
53	ANESTHESIOLOGY		2,755	116,437	119,192	143	191	53
54	RADIOLOGY-DIAGNOSTIC		65,544	744,695	810,239	582	1,560	54
54.01	ULTRASOUND		3,999	57,710	61,709	78	414	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE		13,866	63,649	77,515	85	286	56
57	CT SCAN		20,050	556,455	576,505	108	286	57
59	CARDIAC CATHETERIZATION		39,089	658,906	697,995	248	1,178	59
60	LABORATORY		83,002	159,678	242,680	741	2,324	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		6,977	16,481	23,458	38	223	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		5,760	184,975	190,735	218	605	63.02
65	RESPIRATORY THERAPY		12,579	51,898	64,477	353	1,496	65
66	PHYSICAL THERAPY		43,669	15,375	59,044	228	159	66
67	OCCUPATIONAL THERAPY		1,538	1,969	3,507	132	64	67
68	SPEECH PATHOLOGY		3,668	13,634	17,302	38		68
70	ELECTROENCEPHALOGRAPHY		27,809	38,306	66,115	57	509	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		3,010		3,010			74
75.01	ONCOLOGY		5,314	1,443	6,757	27		75.01
76.97	CARDIAC REHABILITATION		32,938	24,790	57,728	122	573	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		31,085	8,801	39,886	894	637	90
91	EMERGENCY		56,633	198,965	255,598	787	1,178	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		16,953	276	17,229	285	477	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,338,904	6,245,098	8,584,002	15,699	38,867	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,384		6,384			190
192	PHYSICIANS' PRIVATE OFFICES		203,599	67,344	270,943		32	192
194	OTHER NON REIM COST CENTER			1,953	1,953			194

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	2A	4.01	5.01	
194.01	RETAIL PHARMACY					36		194.01
194.03	ADVERTISING EXPENSE		4,809		4,809		223	194.03
194.04	REGENCY HOSPITAL		89,235		89,235		3,788	194.04
194.05	UNUSED SPACE		17,860		17,860			194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		2,660,791	6,314,395	8,975,186	15,735	42,910	202

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	OPERATION OF PLANT	
		5.02	5.03	5.04	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	45,714						5.02
5.03	ADMITTING	789	20,745					5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE			4,494				5.04
5.05	OTHER ADMIN & GENERAL	5,581			934,401			5.05
6	MAINTENANCE & REPAIRS	8,269			76,921	562,445		6
7	OPERATION OF PLANT	2,178			20,123	43,585	300,781	7
8	LAUNDRY & LINEN SERVICE	9			5,074	4,532	2,477	8
9	HOUSEKEEPING	5,623			23,488	3,678	2,010	9
10	DIETARY	5,159			14,915	33,331	18,218	10
11	CAFETERIA				10,938	1,149	628	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	171			14,914	7,646	4,179	13
14	CENTRAL SERVICES & SUPPLY	4			234	7,024	3,839	14
15	PHARMACY	378			20,924	10,252	5,603	15
16	MEDICAL RECORDS & LIBRARY	57			16,090	9,294	5,080	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,088	2,319	506	152,403	147,224	80,471	30
31	INTENSIVE CARE UNIT	567	241	53	28,034	11,251	6,150	31
41	SUBPROVIDER - IRF	640	391	85	36,647	34,903	19,077	41
43	NURSERY		54	12	3,865			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,628	1,824	398	69,124	62,787	34,317	50
51	RECOVERY ROOM	16	134	29	4,146	2,618	1,431	51
52	DELIVERY ROOM & LABOR ROOM		119	26	8,601	5,101	2,788	52
53	ANESTHESIOLOGY	76	271	59	4,155	971	531	53
54	RADIOLOGY-DIAGNOSTIC	535	1,199	262	29,188	23,098	12,625	54
54.01	ULTRASOUND	45	244	53	5,127	1,409	770	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	56	474	103	6,921	4,887	2,671	56
57	CT SCAN	164	1,552	339	12,175	7,066	3,862	57
59	CARDIAC CATHETERIZATION	459	943	206	29,319	13,775	7,529	59
60	LABORATORY	873	3,269	682	47,860	29,251	15,988	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	111	165	36	9,957	2,459	1,344	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	145	643	140	10,137	2,030	1,109	63.02
65	RESPIRATORY THERAPY	85	528	115	16,107	4,433	2,423	65
66	PHYSICAL THERAPY	157	506	110	21,252	15,389	8,411	66
67	OCCUPATIONAL THERAPY	107	334	73	14,219	542	296	67
68	SPEECH PATHOLOGY	65	74	16	4,625	1,292	706	68
70	ELECTROENCEPHALOGRAPHY	71	252	55	3,213	9,800	5,356	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		542	118	32,277			71
72	IMPL. DEV. CHARGED TO PATIENTS		480	105	36,520			72
73	DRUGS CHARGED TO PATIENTS		1,668	364	40,458			73
74	RENAL DIALYSIS		135	29	5,350	1,061	580	74
75.01	ONCOLOGY	33	51	11	1,466	1,873	1,024	75.01
76.97	CARDIAC REHABILITATION	33	28	6	5,773	11,608	6,344	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,057	102	22	18,824	10,955	5,987	90
91	EMERGENCY	836	2,070	452	40,570	19,958	10,908	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	580	133	29	18,197	5,974	3,265	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	44,645	20,745	4,494	920,131	552,206	277,997	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				60	2,250	1,230	190
192	PHYSICIANS' PRIVATE OFFICES	954			4,766			192
194	OTHER NON REIM COST CENTER	23			707			194

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	6	7	
194.01	RETAIL PHARMACY				3,272			194.01
194.03	ADVERTISING EXPENSE	92			3,815	1,695	926	194.03
194.04	REGENCY HOSPITAL				1,482		17,188	194.04
194.05	UNUSED SPACE				168	6,294	3,440	194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	45,714	20,745	4,494	934,401	562,445	300,781	202

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
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	25,715						8
9	HOUSEKEEPING		67,401					9
10	DIETARY		4,144	217,980				10
11	CAFETERIA		143		16,589			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		951		345	120,483		13
14	CENTRAL SERVICES & SUPPLY		873				32,254	14
15	PHARMACY		1,275		453			15
16	MEDICAL RECORDS & LIBRARY		1,156		45			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	9,241	18,303	145,176	5,112	53,364		30
31	INTENSIVE CARE UNIT	1,280	1,399	13,749	733	7,654		31
41	SUBPROVIDER - IRF	1,862	4,340	40,887	1,001	10,450		41
43	NURSERY				110	1,144		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,582	7,807		1,172	12,234		50
51	RECOVERY ROOM	645	325		104	1,088		51
52	DELIVERY ROOM & LABOR ROOM		634		241	4,596		52
53	ANESTHESIOLOGY		121		199			53
54	RADIOLOGY-DIAGNOSTIC	599	2,872		814			54
54.01	ULTRASOUND	363	175		110			54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	186	608		118			56
57	CT SCAN		879		151			57
59	CARDIAC CATHETERIZATION	798	1,713		347	3,623		59
60	LABORATORY		3,637		1,037			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		306		53			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	249	252		305			63.02
65	RESPIRATORY THERAPY		551		494			65
66	PHYSICAL THERAPY	540	1,913		319			66
67	OCCUPATIONAL THERAPY		67		185			67
68	SPEECH PATHOLOGY		161		52			68
70	ELECTROENCEPHALOGRAPHY	270	1,218		80			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						14,499	71
72	IMPL. DEV. CHARGED TO PATIENTS						17,755	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		132					74
75.01	ONCOLOGY		233		38			75.01
76.97	CARDIAC REHABILITATION	259	1,443		171	1,788		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	103	1,362		1,251	13,054		90
91	EMERGENCY	5,091	2,481	297	1,101	11,488		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		743		398			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,068	62,217	200,109	16,539	120,483	32,254	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		280					190
192	PHYSICIANS' PRIVATE OFFICES							192
194	OTHER NON REIM COST CENTER							194

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
194.01	RETAIL PHARMACY				50			194.01
194.03	ADVERTISING EXPENSE		211					194.03
194.04	REGENCY HOSPITAL	1,647	3,910	17,871				194.04
194.05	UNUSED SPACE		783					194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	25,715	67,401	217,980	16,589	120,483	32,254	202

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		15	16	24	25	26		
	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	312,974						15
16	MEDICAL RECORDS & LIBRARY		63,744					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		7,127	1,589,380		1,589,380		30
31	INTENSIVE CARE UNIT		740	263,248		263,248		31
41	SUBPROVIDER - IRF		1,202	331,350		331,350		41
43	NURSERY		166	8,328		8,328		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		5,604	1,685,377		1,685,377		50
51	RECOVERY ROOM		413	26,064		26,064		51
52	DELIVERY ROOM & LABOR ROOM		366	37,119		37,119		52
53	ANESTHESIOLOGY		833	126,742		126,742		53
54	RADIOLOGY-DIAGNOSTIC		3,685	887,258		887,258		54
54.01	ULTRASOUND		751	71,248		71,248		54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE		1,456	95,366		95,366		56
57	CT SCAN		4,769	607,856		607,856		57
59	CARDIAC CATHETERIZATION		2,899	761,032		761,032		59
60	LABORATORY		10,032	358,374		358,374		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		507	38,657		38,657		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		1,977	208,545		208,545		63.02
65	RESPIRATORY THERAPY		1,624	92,686		92,686		65
66	PHYSICAL THERAPY		1,555	109,583		109,583		66
67	OCCUPATIONAL THERAPY		1,027	20,553		20,553		67
68	SPEECH PATHOLOGY		228	24,559		24,559		68
70	ELECTROENCEPHALOGRAPHY		773	87,769		87,769		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,666	49,102		49,102		71
72	IMPL. DEV. CHARGED TO PATIENTS		1,476	56,336		56,336		72
73	DRUGS CHARGED TO PATIENTS	312,974	5,126	360,590		360,590		73
74	RENAL DIALYSIS		414	10,711		10,711		74
75.01	ONCOLOGY		157	11,670		11,670		75.01
76.97	CARDIAC REHABILITATION		86	85,962		85,962		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		314	94,448		94,448		90
91	EMERGENCY		6,362	359,177		359,177		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		409	47,719		47,719		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	312,974	63,744	8,506,809		8,506,809		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			10,204		10,204		190
192	PHYSICIANS' PRIVATE OFFICES			276,695		276,695		192
194	OTHER NON REIM COST CENTER			2,683		2,683		194

KPMG LLP

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		15	16	24	25	26		
194.01	RETAIL PHARMACY			3,358		3,358		194.01
194.03	ADVERTISING EXPENSE			11,771		11,771		194.03
194.04	REGENCY HOSPITAL			135,121		135,121		194.04
194.05	UNUSED SPACE			28,545		28,545		194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	312,974	63,744	8,975,186		8,975,186		202

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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	489,700						1
2	CAP REL COSTS-MVBLE EQUIP		3,501,864					2
4	EMPLOYEE BENEFITS DEPARTMENT			49,175,521				4
4.01	MAINTENANCE OF PERSONNEL	2,896		391,037	86,338			4.01
5.01	NONPATIENT TELEPHONES	915	21,040			1,348		5.01
5.02	PURCHASING RECEIVING & STORES	7,900	1,278	301,564	919	10	1,334,027	5.02
5.03	ADMITTING	3,266	571	900,283	2,811	21	23,038	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE	827						5.04
5.05	OTHER ADMIN & GENERAL	84,614	253,200	4,213,673	4,733	366	162,872	5.05
6	MAINTENANCE & REPAIRS	41,654	138,834	1,196,817	2,003	7	241,246	6
7	OPERATION OF PLANT	22,762	61,316	433,444	803	16	63,546	7
8	LAUNDRY & LINEN SERVICE	2,367	356	89,742	307	2	263	8
9	HOUSEKEEPING	1,921	11,558	1,613,129	5,161	12	164,088	9
10	DIETARY	17,407	25,781	643,364	1,917	25	150,554	10
11	CAFETERIA	600		867,189	2,584			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,993	38,830	1,124,519	1,353	10	4,992	13
14	CENTRAL SERVICES & SUPPLY	3,668				11	125	14
15	PHARMACY	5,354	135,233	1,545,637	1,779	26	11,042	15
16	MEDICAL RECORDS & LIBRARY	4,854	2,461	103,639	177	37	1,677	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	76,888	298,709	10,599,623	20,064	157	90,119	30
31	INTENSIVE CARE UNIT	5,876	87,795	1,947,117	2,878	20	16,539	31
41	SUBPROVIDER - IRF	18,228	43,844	2,041,849	3,929	33	18,664	41
43	NURSERY		1,608	285,135	430			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	32,790	720,564	2,966,795	4,600	82	193,407	50
51	RECOVERY ROOM	1,367	4,151	300,667	409	4	475	51
52	DELIVERY ROOM & LABOR ROOM	2,664		628,911	946			52
53	ANESTHESIOLOGY	507	64,574	141,515	782	6	2,222	53
54	RADIOLOGY-DIAGNOSTIC	12,063	412,996	1,600,083	3,194	49	15,609	54
54.01	ULTRASOUND	736	32,005	352,234	430	13	1,319	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	2,552	35,299	468,492	464	9	1,629	56
57	CT SCAN	3,690	308,601	383,361	593	9	4,780	57
59	CARDIAC CATHETERIZATION	7,194	365,419	1,019,360	1,362	37	13,407	59
60	LABORATORY	15,276	88,555	2,059,892	4,068	73	25,464	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,284	9,140	132,944	209	7	3,246	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	1,060	102,584	626,337	1,195	19	4,223	63.02
65	RESPIRATORY THERAPY	2,315	28,782	1,174,651	1,937	47	2,495	65
66	PHYSICAL THERAPY	8,037	8,527	891,761	1,250	5	4,592	66
67	OCCUPATIONAL THERAPY	283	1,092	408,108	725	2	3,118	67
68	SPEECH PATHOLOGY	675	7,561	179,502	206		1,895	68
70	ELECTROENCEPHALOGRAPHY	5,118	21,244	157,178	313	16	2,083	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	554						74
75.01	ONCOLOGY	978	800	100,684	148		975	75.01
76.97	CARDIAC REHABILITATION	6,062	13,748	439,621	672	18	961	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	5,721	4,881	2,953,722	4,908	20	30,855	90
91	EMERGENCY	10,423	110,343	2,595,272	4,319	37	24,387	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	3,120	153	1,130,500	1,562	15	16,927	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	430,459	3,463,433	49,009,351	86,140	1,221	1,302,834	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,175						190
192	PHYSICIANS' PRIVATE OFFICES	37,471	37,348			1	27,833	192

KPMG LLP

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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	
194	OTHER NON REIM COST CENTER		1,083				679	194
194.01	RETAIL PHARMACY			160,485	198			194.01
194.03	ADVERTISING EXPENSE	885		5,685		7	2,681	194.03
194.04	REGENCY HOSPITAL	16,423				119		194.04
194.05	UNUSED SPACE	3,287						194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,660,791	6,314,395	12,888,551	734,154	512,231	533,692	202
203	UNIT COST MULT-WS B PT I	5.433512	1.803153	0.262093	8.503255	379.993323	0.400061	203
204	COST TO BE ALLOC PER B PT II				15,735	42,910	45,714	204
205	UNIT COST MULT-WS B PT II				0.182249	31.832344	0.034268	205

KPMG LLP

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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	377,990,256						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE		377,990,256					5.04
5.05	OTHER ADMIN & GENERAL			-21,292,105	99,493,930			5.05
6	MAINTENANCE & REPAIRS				8,190,039	293,734		6
7	OPERATION OF PLANT				2,142,545	22,762	287,395	7
8	LAUNDRY & LINEN SERVICE				540,238	2,367	2,367	8
9	HOUSEKEEPING				2,500,878	1,921	1,921	9
10	DIETARY				1,588,074	17,407	17,407	10
11	CAFETERIA				1,164,609	600	600	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				1,587,950	3,993	3,993	13
14	CENTRAL SERVICES & SUPPLY				24,903	3,668	3,668	14
15	PHARMACY				2,227,889	5,354	5,354	15
16	MEDICAL RECORDS & LIBRARY				1,713,188	4,854	4,854	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	42,172,141	42,172,141		16,231,286	76,888	76,888	30
31	INTENSIVE CARE UNIT	4,378,571	4,378,571		2,984,837	5,876	5,876	31
41	SUBPROVIDER - IRF	7,113,420	7,113,420		3,901,957	18,228	18,228	41
43	NURSERY	982,000	982,000		411,537			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	33,158,700	33,158,700		7,359,923	32,790	32,790	50
51	RECOVERY ROOM	2,441,709	2,441,709		441,490	1,367	1,367	51
52	DELIVERY ROOM & LABOR ROOM	2,164,545	2,164,545		915,767	2,664	2,664	52
53	ANESTHESIOLOGY	4,926,510	4,926,510		442,408	507	507	53
54	RADIOLOGY-DIAGNOSTIC	21,804,202	21,804,202		3,107,781	12,063	12,063	54
54.01	ULTRASOUND	4,443,034	4,443,034		545,887	736	736	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	8,618,195	8,618,195		736,926	2,552	2,552	56
57	CT SCAN	28,217,715	28,217,715		1,296,283	3,690	3,690	57
59	CARDIAC CATHETERIZATION	17,153,899	17,153,899		3,121,671	7,194	7,194	59
60	LABORATORY	60,184,566	60,184,566		5,095,818	15,276	15,276	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,002,731	3,002,731		1,060,196	1,284	1,284	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	11,697,962	11,697,962		1,079,371	1,060	1,060	63.02
65	RESPIRATORY THERAPY	9,606,786	9,606,786		1,715,014	2,315	2,315	65
66	PHYSICAL THERAPY	9,200,617	9,200,617		2,262,792	8,037	8,037	66
67	OCCUPATIONAL THERAPY	6,074,022	6,074,022		1,513,973	283	283	67
68	SPEECH PATHOLOGY	1,346,261	1,346,261		492,422	675	675	68
70	ELECTROENCEPHALOGRAPHY	4,574,727	4,574,727		342,106	5,118	5,118	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,858,027	9,858,027		3,436,600			71
72	IMPL. DEV. CHARGED TO PATIENTS	8,731,289	8,731,289		3,888,438			72
73	DRUGS CHARGED TO PATIENTS	30,330,664	30,330,664		4,307,746			73
74	RENAL DIALYSIS	2,446,772	2,446,772		569,658	554	554	74
75.01	ONCOLOGY	929,165	929,165		156,074	978	978	75.01
76.97	CARDIAC REHABILITATION	509,978	509,978		614,681	6,062	6,062	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,858,692	1,858,692		2,004,256	5,721	5,721	90
91	EMERGENCY	37,642,415	37,642,415		4,319,686	10,423	10,423	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	2,420,941	2,420,941		1,937,545	3,120	3,120	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	377,990,256	377,990,256	-21,292,105	97,974,442	288,387	265,625	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				6,384	1,175	1,175	190
192	PHYSICIANS' PRIVATE OFFICES				507,488			192

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COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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	
194	OTHER NON REIM COST CENTER				75,303			194
194.01	RETAIL PHARMACY				348,402			194.01
194.03	ADVERTISING EXPENSE				406,221	885	885	194.03
194.04	REGENCY HOSPITAL				157,830		16,423	194.04
194.05	UNUSED SPACE				17,860	3,287	3,287	194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,248,109	12,885		21,292,105	9,942,740	3,371,540	202
203	UNIT COST MULT-WS B PT I	0.003302	0.000034		0.214004	33.849469	11.731380	203
204	COST TO BE ALLOC PER B PT II	20,745	4,494		934,401	562,445	300,781	204
205	UNIT COST MULT-WS B PT II	0.000055	0.000012		0.009392	1.914811	1.046577	205

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	190,656						8
9	HOUSEKEEPING		283,107					9
10	DIETARY		17,407	137,793				10
11	CAFETERIA		600		65,100			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		3,993		1,353	942,213		13
14	CENTRAL SERVICES & SUPPLY		3,668				7,011,322	14
15	PHARMACY		5,354		1,779			15
16	MEDICAL RECORDS & LIBRARY		4,854		177			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	68,524	76,888	91,771	20,064	417,326		30
31	INTENSIVE CARE UNIT	9,492	5,876	8,691	2,878	59,853		31
41	SUBPROVIDER - IRF	13,804	18,228	25,846	3,929	81,722		41
43	NURSERY				430	8,947		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	19,144	32,790		4,600	95,670		50
51	RECOVERY ROOM	4,780	1,367		409	8,511		51
52	DELIVERY ROOM & LABOR ROOM		2,664		946	35,945		52
53	ANESTHESIOLOGY		507		782			53
54	RADIOLOGY-DIAGNOSTIC	4,440	12,063		3,194			54
54.01	ULTRASOUND	2,688	736		430			54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	1,380	2,552		464			56
57	CT SCAN		3,690		593			57
59	CARDIAC CATHETERIZATION	5,920	7,194		1,362	28,333		59
60	LABORATORY		15,276		4,068			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		1,284		209			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	1,848	1,060		1,195			63.02
65	RESPIRATORY THERAPY		2,315		1,937			65
66	PHYSICAL THERAPY	4,000	8,037		1,250			66
67	OCCUPATIONAL THERAPY		283		725			67
68	SPEECH PATHOLOGY		675		206			68
70	ELECTROENCEPHALOGRAPHY	2,004	5,118		313			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						3,152,012	71
72	IMPL. DEV. CHARGED TO PATIENTS						3,859,310	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		554					74
75.01	ONCOLOGY		978		148			75.01
76.97	CARDIAC REHABILITATION	1,920	6,062		672	13,983		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	760	5,721		4,908	102,086		90
91	EMERGENCY	37,744	10,423	188	4,319	89,837		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		3,120		1,562			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	178,448	261,337	126,496	64,902	942,213	7,011,322	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,175					190
192	PHYSICIANS' PRIVATE OFFICES							192

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY				198			194.01
194.03	ADVERTISING EXPENSE		885					194.03
194.04	REGENCY HOSPITAL	12,208	16,423	11,297				194.04
194.05	UNUSED SPACE		3,287					194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	763,741	3,123,637	2,913,413	1,447,809	2,183,928	237,894	202
203	UNIT COST MULT-WS B PT I	4.005859	11.033415	21.143404	22.239770	2.317871	0.033930	203
204	COST TO BE ALLOC PER B PT II	25,715	67,401	217,980	16,589	120,483	32,254	204
205	UNIT COST MULT-WS B PT II	0.134876	0.238076	1.581938	0.254823	0.127872	0.004600	205

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE					
		15	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	10,000						15
16	MEDICAL RECORDS & LIBRARY		377,990,256					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		42,172,141					30
31	INTENSIVE CARE UNIT		4,378,571					31
41	SUBPROVIDER - IRF		7,113,420					41
43	NURSERY		982,000					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		33,158,700					50
51	RECOVERY ROOM		2,441,709					51
52	DELIVERY ROOM & LABOR ROOM		2,164,545					52
53	ANESTHESIOLOGY		4,926,510					53
54	RADIOLOGY-DIAGNOSTIC		21,804,202					54
54.01	ULTRASOUND		4,443,034					54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE		8,618,195					56
57	CT SCAN		28,217,715					57
59	CARDIAC CATHETERIZATION		17,153,899					59
60	LABORATORY		60,184,566					60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		3,002,731					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		11,697,962					63.02
65	RESPIRATORY THERAPY		9,606,786					65
66	PHYSICAL THERAPY		9,200,617					66
67	OCCUPATIONAL THERAPY		6,074,022					67
68	SPEECH PATHOLOGY		1,346,261					68
70	ELECTROENCEPHALOGRAPHY		4,574,727					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		9,858,027					71
72	IMPL. DEV. CHARGED TO PATIENTS		8,731,289					72
73	DRUGS CHARGED TO PATIENTS	10,000	30,330,664					73
74	RENAL DIALYSIS		2,446,772					74
75.01	ONCOLOGY		929,165					75.01
76.97	CARDIAC REHABILITATION		509,978					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		1,858,692					90
91	EMERGENCY		37,642,415					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		2,420,941					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	377,990,256					118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE					
		15	16					
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
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,047,344	2,358,558					202
203	UNIT COST MULT-WS B PT I	304.734400	0.006240					203
204	COST TO BE ALLOC PER B PT II	312,974	63,744					204
205	UNIT COST MULT-WS B PT II	31.297400	0.000169					205

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPU-MAX

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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 DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	27,949,342		27,949,342	3,378	27,952,720	30
31	INTENSIVE CARE UNIT	4,408,110		4,408,110	13,363	4,421,473	31
41	SUBPROVIDER - IRF	6,691,914		6,691,914		6,691,914	41
43	NURSERY	536,037		536,037		536,037	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	11,399,010		11,399,010	18,979	11,417,989	50
51	RECOVERY ROOM	676,570		676,570		676,570	51
52	DELIVERY ROOM & LABOR ROOM	1,380,427		1,380,427		1,380,427	52
53	ANESTHESIOLOGY	613,922		613,922		613,922	53
54	RADIOLOGY-DIAGNOSTIC	4,680,675		4,680,675		4,680,675	54
54.01	ULTRASOUND	752,433		752,433		752,433	54.01
54.02	AUDIOLOGY						54.02
56	RADIOISOTOPE	1,108,735		1,108,735		1,108,735	56
57	CT SCAN	1,971,867		1,971,867		1,971,867	57
59	CARDIAC CATHETERIZATION	4,423,722		4,423,722	21,755	4,445,477	59
60	LABORATORY	7,517,104		7,517,104	11,651	7,528,755	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,383,160		1,383,160		1,383,160	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,477,346		1,477,346		1,477,346	63.02
65	RESPIRATORY THERAPY	2,316,120		2,316,120	4,423	2,320,543	65
66	PHYSICAL THERAPY	3,303,283		3,303,283	18,635	3,321,918	66
67	OCCUPATIONAL THERAPY	1,908,016		1,908,016		1,908,016	67
68	SPEECH PATHOLOGY	648,999		648,999		648,999	68
70	ELECTROENCEPHALOGRAPHY	748,605		748,605	113	748,718	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,340,508		4,340,508		4,340,508	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,906,008		4,906,008		4,906,008	72
73	DRUGS CHARGED TO PATIENTS	8,466,228		8,466,228		8,466,228	73
74	RENAL DIALYSIS	738,200		738,200		738,200	74
75.01	ONCOLOGY	253,932		253,932		253,932	75.01
76.97	CARDIAC REHABILITATION	1,147,650		1,147,650	3,528	1,151,178	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	3,117,482		3,117,482	4,939	3,122,421	90
91	EMERGENCY	6,528,552		6,528,552	184,995	6,713,547	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,404,429		3,404,429		3,404,429	92
	OTHER REIMBURSABLE COST CENTERS						
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	2,578,669		2,578,669		2,578,669	101
200	SUBTOTAL (SEE INSTRUCTIONS)	121,377,055		121,377,055	285,759	121,662,814	200
201	LESS OBSERVATION BEDS	3,404,429		3,404,429		3,404,429	201
202	TOTAL (SEE INSTRUCTIONS)	117,972,626		117,972,626		118,258,385	202

KPMG LLP

COMPU-MAX

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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 SERV COST CENTERS							
30	ADULTS & PEDIATRICS	34,986,318		34,986,318				30
31	INTENSIVE CARE UNIT	4,378,571		4,378,571				31
41	SUBPROVIDER - IRF	7,113,420		7,113,420				41
43	NURSERY	982,000		982,000				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	12,278,509	20,880,191	33,158,700	0.343771	0.343771	0.344344	50
51	RECOVERY ROOM	977,329	1,464,380	2,441,709	0.277089	0.277089	0.277089	51
52	DELIVERY ROOM & LABOR ROOM	1,724,864	439,681	2,164,545	0.637745	0.637745	0.637745	52
53	ANESTHESIOLOGY	2,068,220	2,858,290	4,926,510	0.124616	0.124616	0.124616	53
54	RADIOLOGY-DIAGNOSTIC	6,258,548	15,545,654	21,804,202	0.214668	0.214668	0.214668	54
54.01	ULTRASOUND	891,202	3,551,832	4,443,034	0.169351	0.169351	0.169351	54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE	2,211,034	6,407,161	8,618,195	0.128650	0.128650	0.128650	56
57	CT SCAN	9,814,510	18,403,205	28,217,715	0.069880	0.069880	0.069880	57
59	CARDIAC CATHETERIZATION	9,635,721	7,518,178	17,153,899	0.257884	0.257884	0.259153	59
60	LABORATORY	25,116,307	35,068,259	60,184,566	0.124901	0.124901	0.125094	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,341,404	661,327	3,002,731	0.460634	0.460634	0.460634	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	5,004,819	6,693,143	11,697,962	0.126291	0.126291	0.126291	63.02
65	RESPIRATORY THERAPY	8,257,127	1,349,659	9,606,786	0.241092	0.241092	0.241552	65
66	PHYSICAL THERAPY	6,187,187	3,013,430	9,200,617	0.359028	0.359028	0.361054	66
67	OCCUPATIONAL THERAPY	4,917,962	1,156,060	6,074,022	0.314127	0.314127	0.314127	67
68	SPEECH PATHOLOGY	682,757	663,504	1,346,261	0.482075	0.482075	0.482075	68
70	ELECTROENCEPHALOGRAPHY	1,872,731	2,701,996	4,574,727	0.163639	0.163639	0.163664	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,464,105	4,393,922	9,858,027	0.440302	0.440302	0.440302	71
72	IMPL. DEV. CHARGED TO PATIENTS	6,551,664	2,179,625	8,731,289	0.561888	0.561888	0.561888	72
73	DRUGS CHARGED TO PATIENTS	19,715,406	10,615,258	30,330,664	0.279131	0.279131	0.279131	73
74	RENAL DIALYSIS	2,293,556	153,216	2,446,772	0.301704	0.301704	0.301704	74
75.01	ONCOLOGY	6,303	922,862	929,165	0.273291	0.273291	0.273291	75.01
76.97	CARDIAC REHABILITATION	156,766	353,212	509,978	2.250391	2.250391	2.257309	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	16,461	1,842,231	1,858,692	1.677245	1.677245	1.679902	90
91	EMERGENCY	9,415,468	28,226,947	37,642,415	0.173436	0.173436	0.178351	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	416,276	6,769,547	7,185,823	0.473770	0.473770	0.473770	92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		2,420,941	2,420,941				101
200	SUBTOTAL (SEE INSTRUCTIONS)	191,736,545	186,253,711	377,990,256				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	191,736,545	186,253,711	377,990,256				202

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COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] PPS**
[XX] TITLE XVIII, PART A **[ ] TEFRA**
[ ] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,589,380		1,589,380	28,721	55.34	10,449	578,248	30
31	INTENSIVE CARE UNIT	263,248		263,248	2,352	111.93	1,066	119,317	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	331,350		331,350	8,806	37.63	7,058	265,593	41
42	SUBPROVIDER I								42
43	NURSERY	8,328		8,328	981	8.49			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,192,306		2,192,306	40,860		18,573	963,158	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,685,377	33,158,700	0.050828	4,779,087	242,911	50
51	RECOVERY ROOM	26,064	2,441,709	0.010674	345,696	3,690	51
52	DELIVERY ROOM & LABOR ROOM	37,119	2,164,545	0.017149	9,840	169	52
53	ANESTHESIOLOGY	126,742	4,926,510	0.025727	767,826	19,754	53
54	RADIOLOGY-DIAGNOSTIC	887,258	21,804,202	0.040692	2,261,088	92,008	54
54.01	ULTRASOUND	71,248	4,443,034	0.016036	305,792	4,904	54.01
54.02	AUDIOLOGY						54.02
56	RADIOISOTOPE	95,366	8,618,195	0.011066	910,426	10,075	56
57	CT SCAN	607,856	28,217,715	0.021542	3,629,545	78,188	57
59	CARDIAC CATHETERIZATION	761,032	17,153,899	0.044365	5,134,646	227,799	59
60	LABORATORY	358,374	60,184,566	0.005955	9,213,923	54,869	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,657	3,002,731	0.012874	882,801	11,365	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,545	11,697,962	0.017827	2,299,397	40,991	63.02
65	RESPIRATORY THERAPY	92,686	9,606,786	0.009648	3,552,745	34,277	65
66	PHYSICAL THERAPY	109,583	9,200,617	0.011910	978,575	11,655	66
67	OCCUPATIONAL THERAPY	20,553	6,074,022	0.003384	484,992	1,641	67
68	SPEECH PATHOLOGY	24,559	1,346,261	0.018242	156,525	2,855	68
70	ELECTROENCEPHALOGRAPHY	87,769	4,574,727	0.019186	415,161	7,965	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,102	9,858,027	0.004981	2,785,117	13,873	71
72	IMPL. DEV. CHARGED TO PATIENTS	56,336	8,731,289	0.006452	3,709,784	23,936	72
73	DRUGS CHARGED TO PATIENTS	360,590	30,330,664	0.011889	6,406,177	76,163	73
74	RENAL DIALYSIS	10,711	2,446,772	0.004378	1,076,466	4,713	74
75.01	ONCOLOGY	11,670	929,165	0.012560			75.01
76.97	CARDIAC REHABILITATION	85,962	509,978	0.168560	77,691	13,096	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	94,448	1,858,692	0.050814			90
91	EMERGENCY	359,177	37,642,415	0.009542	3,212,557	30,654	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	193,576	7,185,823	0.026939	211,124	5,687	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,460,360	328,109,006		53,606,981	1,013,238	200

(A) Worksheet A line numbers

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COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV 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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	28,721		10,449		30
31	INTENSIVE CARE UNIT	2,352		1,066		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	8,806		7,058		41
42	SUBPROVIDER I					42
43	NURSERY	981				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	40,860		18,573		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0008** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD 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
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

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COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0008** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		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	33,158,700			4,779,087		8,712,594		50
51	RECOVERY ROOM	2,441,709			345,696		248,471		51
52	DELIVERY ROOM & LABOR ROOM	2,164,545			9,840				52
53	ANESTHESIOLOGY	4,926,510			767,826		634,158		53
54	RADIOLOGY-DIAGNOSTIC	21,804,202			2,261,088		4,002,123		54
54.01	ULTRASOUND	4,443,034			305,792		432,555		54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	8,618,195			910,426		2,259,547		56
57	CT SCAN	28,217,715			3,629,545		4,769,947		57
59	CARDIAC CATHETERIZATION	17,153,899			5,134,646		3,930,452		59
60	LABORATORY	60,184,566			9,213,923		2,354,035		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,002,731			882,801		188,876		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,697,962			2,299,397		3,058,673		63.02
65	RESPIRATORY THERAPY	9,606,786			3,552,745		461,893		65
66	PHYSICAL THERAPY	9,200,617			978,575		29,238		66
67	OCCUPATIONAL THERAPY	6,074,022			484,992				67
68	SPEECH PATHOLOGY	1,346,261			156,525		70,039		68
70	ELECTROENCEPHALOGRAPHY	4,574,727			415,161		858,146		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,858,027			2,785,117		2,071,533		71
72	IMPL. DEV. CHARGED TO PATIENTS	8,731,289			3,709,784		858,843		72
73	DRUGS CHARGED TO PATIENTS	30,330,664			6,406,177		4,872,057		73
74	RENAL DIALYSIS	2,446,772			1,076,466		139,217		74
75.01	ONCOLOGY	929,165					451,480		75.01
76.97	CARDIAC REHABILITATION	509,978			77,691		147,956		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,858,692					208,617		90
91	EMERGENCY	37,642,415			3,212,557		4,153,687		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	7,185,823			211,124		1,864,465		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	328,109,006			53,606,981		46,778,602		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-0008** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[XX] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF
[ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			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	0.343771	8,712,594			2,995,137			50
51	RECOVERY ROOM	0.277089	248,471			68,849			51
52	DELIVERY ROOM & LABOR ROOM	0.637745							52
53	ANESTHESIOLOGY	0.124616	634,158			79,026			53
54	RADIOLOGY-DIAGNOSTIC	0.214668	4,002,123			859,128			54
54.01	ULTRASOUND	0.169351	432,555			73,254			54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	0.128650	2,259,547			290,691			56
57	CT SCAN	0.069880	4,769,947			333,324			57
59	CARDIAC CATHETERIZATION	0.257884	3,930,452			1,013,601			59
60	LABORATORY	0.124901	2,354,035			294,021			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634	188,876			87,003			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.126291	3,058,673			386,283			63.02
65	RESPIRATORY THERAPY	0.241092	461,893			111,359			65
66	PHYSICAL THERAPY	0.359028	29,238			10,497			66
67	OCCUPATIONAL THERAPY	0.314127							67
68	SPEECH PATHOLOGY	0.482075	70,039			33,764			68
70	ELECTROENCEPHALOGRAPHY	0.163639	858,146			140,426			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302	2,071,533			912,100			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888	858,843			482,574			72
73	DRUGS CHARGED TO PATIENTS	0.279131	4,872,057		46,438	1,359,942		12,962	73
74	RENAL DIALYSIS	0.301704	139,217			42,002			74
75.01	ONCOLOGY	0.273291	451,480			123,385			75.01
76.97	CARDIAC REHABILITATION	2.250391	147,956			332,959			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.677245	208,617			349,902			90
91	EMERGENCY	0.173436	4,153,687			720,399			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770	1,864,465			883,328			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		46,778,602		46,438	11,982,954		12,962	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		46,778,602		46,438	11,982,954		12,962	202

(A) Worksheet A line numbers

KPMG LLP

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-T008** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,685,377	33,158,700	0.050828	71,334	3,626	50
51	RECOVERY ROOM	26,064	2,441,709	0.010674	9,498	101	51
52	DELIVERY ROOM & LABOR ROOM	37,119	2,164,545	0.017149			52
53	ANESTHESIOLOGY	126,742	4,926,510	0.025727	18,244	469	53
54	RADIOLOGY-DIAGNOSTIC	887,258	21,804,202	0.040692	363,218	14,780	54
54.01	ULTRASOUND	71,248	4,443,034	0.016036	21,318	342	54.01
54.02	AUDIOLOGY						54.02
56	RADIOISOTOPE	95,366	8,618,195	0.011066	62,317	690	56
57	CT SCAN	607,856	28,217,715	0.021542	293,692	6,327	57
59	CARDIAC CATHETERIZATION	761,032	17,153,899	0.044365	94,733	4,203	59
60	LABORATORY	358,374	60,184,566	0.005955	1,665,665	9,919	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,657	3,002,731	0.012874	119,224	1,535	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,545	11,697,962	0.017827	371,644	6,625	63.02
65	RESPIRATORY THERAPY	92,686	9,606,786	0.009648	750,522	7,241	65
66	PHYSICAL THERAPY	109,583	9,200,617	0.011910	3,345,146	39,841	66
67	OCCUPATIONAL THERAPY	20,553	6,074,022	0.003384	3,221,444	10,901	67
68	SPEECH PATHOLOGY	24,559	1,346,261	0.018242	299,182	5,458	68
70	ELECTROENCEPHALOGRAPHY	87,769	4,574,727	0.019186	612,033	11,742	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,102	9,858,027	0.004981	620,067	3,089	71
72	IMPL. DEV. CHARGED TO PATIENTS	56,336	8,731,289	0.006452	67,641	436	72
73	DRUGS CHARGED TO PATIENTS	360,590	30,330,664	0.011889	2,867,192	34,088	73
74	RENAL DIALYSIS	10,711	2,446,772	0.004378	350,112	1,533	74
75.01	ONCOLOGY	11,670	929,165	0.012560			75.01
76.97	CARDIAC REHABILITATION	85,962	509,978	0.168560	221	37	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	94,448	1,858,692	0.050814	366	19	90
91	EMERGENCY	359,177	37,642,415	0.009542	22,676	216	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		7,185,823				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,266,784	328,109,006		15,247,489	163,218	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST (1)	NURSING SCHOOL (2)	ALLIED HEALTH (3)	ALL OTHER MEDICAL EDUCATION COST (4)	TOTAL COST (sum of col. 1 through col. 4) (5)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) (6)	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD 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
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		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	33,158,700			71,334				50
51	RECOVERY ROOM	2,441,709			9,498				51
52	DELIVERY ROOM & LABOR ROOM	2,164,545							52
53	ANESTHESIOLOGY	4,926,510			18,244				53
54	RADIOLOGY-DIAGNOSTIC	21,804,202			363,218		6,390		54
54.01	ULTRASOUND	4,443,034			21,318				54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	8,618,195			62,317				56
57	CT SCAN	28,217,715			293,692				57
59	CARDIAC CATHETERIZATION	17,153,899			94,733				59
60	LABORATORY	60,184,566			1,665,665				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,002,731			119,224				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,697,962			371,644		205		63.02
65	RESPIRATORY THERAPY	9,606,786			750,522				65
66	PHYSICAL THERAPY	9,200,617			3,345,146				66
67	OCCUPATIONAL THERAPY	6,074,022			3,221,444				67
68	SPEECH PATHOLOGY	1,346,261			299,182				68
70	ELECTROENCEPHALOGRAPHY	4,574,727			612,033		9,097		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,858,027			620,067		4,149		71
72	IMPL. DEV. CHARGED TO PATIENTS	8,731,289			67,641				72
73	DRUGS CHARGED TO PATIENTS	30,330,664			2,867,192		3,969		73
74	RENAL DIALYSIS	2,446,772			350,112				74
75.01	ONCOLOGY	929,165							75.01
76.97	CARDIAC REHABILITATION	509,978			221				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,858,692			366				90
91	EMERGENCY	37,642,415			22,676				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	7,185,823							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	328,109,006			15,247,489		23,810		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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/MR

			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	0.343771							50
51	RECOVERY ROOM	0.277089							51
52	DELIVERY ROOM & LABOR ROOM	0.637745							52
53	ANESTHESIOLOGY	0.124616							53
54	RADIOLOGY-DIAGNOSTIC	0.214668	6,390			1,372			54
54.01	ULTRASOUND	0.169351							54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	0.128650							56
57	CT SCAN	0.069880							57
59	CARDIAC CATHETERIZATION	0.257884							59
60	LABORATORY	0.124901							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.126291	205			26			63.02
65	RESPIRATORY THERAPY	0.241092							65
66	PHYSICAL THERAPY	0.359028							66
67	OCCUPATIONAL THERAPY	0.314127							67
68	SPEECH PATHOLOGY	0.482075							68
70	ELECTROENCEPHALOGRAPHY	0.163639	9,097			1,489			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302	4,149			1,827			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888							72
73	DRUGS CHARGED TO PATIENTS	0.279131	3,969		2,906	1,108		811	73
74	RENAL DIALYSIS	0.301704							74
75.01	ONCOLOGY	0.273291							75.01
76.97	CARDIAC REHABILITATION	2.250391							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.677245							90
91	EMERGENCY	0.173436							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		23,810		2,906	5,822		811	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		23,810		2,906	5,822		811	202

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V [XX] PPS**
[ ] TITLE XVIII, PART A [ ] TEFRA
[XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,589,380		1,589,380	28,721	55.34	4,268	236,191	30
31	INTENSIVE CARE UNIT	263,248		263,248	2,352	111.93	394	44,100	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	331,350		331,350	8,806	37.63	496	18,664	41
42	SUBPROVIDER I								42
43	NURSERY	8,328		8,328	981	8.49	204	1,732	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,192,306		2,192,306	40,860		5,362	300,687	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,685,377	33,158,700	0.050828	1,685,536	85,672	50
51	RECOVERY ROOM	26,064	2,441,709	0.010674	81,059	865	51
52	DELIVERY ROOM & LABOR ROOM	37,119	2,164,545	0.017149	88,519	1,518	52
53	ANESTHESIOLOGY	126,742	4,926,510	0.025727	211,476	5,441	53
54	RADIOLOGY-DIAGNOSTIC	887,258	21,804,202	0.040692	859,308	34,967	54
54.01	ULTRASOUND	71,248	4,443,034	0.016036	100,505	1,612	54.01
54.02	AUDIOLOGY						54.02
56	RADIOISOTOPE	95,366	8,618,195	0.011066	346,906	3,839	56
57	CT SCAN	607,856	28,217,715	0.021542	1,329,042	28,630	57
59	CARDIAC CATHETERIZATION	761,032	17,153,899	0.044365	346,500	15,372	59
60	LABORATORY	358,374	60,184,566	0.005955	3,596,064	21,415	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,657	3,002,731	0.012874	148,644	1,914	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,545	11,697,962	0.017827	988,525	17,622	63.02
65	RESPIRATORY THERAPY	92,686	9,606,786	0.009648	713,710	6,886	65
66	PHYSICAL THERAPY	109,583	9,200,617	0.011910	264,292	3,148	66
67	OCCUPATIONAL THERAPY	20,553	6,074,022	0.003384	137,871	467	67
68	SPEECH PATHOLOGY	24,559	1,346,261	0.018242	53,433	975	68
70	ELECTROENCEPHALOGRAPHY	87,769	4,574,727	0.019186	184,756	3,545	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,102	9,858,027	0.004981	968,129	4,822	71
72	IMPL. DEV. CHARGED TO PATIENTS	56,336	8,731,289	0.006452	543,893	3,509	72
73	DRUGS CHARGED TO PATIENTS	360,590	30,330,664	0.011889	3,148,192	37,429	73
74	RENAL DIALYSIS	10,711	2,446,772	0.004378	269,041	1,178	74
75.01	ONCOLOGY	11,670	929,165	0.012560			75.01
76.97	CARDIAC REHABILITATION	85,962	509,978	0.168560	23,606	3,979	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	94,448	1,858,692	0.050814	2,562	130	90
91	EMERGENCY	359,177	37,642,415	0.009542	1,386,234	13,227	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	193,576	7,185,823	0.026939	49,060	1,322	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,460,360	328,109,006		17,526,863	299,484	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: **[ ] TITLE V [XX] PPS**
[ ] TITLE XVIII, PART A [ ] TEFRA
[XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV 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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS; [ ] TITLE XVIII, PART A [ ] TEFRA; [XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	28,721		4,268		30
31	INTENSIVE CARE UNIT	2,352		394		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	8,806		496		41
42	SUBPROVIDER I					42
43	NURSERY	981		204		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	40,860		5,362		200

(A) Worksheet A line numbers

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0008** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD 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
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-0008** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		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	33,158,700			1,685,536				50
51	RECOVERY ROOM	2,441,709			81,059				51
52	DELIVERY ROOM & LABOR ROOM	2,164,545			88,519				52
53	ANESTHESIOLOGY	4,926,510			211,476				53
54	RADIOLOGY-DIAGNOSTIC	21,804,202			859,308				54
54.01	ULTRASOUND	4,443,034			100,505				54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	8,618,195			346,906				56
57	CT SCAN	28,217,715			1,329,042				57
59	CARDIAC CATHETERIZATION	17,153,899			346,500				59
60	LABORATORY	60,184,566			3,596,064				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,002,731			148,644				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,697,962			988,525				63.02
65	RESPIRATORY THERAPY	9,606,786			713,710				65
66	PHYSICAL THERAPY	9,200,617			264,292				66
67	OCCUPATIONAL THERAPY	6,074,022			137,871				67
68	SPEECH PATHOLOGY	1,346,261			53,433				68
70	ELECTROENCEPHALOGRAPHY	4,574,727			184,756				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,858,027			968,129				71
72	IMPL. DEV. CHARGED TO PATIENTS	8,731,289			543,893				72
73	DRUGS CHARGED TO PATIENTS	30,330,664			3,148,192				73
74	RENAL DIALYSIS	2,446,772			269,041				74
75.01	ONCOLOGY	929,165							75.01
76.97	CARDIAC REHABILITATION	509,978			23,606				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,858,692			2,562				90
91	EMERGENCY	37,642,415			1,386,234				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	7,185,823			49,060				92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	328,109,006			17,526,863				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-0008** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[ ] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF
[XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			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	0.343771							50
51	RECOVERY ROOM	0.277089							51
52	DELIVERY ROOM & LABOR ROOM	0.637745							52
53	ANESTHESIOLOGY	0.124616							53
54	RADIOLOGY-DIAGNOSTIC	0.214668							54
54.01	ULTRASOUND	0.169351							54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	0.128650							56
57	CT SCAN	0.069880							57
59	CARDIAC CATHETERIZATION	0.257884							59
60	LABORATORY	0.124901							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.126291							63.02
65	RESPIRATORY THERAPY	0.241092							65
66	PHYSICAL THERAPY	0.359028							66
67	OCCUPATIONAL THERAPY	0.314127							67
68	SPEECH PATHOLOGY	0.482075							68
70	ELECTROENCEPHALOGRAPHY	0.163639							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888							72
73	DRUGS CHARGED TO PATIENTS	0.279131							73
74	RENAL DIALYSIS	0.301704							74
75.01	ONCOLOGY	0.273291							75.01
76.97	CARDIAC REHABILITATION	2.250391							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.677245							90
91	EMERGENCY	0.173436							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770							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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-T008** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES:
[ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX
[ ] HOSPITAL [ ] IPF [XX] IRF
[ ] SUB (OTHER)
[XX] PPS [ ] TEFRA

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,685,377	33,158,700	0.050828	22,576	1,147	50
51	RECOVERY ROOM	26,064	2,441,709	0.010674	1,824	19	51
52	DELIVERY ROOM & LABOR ROOM	37,119	2,164,545	0.017149			52
53	ANESTHESIOLOGY	126,742	4,926,510	0.025727	2,828	73	53
54	RADIOLOGY-DIAGNOSTIC	887,258	21,804,202	0.040692	16,512	672	54
54.01	ULTRASOUND	71,248	4,443,034	0.016036	1,300	21	54.01
54.02	AUDIOLOGY						54.02
56	RADIOISOTOPE	95,366	8,618,195	0.011066			56
57	CT SCAN	607,856	28,217,715	0.021542	18,597	401	57
59	CARDIAC CATHETERIZATION	761,032	17,153,899	0.044365			59
60	LABORATORY	358,374	60,184,566	0.005955	113,056	673	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,657	3,002,731	0.012874	2,040	26	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	208,545	11,697,962	0.017827	2,952	53	63.02
65	RESPIRATORY THERAPY	92,686	9,606,786	0.009648	53,219	513	65
66	PHYSICAL THERAPY	109,583	9,200,617	0.011910	296,685	3,534	66
67	OCCUPATIONAL THERAPY	20,553	6,074,022	0.003384	292,319	989	67
68	SPEECH PATHOLOGY	24,559	1,346,261	0.018242	64,798	1,182	68
70	ELECTROENCEPHALOGRAPHY	87,769	4,574,727	0.019186	82,443	1,582	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,102	9,858,027	0.004981	27,546	137	71
72	IMPL. DEV. CHARGED TO PATIENTS	56,336	8,731,289	0.006452	2,206	14	72
73	DRUGS CHARGED TO PATIENTS	360,590	30,330,664	0.011889	326,966	3,887	73
74	RENAL DIALYSIS	10,711	2,446,772	0.004378	51,876	227	74
75.01	ONCOLOGY	11,670	929,165	0.012560	1,540	19	75.01
76.97	CARDIAC REHABILITATION	85,962	509,978	0.168560			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	94,448	1,858,692	0.050814			90
91	EMERGENCY	359,177	37,642,415	0.009542			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		7,185,823				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,266,784	328,109,006		1,381,283	15,169	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	RADIOISOTOPE							56
57	CT SCAN							57
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD 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
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	33,158,700			22,576				50
51	RECOVERY ROOM	2,441,709			1,824				51
52	DELIVERY ROOM & LABOR ROOM	2,164,545							52
53	ANESTHESIOLOGY	4,926,510			2,828				53
54	RADIOLOGY-DIAGNOSTIC	21,804,202			16,512				54
54.01	ULTRASOUND	4,443,034			1,300				54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	8,618,195							56
57	CT SCAN	28,217,715			18,597				57
59	CARDIAC CATHETERIZATION	17,153,899							59
60	LABORATORY	60,184,566			113,056				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,002,731			2,040				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,697,962			2,952				63.02
65	RESPIRATORY THERAPY	9,606,786			53,219				65
66	PHYSICAL THERAPY	9,200,617			296,685				66
67	OCCUPATIONAL THERAPY	6,074,022			292,319				67
68	SPEECH PATHOLOGY	1,346,261			64,798				68
70	ELECTROENCEPHALOGRAPHY	4,574,727			82,443				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,858,027			27,546				71
72	IMPL. DEV. CHARGED TO PATIENTS	8,731,289			2,206				72
73	DRUGS CHARGED TO PATIENTS	30,330,664			326,966				73
74	RENAL DIALYSIS	2,446,772			51,876				74
75.01	ONCOLOGY	929,165			1,540				75.01
76.97	CARDIAC REHABILITATION	509,978							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,858,692							90
91	EMERGENCY	37,642,415							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	7,185,823							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	328,109,006			1,381,283				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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 [XX] TITLE XIX - O/P [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			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	0.343771							50
51	RECOVERY ROOM	0.277089							51
52	DELIVERY ROOM & LABOR ROOM	0.637745							52
53	ANESTHESIOLOGY	0.124616							53
54	RADIOLOGY-DIAGNOSTIC	0.214668							54
54.01	ULTRASOUND	0.169351							54.01
54.02	AUDIOLOGY								54.02
56	RADIOISOTOPE	0.128650							56
57	CT SCAN	0.069880							57
59	CARDIAC CATHETERIZATION	0.257884							59
60	LABORATORY	0.124901							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.126291							63.02
65	RESPIRATORY THERAPY	0.241092							65
66	PHYSICAL THERAPY	0.359028							66
67	OCCUPATIONAL THERAPY	0.314127							67
68	SPEECH PATHOLOGY	0.482075							68
70	ELECTROENCEPHALOGRAPHY	0.163639							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888							72
73	DRUGS CHARGED TO PATIENTS	0.279131							73
74	RENAL DIALYSIS	0.301704							74
75.01	ONCOLOGY	0.273291							75.01
76.97	CARDIAC REHABILITATION	2.250391							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.677245							90
91	EMERGENCY	0.173436							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770							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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	28,721	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	28,721	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)	25,223	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	10,449	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	27,952,720	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	27,952,720	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 - line 36)	27,952,720	37

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	973.25	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	10,169,489	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)	10,169,489	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	4,421,473	2,352	1,879.88	1,066	2,003,952	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 (Worksheet D-3, column 3, line 200)	13,710,948	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	25,884,389	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	697,565	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	1,013,238	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	1,710,803	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	24,173,586	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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0008** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					3,498	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					973.25	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					3,404,429	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,589,380	27,952,720	0.056860	3,404,429	193,576	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	8,806	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	8,806	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	8,806	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	7,058	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	6,691,914	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	6,691,914	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 - line 36)	6,691,914	37

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	759.93	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	5,363,586	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)	5,363,586	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	4,341,899	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	9,705,485	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	265,593	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	163,218	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	428,811	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	9,276,674	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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	28,721	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	28,721	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)	25,223	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	4,268	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 Title XIX only)	981	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	204	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)	27,952,720	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	27,952,720	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 - line 36)	27,952,720	37

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	973.25	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	4,153,831	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	4,153,831	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)	536,037	981	546.42	204	111,470	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,421,473	2,352	1,879.88	394	740,673	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 (Worksheet D-3, column 3, line 200)	4,144,617	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	9,150,591	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	282,023	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	299,484	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	581,507	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	8,569,084	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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-0008** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					3,498	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 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] TITLE XVIII, PART A [XX] TITLE XIX - I/P | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	8,806	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	8,806	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	8,806	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	496	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	6,691,914	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	6,691,914	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 - line 36)	6,691,914	37

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] TITLE XVIII, PART A [XX] TITLE XIX - I/P [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	759.93	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	376,925	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)	376,925	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	406,388	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	783,313	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	18,664	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	15,169	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	33,833	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	749,480	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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES:
[ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF [XX] PPS
[XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] SWING BED NF [ ] TEFRA
[ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		13,014,009		30
31	INTENSIVE CARE UNIT		2,096,545		31
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.344344	4,779,087	1,645,650	50
51	RECOVERY ROOM	0.277089	345,696	95,789	51
52	DELIVERY ROOM & LABOR ROOM	0.637745	9,840	6,275	52
53	ANESTHESIOLOGY	0.124616	767,826	95,683	53
54	RADIOLOGY-DIAGNOSTIC	0.214668	2,261,088	485,383	54
54.01	ULTRASOUND	0.169351	305,792	51,786	54.01
54.02	AUDIOLOGY				54.02
56	RADIOISOTOPE	0.128650	910,426	117,126	56
57	CT SCAN	0.069880	3,629,545	253,633	57
59	CARDIAC CATHETERIZATION	0.259153	5,134,646	1,330,659	59
60	LABORATORY	0.125094	9,213,923	1,152,606	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634	882,801	406,648	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.126291	2,299,397	290,393	63.02
65	RESPIRATORY THERAPY	0.241552	3,552,745	858,173	65
66	PHYSICAL THERAPY	0.361054	978,575	353,318	66
67	OCCUPATIONAL THERAPY	0.314127	484,992	152,349	67
68	SPEECH PATHOLOGY	0.482075	156,525	75,457	68
70	ELECTROENCEPHALOGRAPHY	0.163664	415,161	67,947	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302	2,785,117	1,226,293	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888	3,709,784	2,084,483	72
73	DRUGS CHARGED TO PATIENTS	0.279131	6,406,177	1,788,163	73
74	RENAL DIALYSIS	0.301704	1,076,466	324,774	74
75.01	ONCOLOGY	0.273291			75.01
76.97	CARDIAC REHABILITATION	2.257309	77,691	175,373	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.679902			90
91	EMERGENCY	0.178351	3,212,557	572,963	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770	211,124	100,024	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		53,606,981	13,710,948	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		53,606,981		202

(A) Worksheet A line numbers

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF		5,612,634		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.344344	71,334	24,563	50
51	RECOVERY ROOM	0.277089	9,498	2,632	51
52	DELIVERY ROOM & LABOR ROOM	0.637745			52
53	ANESTHESIOLOGY	0.124616	18,244	2,273	53
54	RADIOLOGY-DIAGNOSTIC	0.214668	363,218	77,971	54
54.01	ULTRASOUND	0.169351	21,318	3,610	54.01
54.02	AUDIOLOGY				54.02
56	RADIOISOTOPE	0.128650	62,317	8,017	56
57	CT SCAN	0.069880	293,692	20,523	57
59	CARDIAC CATHETERIZATION	0.259153	94,733	24,550	59
60	LABORATORY	0.125094	1,665,665	208,365	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634	119,224	54,919	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.126291	371,644	46,935	63.02
65	RESPIRATORY THERAPY	0.241552	750,522	181,290	65
66	PHYSICAL THERAPY	0.361054	3,345,146	1,207,778	66
67	OCCUPATIONAL THERAPY	0.314127	3,221,444	1,011,943	67
68	SPEECH PATHOLOGY	0.482075	299,182	144,228	68
70	ELECTROENCEPHALOGRAPHY	0.163664	612,033	100,168	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302	620,067	273,017	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888	67,641	38,007	72
73	DRUGS CHARGED TO PATIENTS	0.279131	2,867,192	800,322	73
74	RENAL DIALYSIS	0.301704	350,112	105,630	74
75.01	ONCOLOGY	0.273291			75.01
76.97	CARDIAC REHABILITATION	2.257309	221	499	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.679902	366	615	90
91	EMERGENCY	0.178351	22,676	4,044	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		15,247,489	4,341,899	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		15,247,489		202

(A) Worksheet A line numbers

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		6,461,482		30
31	INTENSIVE CARE UNIT		617,098		31
41	SUBPROVIDER - IRF				41
43	NURSERY		215,600		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.344344	1,685,536	580,404	50
51	RECOVERY ROOM	0.277089	81,059	22,461	51
52	DELIVERY ROOM & LABOR ROOM	0.637745	88,519	56,453	52
53	ANESTHESIOLOGY	0.124616	211,476	26,353	53
54	RADIOLOGY-DIAGNOSTIC	0.214668	859,308	184,466	54
54.01	ULTRASOUND	0.169351	100,505	17,021	54.01
54.02	AUDIOLOGY				54.02
56	RADIOISOTOPE	0.128650	346,906	44,629	56
57	CT SCAN	0.069880	1,329,042	92,873	57
59	CARDIAC CATHETERIZATION	0.259153	346,500	89,797	59
60	LABORATORY	0.125094	3,596,064	449,846	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634	148,644	68,470	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.126291	988,525	124,842	63.02
65	RESPIRATORY THERAPY	0.241552	713,710	172,398	65
66	PHYSICAL THERAPY	0.361054	264,292	95,424	66
67	OCCUPATIONAL THERAPY	0.314127	137,871	43,309	67
68	SPEECH PATHOLOGY	0.482075	53,433	25,759	68
70	ELECTROENCEPHALOGRAPHY	0.163664	184,756	30,238	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302	968,129	426,269	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888	543,893	305,607	72
73	DRUGS CHARGED TO PATIENTS	0.279131	3,148,192	878,758	73
74	RENAL DIALYSIS	0.301704	269,041	81,171	74
75.01	ONCOLOGY	0.273291			75.01
76.97	CARDIAC REHABILITATION	2.257309	23,606	53,286	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.679902	2,562	4,304	90
91	EMERGENCY	0.178351	1,386,234	247,236	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770	49,060	23,243	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		17,526,863	4,144,617	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		17,526,863		202

(A) Worksheet A line numbers

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF		501,681		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.344344	22,576	7,774	50
51	RECOVERY ROOM	0.277089	1,824	505	51
52	DELIVERY ROOM & LABOR ROOM	0.637745			52
53	ANESTHESIOLOGY	0.124616	2,828	352	53
54	RADIOLOGY-DIAGNOSTIC	0.214668	16,512	3,545	54
54.01	ULTRASOUND	0.169351	1,300	220	54.01
54.02	AUDIOLOGY				54.02
56	RADIOISOTOPE	0.128650			56
57	CT SCAN	0.069880	18,597	1,300	57
59	CARDIAC CATHETERIZATION	0.259153			59
60	LABORATORY	0.125094	113,056	14,143	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.460634	2,040	940	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.126291	2,952	373	63.02
65	RESPIRATORY THERAPY	0.241552	53,219	12,855	65
66	PHYSICAL THERAPY	0.361054	296,685	107,119	66
67	OCCUPATIONAL THERAPY	0.314127	292,319	91,825	67
68	SPEECH PATHOLOGY	0.482075	64,798	31,237	68
70	ELECTROENCEPHALOGRAPHY	0.163664	82,443	13,493	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440302	27,546	12,129	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.561888	2,206	1,240	72
73	DRUGS CHARGED TO PATIENTS	0.279131	326,966	91,266	73
74	RENAL DIALYSIS	0.301704	51,876	15,651	74
75.01	ONCOLOGY	0.273291	1,540	421	75.01
76.97	CARDIAC REHABILITATION	2.257309			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.679902			90
91	EMERGENCY	0.178351			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.473770			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,381,283	406,388	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,381,283		202

(A) Worksheet A line numbers

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

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, 2013 (see instructions)	4,943,393			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	14,559,448			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	250,199			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	151.42			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 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 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
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
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 (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.1067			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.3039			31
32	SUM OF LINES 30 AND 31	0.4106			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.2309			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,981,873			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000267556		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		2,420,413		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,810,336		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,810,336			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	23,545,249			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 SCH AND MDH ONLY (see instructions)	23,545,249			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,713,252			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part 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, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	25,258,501			59
60	PRIMARY PAYER PAYMENTS	16,701			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	25,241,800			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1,911,172			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	129,064			63
64	ALLOWABLE BAD DEBTS (see instructions)	418,196			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	271,827			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	112,794			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	23,473,391			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (ER ADJUSTMENT PER PSR)	849			70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	88,016			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-76,799			70.94
71	AMOUNT DUE PROVIDER (see instructions)	23,485,457			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	469,709			71.01
72	INTERIM PAYMENTS	22,603,294			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	412,454			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	186,775			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	12,962			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	11,982,954			2
3	PPS PAYMENTS	9,824,364			3
4	OUTLIER PAYMENT (see instructions)	47,622			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	12,962			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	46,438			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	46,438			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)	46,438			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	33,476			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	12,962			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	9,871,986			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,109,668			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	7,775,280			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)	7,775,280			30
31	PRIMARY PAYER PAYMENTS	4,589			31
32	SUBTOTAL (line 30 minus line 31)	7,770,691			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)	430,167			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	279,609			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	199,769			36
37	SUBTOTAL (see instructions)	8,050,300			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-327			38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)	8,050,627			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	161,013			40.01
41	INTERIM PAYMENTS	7,831,011			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	58,603			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	811			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	5,822			2
3	PPS PAYMENTS	1,463			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	811			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	2,906			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	2,906			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)	2,906			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	2,095			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	811			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	1,463			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	252			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,022			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)	2,022			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	2,022			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)	2,022			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)	2,022			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	40			40.01
41	INTERIM PAYMENTS	1,759			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	223			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				22,363,178		7,610,203	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO				240,116		220,808	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				22,603,294		7,831,011	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [XX] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				10,232,089		1,759	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				10,232,089		1,759	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	6,980	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	11,515	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,522	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	27,575	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	377,990,256	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	22,439,406	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,193,499	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	23,870	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,169,629	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,353,569	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-183,940	32

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOX: **[ ] HOSPITAL** **[XX] SUBPROVIDER IRF**

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	2,395,942	7,621,242	1
2	MEDICARE SSI RATIO (see instructions)	0.049000		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	148,309	321,616	3
4	OUTLIER PAYMENTS	113,862		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 CLOSUE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING 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)	24.126027		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	10,600,971		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	10,600,971		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	10,600,971		19
20	DEDUCTIBLES	132,832		20
21	SUBTOTAL (line 19 minus line 20)	10,468,139		21
22	COINSURANCE	62,712		22
23	SUBTOTAL (line 21 minus line 22)	10,405,427		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	25,501		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	16,576		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	9,019		26
27	SUBTOTAL (sum of lines 23 and 25)	10,422,003		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	10,422,003		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	208,440		32.01
33	INTERIM PAYMENTS	10,232,089		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	-18,526		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	280,611		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART 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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[XX] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[ ] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT 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	7,168,506		8
9	ANCILLARY SERVICE CHARGES	17,526,863		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)	24,695,369		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	24,695,369		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	24,695,369		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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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	SUM OF LINES 27 AND 21			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 Worksheet 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 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[ ] HOSPITAL**	**[ ] NF**	**[XX] PPS**
	[XX] TITLE XIX	**[XX] SUBPROVIDER IRF**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[ ] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT 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	500,270		8
9	ANCILLARY SERVICE CHARGES	1,381,283		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)	1,881,553		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	1,881,553		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	1,881,553		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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			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	SUM OF LINES 27 AND 21			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 Worksheet 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 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	5,992,019				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	17,423,069				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	5,082,392				7
8	PREPAID EXPENSES	2,545,981				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS	7,878,292				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	38,921,753				11
	FIXED ASSETS					
12	LAND	27,294,767				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS					15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES 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)	27,294,767				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	646,159				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	646,159				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	66,862,679				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	2,891,317				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	12,241				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	22,983,595				43
44	OTHER CURRENT LIABILITIES	10,892,405				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	36,779,558				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	1,524,750				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	1,524,750				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	38,304,308				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	28,558,371				52
53	SPECIFIC PURPOSE FUND BALANCE					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 52-58)	28,558,371				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	66,862,679				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		33,636,886			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-5,078,515			2
3	TOTAL (sun of line 1 and line 2)		28,558,371			3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS RELEASED FROM RESTRICTIO					5
6	NET ASSETS TRANSFERRED					6
7	OTHER					7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		28,558,371			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		28,558,371			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS RELEASED FROM RESTRICTIO					5
6	NET ASSETS TRANSFERRED					6
7	OTHER					7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	34,292,612		34,292,612	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	26,432,532		26,432,532	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)	60,725,144		60,725,144	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	4,597,640		4,597,640	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)	4,597,640		4,597,640	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	65,322,784		65,322,784	17
18	ANCILLARY SERVICES	122,652,466		122,652,466	18
19	OUTPATIENT SERVICES		187,595,360	187,595,360	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		2,420,942	2,420,942	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	ANESTHESIOLOGISTS REVENUE	5,186,285		5,186,285	27
27.01	PHYSICIAN REVENUE		92,132	92,132	27.01
27.02	CAPITATION		-3,129,957	-3,129,957	27.02
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	193,161,535	186,978,477	380,140,012	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		162,969,517	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)		162,969,517	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)	380,140,012	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	253,538,785	2
3	NET PATIENT REVENUES (line 1 minus line 2)	126,601,227	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	162,969,517	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-36,368,290	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	118,520	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,300	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	638,798	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	190	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	3,474	21
22	RENTAL OF HOSPITAL SPACE	1,121,608	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.01	OTHER (CAPITATION REVENUE)	24,088,659	24.01
24.02	OTHER (GRANT INCOME)	64,598	24.02
24.03	OTHER (OTHER INCOME)	3,592,860	24.03
24.04	OTHER (PHARMACY INCOME)	1,621,979	24.04
24.05	OTHER (PHO INCOME)	20,650	24.05
24.06	OTHER (GAIN ON SALE OF ASSETS)	14,340	24.06
24.07	OTHER (PHOTOCOPYING INCOME)	100	24.07
24.08	OTHER (CLASSES)	2,699	24.08
25	TOTAL OTHER INCOME (sum of lines 6-24)	31,289,775	25
26	TOTAL (line 5 plus line 25)	-5,078,515	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-5,078,515	29

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	365,820		51,695	1,089	26,156	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	686,854					6
7	PHYSICAL THERAPY				221,658		7
8	OCCUPATIONAL THERAPY				52,900		8
9	SPEECH PATHOLOGY				300		9
10	MEDICAL SOCIAL SERVICES				974		10
11	HOME HEALTH AIDE	77,826					11
12	SUPPLIES (see instructions)					104,918	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	1,130,500		51,695	276,921	131,074	24

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	444,760		444,760		444,760	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	686,854		686,854		686,854	6
7	PHYSICAL THERAPY	221,658		221,658		221,658	7
8	OCCUPATIONAL THERAPY	52,900		52,900		52,900	8
9	SPEECH PATHOLOGY	300		300		300	9
10	MEDICAL SOCIAL SERVICES	974		974		974	10
11	HOME HEALTH AIDE	77,826		77,826		77,826	11
12	SUPPLIES (see instructions)	104,918		104,918		104,918	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	1,590,190		1,590,190		1,590,190	24

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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	444,760				5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE	686,854				6
7	PHYSICAL THERAPY	221,658				7
8	OCCUPATIONAL THERAPY	52,900				8
9	SPEECH PATHOLOGY	300				9
10	MEDICAL SOCIAL SERVICES	974				10
11	HOME HEALTH AIDE	77,826				11
12	SUPPLIES (see instructions)	104,918				12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	1,590,190				24

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		444,760	444,760		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		686,854	266,699	953,553	6
7	PHYSICAL THERAPY		221,658	86,068	307,726	7
8	OCCUPATIONAL THERAPY		52,900	20,541	73,441	8
9	SPEECH PATHOLOGY		300	116	416	9
10	MEDICAL SOCIAL SERVICES		974	378	1,352	10
11	HOME HEALTH AIDE		77,826	30,219	108,045	11
12	SUPPLIES (see instructions)		104,918	40,739	145,657	12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		1,590,190		1,590,190	24

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-444,760	1,145,430	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						686,854	6
7	PHYSICAL THERAPY						221,658	7
8	OCCUPATIONAL THERAPY						52,900	8
9	SPEECH PATHOLOGY						300	9
10	MEDICAL SOCIAL SERVICES						974	10
11	HOME HEALTH AIDE						77,826	11
12	SUPPLIES (see instructions)						104,918	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					-444,760	1,145,430	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						444,760	25
26	UNIT COST MULTIPLIER						0.388291	26

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
1	ADMINISTRATIVE AND GENERAL		16,953	276	296,296	13,282	5,700	1
2	SKILLED NURSING CARE	953,553						2
3	PHYSICAL THERAPY	307,726						3
4	OCCUPATIONAL THERAPY	73,441						4
5	SPEECH PATHOLOGY	416						5
6	MEDICAL SOCIAL SERVICES	1,352						6
7	HOME HEALTH AIDE	108,045						7
8	SUPPLIES	145,657						8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	1,590,190	16,953	276	296,296	13,282	5,700	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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

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

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING & STORES	ADMITTING	CASHIERING ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMIN GENERAL	MAIN-TENANCE + REPAIRS	
		5.02	5.03	5.04	4A	5.05	6	
1	ADMINISTRATIVE AND GENERAL	6,772	7,994	82	347,355	74,335	105,610	1
2	SKILLED NURSING CARE				953,553	204,064		2
3	PHYSICAL THERAPY				307,726	65,855		3
4	OCCUPATIONAL THERAPY				73,441	15,717		4
5	SPEECH PATHOLOGY				416	89		5
6	MEDICAL SOCIAL SERVICES				1,352	289		6
7	HOME HEALTH AIDE				108,045	23,122		7
8	SUPPLIES				145,657	31,171		8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	6,772	7,994	82	1,937,545	414,642	105,610	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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

KPMG LLP

COMPU-MAX

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL	36,602		34,424		34,739		1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	36,602		34,424		34,739		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER (omit cents)	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL				15,107			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)				15,107			20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER (omit cents)	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	
		20	21	22	23	24	25	
1	ADMINISTRATIVE AND GENERAL					648,172		1
2	SKILLED NURSING CARE					1,157,617		2
3	PHYSICAL THERAPY					373,581		3
4	OCCUPATIONAL THERAPY					89,158		4
5	SPEECH PATHOLOGY					505		5
6	MEDICAL SOCIAL SERVICES					1,641		6
7	HOME HEALTH AIDE					131,167		7
8	SUPPLIES					176,828		8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)					2,578,669		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER (omit cents)	SUBTOTAL (sum of col.4A-23)	ALLOCATED HHA A&G (see Pt.2)	TOTAL HHA COSTS				
		26	27	28				
1	ADMINISTRATIVE AND GENERAL	648,172						1
2	SKILLED NURSING CARE	1,157,617	388,674	1,546,291				2
3	PHYSICAL THERAPY	373,581	125,431	499,012				3
4	OCCUPATIONAL THERAPY	89,158	29,935	119,093				4
5	SPEECH PATHOLOGY	505	170	675				5
6	MEDICAL SOCIAL SERVICES	1,641	551	2,192				6
7	HOME HEALTH AIDE	131,167	44,040	175,207				7
8	SUPPLIES	176,828	59,371	236,199				8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	2,578,669	648,172	2,578,669				20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.		0.335754					21

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

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DEPRECIATI EXPENSE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINT OF PERSONNEL FTE'S	NONPATIENT TELEPHONES NUMBER OF TELEPHONES	PURCHASING RECEIVING & STORES COSTED REQ	
		1	2	4	4.01	5.01	5.02	
1	ADMINISTRATIVE AND GENERAL	3,120	153	1,130,500	1,562	15	16,927	1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	3,120	153	1,130,500	1,562	15	16,927	20
21	TOTAL COST TO BE ALLOCATED	16,953	276	296,296	13,282	5,700	6,772	21
22	UNIT COST MULTIPLIER	5.433654		0.262093		380.000000		22
22	UNIT COST MULTIPLIER		1.803922		8.503201		0.400071	22

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER	ADMITTING GROSS REVENUE	CASHIERING ACCOUNTS RECEIVABLE GROSS REVENUE	RECON-CILIATION	OTHER ADMIN GENERAL ACCUM. COST	MAIN-TENANCE + REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.03	5.04	4A.05	5.05	6	7	
1	ADMINISTRATIVE AND GENERAL	2,420,941	2,420,941		347,355	3,120	3,120	1
2	SKILLED NURSING CARE				953,553			2
3	PHYSICAL THERAPY				307,726			3
4	OCCUPATIONAL THERAPY				73,441			4
5	SPEECH PATHOLOGY				416			5
6	MEDICAL SOCIAL SERVICES				1,352			6
7	HOME HEALTH AIDE				108,045			7
8	SUPPLIES				145,657			8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	2,420,941	2,420,941		1,937,545	3,120	3,120	20
21	TOTAL COST TO BE ALLOCATED	7,994	82		414,642	105,610	36,602	21
22	UNIT COST MULTIPLIER	0.003302				33.849359		22
22	UNIT COST MULTIPLIER		0.000034		0.214004		11.731410	22

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	
		8	9	10	11	12	13	
1	ADMINISTRATIVE AND GENERAL		3,120		1,562			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)		3,120		1,562			20
21	TOTAL COST TO BE ALLOCATED		34,424		34,739			21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER		11.033333		22.240077			22

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	
		14	15	16	17	19	20	
1	ADMINISTRATIVE AND GENERAL			2,420,941				1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)			2,420,941				20
21	TOTAL COST TO BE ALLOCATED			15,107				21
22	UNIT COST MULTIPLIER			0.006240				22
22	UNIT COST MULTIPLIER							22

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

	HHA COST CENTER	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME				
		21	22	23				
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION

	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PEr VISIT (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,546,291		1,546,291	13,378	115.58	1
2	PHYSICAL THERAPY	3	499,012		499,012	3,749	133.11	2
3	OCCUPATIONAL THERAPY	4	119,093		119,093	854	139.45	3
4	SPEECH PATHOLOGY	5	675		675	6	112.50	4
5	MEDICAL SOCIAL SERVICES	6	2,192		2,192	12	182.67	5
6	HOME HEALTH AIDE	7	175,207		175,207	4,101	42.72	6
7	TOTAL (sum of lines 1-6)		2,342,470		2,342,470	22,100		7

LIMITATION COST COMPUTATION

	PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			
			PART A	PART B		
				NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
		1	2	3	4	
8	SKILLED NURSING CARE	23844	1,753	8,547		8
9	PHYSICAL THERAPY	23844	548	2,343		9
10	OCCUPATIONAL THERAPY	23844	223	499		10
11	SPEECH PATHOLOGY	23844				11
12	MEDICAL SOCIAL SERVICES	23844	3	6		12
13	HOME HEALTH AIDE	23844	459	3,186		13
14	TOTAL (sum of lines 8-13)		2,986	14,581		14

SUPPLIES AND DRUGS COSTS COMPUTATIONS

	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	236,199		236,199	264,115	0.894304	15
16	COST OF DRUGS	9						16

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

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED	
			1	2	3	4	
1	PHYSICAL THERAPY	66	0.359028			col. 2, line 2	1
2	OCCUPATIONAL THERAPY	67	0.314127			col. 2, line 3	2
3	SPEECH PATHOLOGY	68	0.482075			col. 2, line 4	3
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.440302			col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.279131			col. 2, line 16	5

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS			COST OF SERVICES				
			PART B			PART B			
	PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL PROGRAM COST (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	1,753	8,547		202,612	987,862		1,190,474	1
2	PHYSICAL THERAPY	548	2,343		72,944	311,877		384,821	2
3	OCCUPATIONAL THERAPY	223	499		31,097	69,586		100,683	3
4	SPEECH PATHOLOGY								4
5	MEDICAL SOCIAL SERVICES	3	6		548	1,096		1,644	5
6	HOME HEALTH AIDE	459	3,186		19,608	136,106		155,714	6
7	TOTAL (sum of lines 1-6)	2,986	14,581		326,809	1,506,527		1,833,336	7

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES			
			PART B			PART B		
	OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS-URANCE	SUBJECT TO DEDUCTIBLES & COINS-URANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS-URANCE	SUBJECT TO DEDUCTIBLES & COINS-URANCE	
		6	7	8	9	10	11	
15	COST OF MEDICAL SUPPLIES							15
16	COST OF DRUGS							16

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/25/2014 Run Time: 22:49 Version: 2014.10

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

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

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

			PART B		
	DESCRIPTION	PART A 1	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES				2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE I ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to excced 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)				6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS	500	8,425		9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (see instructions)	-500	-8,425	10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	319,158	1,383,350	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	8,678	103,348	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	2,129	12,332	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	7,529	11,130	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	1,242	18,347	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES	186		16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	338,422	1,520,082	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	338,422	1,520,082	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	338,422	1,520,082	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	338,422	1,520,082	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	338,422	1,520,082	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	6,769	30,403	31.01
32	INTERIM PAYMENTS (see instructions)	331,653	1,489,679	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35

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

				PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				331,653		1,489,679	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				331,653		1,489,679	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	1,556,602	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	21,693	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)	75.55	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.1067	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.3039	8
9	SUM OF LINES 7 AND 8	0.4106	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0867	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	134,957	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,713,252	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 APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		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 (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		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	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
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
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
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

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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		
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
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202