

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report		Date: 11/25/2015 Time: 16:03	
		2. <input type="checkbox"/> Manually submitted cost report			
		3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report			
		4. <input type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.			
Contractor use only	5. <input type="checkbox"/> Cost Report Status	6. Date Received: _____		10. NPR Date: _____	
	(1) As Submitted	7. Contractor No.: _____		11. Contractor's Vendor Code: ____	
	(2) Settled without audit	8. <input type="checkbox"/> Initial Report for this Provider CCN		12. <input type="checkbox"/> If line 5, column 1 is 4:	
	(3) Settled with audit	9. <input type="checkbox"/> Final Report for this Provider CCN		Enter number of times reopened = 0-9.	
	(4) Reopened				
	(5) Amended				

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

ECR Encryption: 11/25/2015 16:03
yGOC017yj:dvk8q1MEfntFluQhwjF0
BqmV404ADmngkYwccC6qd5tt48Q7DH
rzYe15hmxD0Pg9XT

(Signed) *John R. Bell*
Officer or Administrator of Provider(s)
CEO
Title
11-30-2015
Date

PI Encryption: 11/25/2015 16:03
ST6hNNxHGYpJfbdzFlqNtes0GWt8W0
3BRkk0qxmZ:mfUuszoQALaXWgZr2vg
SfK0QKfc00Pg32J

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				TITLE XIX	
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		673,746	226,169	-136,690		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		-29,026	8			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		644,720	226,177	-136,690		200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,944	493	288	365	3,976		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	516	170	14	11	54		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
		I	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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 osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count 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 received HRSA PCRE funding (see instructions)			62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)			62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

**WORKSHEET S-2
PART I**

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

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

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
	1	2	3	4	5		
67							67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	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, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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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 applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	

Miscellaneous Cost Reporting Information

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

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 certified 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 certified 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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N	N	N	160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.50			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 / 2013	09 / 30 / 2014		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**

COMPLETED BY ALL HOSPITALS

		Y/N	Date	
Provider Organization and Operation				
1	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
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				
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N		5

		Y/N	Y/N
Approved Educational Activities			
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N	
7	Are costs claimed for allied health programs? If yes, see instructions.	N	
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N	
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N	
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N	
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	

		Y/N
Bad Debts		
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

Bed Complement	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/06/2015	Y	11/06/2015
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	
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	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information			
41	First name: JANE	Last name: BACHMANN	Title: CONSULTANT
42	Employer: BACHMANN ASSOCIATES		
43	Phone number: 3122852828	E-mail Address: JBOPIL@ATT.NET	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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			11,287	4,299	26,920	1
2	HMO and other (see instructions)						1,636	4,940		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						276	249		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			11,287	4,299	26,920	7
8	Intensive Care Unit	31	10	3,650			1,244	327	2,469	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						270	1,236	13
14	Total (see instructions)		161	58,765			12,531	4,896	30,625	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	30	10,950			7,352	516	9,018	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					14,971		22,158	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								3,792	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							230	598	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,490	988	6,639	1
2	HMO and other (see instructions)					260	1,169		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider						23		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)		807.80			2,490	988	6,639	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF		39.06			685	53	842	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		15.54						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)		862.40						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassi- fication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)		
	1	2	3	4	5	6		
SALARIES								
1	Total salaries (see instructions)	200	53,236,932	53,236,932	1,808,930.00	29.43	1	
2	Non-physician anesthetist Part A						2	
3	Non-physician anesthetest 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)		3,590,616	3,590,616	118,463.00	30.31	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		7,744,397	7,744,397	196,760.00	39.36	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)		12,609,093	12,609,093			17	
18	Wage-related costs (other)(see instructions)						18	
19	Excluded areas		911,797	911,797			19	
20	Non-physician anesthetist Part A						20	
21	Non-physician anesthetist Part B		141,910	141,910			21	
22	Physician Part A - Administrative						22	
22.01	Physician Part A - Teaching						22.01	
23	Physician Part B		307,092	307,092			23	
24	Wage-related costs (RHC/FQHC)						24	
25	Interns & residents (in an approved program)						25	
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits Department		473,504	473,504	12,881.00	36.76	26	
27	Administrative & General		5,898,628	5,898,628	176,024.00	33.51	27	
28	Administrative & General under contract (see instructions)		1,282,954	1,282,954	9,176.00	139.82	28	
29	Maintenance & Repairs		1,196,107	1,196,107	41,662.00	28.71	29	
30	Operation of Plant		558,526	558,526	16,712.00	33.42	30	
31	Laundry & Linen Service		88,412	88,412	6,382.00	13.85	31	
32	Housekeeping		1,689,164	1,689,164	107,350.00	15.74	32	
33	Housekeeping under contract (see instructions)						33	
34	Dietary		1,516,431	-861,233	655,198	39,873.00	16.43	34
35	Dietary under contract (see instructions)						35	
36	Cafeteria			861,233	861,233	53,748.00	16.02	36
37	Maintenance of Personnel						37	
38	Nursing Administration		1,103,737	1,103,737	28,138.00	39.23	38	
39	Central Services and Supply						39	
40	Pharmacy		1,578,212	1,578,212	37,006.00	42.65	40	
41	Medical Records & Medical Records Library		97,683	97,683	3,687.00	26.49	41	
42	Social Service						42	
43	Other General Service						43	

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		51,722,638	51,722,638	1,797,813.00	28.77	1
2	Excluded area salaries (see instructions)		3,590,616	3,590,616	118,463.00	30.31	2
3	Subtotal salaries (line 1 minus line 2)		48,132,022	48,132,022	1,679,350.00	28.66	3
4	Subtotal other wages & related costs (see instructions)		9,246,149	9,246,149	209,149.00	44.21	4
5	Subtotal wage-related costs (see instructions)		12,609,093	12,609,093		26.20%	5
6	Total (sum of lines 3 through 5)		69,987,264	69,987,264	1,888,499.00	37.06	6
7	Total overhead cost (see instructions)		15,483,358	15,483,358	532,639.00	29.07	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)	7,174,355	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	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	113,063	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	633,654	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	2,789,402	17
18	Medicare Taxes - Employers Portion Only	686,775	18
19	Unemployment Insurance	43,770	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	41,007	23
24	Total Wage Related cost (Sum of lines 1-23)	13,969,893	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: 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 MOonths 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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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor 1	Benefit Cost 2	
	0			
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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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		2,872		766	3,638	1
2	Unduplicated Census Count (see instructions)		336.00		218.00	554.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)		2.03		2.03
5	Other Administrative Personnel		5.16		5.16
6	Direct Nursing Service		6.88		6.88
7	Nursing Supervisor				7
8	Physical Therapy Service			1.99	1.99
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service			0.54	0.54
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service			0.10	0.10
13	Speech Pathology Supervisor				13
14	Medical Social Service		0.01	0.01	0.02
15	Medical Social Service Supervisor				15
16	Home Health Aide		1.98		1.98
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		Full Episodes				Total (columns 1 through 4)	
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes		
		1	2	3	4		
21	Skilled Nursing Visits	7,302	1,331	98	46	8,777	21
22	Skilled Nursing Visit Charges	1,170,508	213,807	15,708	7,380	1,407,403	22
23	Physical Therapy Visits	2,305	249	5	22	2,581	23
24	Physical Therapy Visit Charges	429,187	46,661	925	4,122	480,895	24
25	Occupational Therapy Visits	483	82		17	582	25
26	Occupational Therapy Visit Charges	90,359	15,382		3,189	108,930	26
27	Speech Pathology Visits	92	47		6	145	27
28	Speech Pathology Visit Charges	17,132	8,719		1,110	26,961	28
29	Medical Social Service Visits	14				14	29
30	Medical Social Service Visit Charges	2,986				2,986	30
31	Home Health Aide Visits	2,276	554	3	39	2,872	31
32	Home Health Aide Visit Charges	272,822	66,504	361	4,679	344,366	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	12,472	2,263	106	130	14,971	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	1,982,994	351,073	16,994	20,480	2,371,541	35
36	Total Number of Episodes (standard/non-outlier)	542		42	4	588	36
37	Total Number of Outlier Episodes		46		2	48	37
38	Total Non-Routine Medical Supply Charges	184,293	33,838	2,384	479	220,994	38

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.290102	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		24,424,535	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5,360,621	5
6	Medicaid charges		111,411,153	6
7	Medicaid cost (line 1 times line 6)		32,320,598	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.		2,535,442	8

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

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

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

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		6,192	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		58,269	14
15	State or local indigent care program cost (line 1 times line 14)		16,904	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.		10,712	16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		4,552	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)		2,546,154	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	18,033,813		18,033,813
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,231,645		5,231,645
22	Partial payment by patients approved for charity care	135,148		135,148
23	Cost of charity care (line 21 minus line 22)	5,096,497		5,096,497

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)		9,603,185	26
27	Medicare bad debts for the entire hospital complex (see instructions)		1,008,398	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		8,594,787	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,493,365	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		7,589,862	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,136,016	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				1,939,034	1,939,034	862,649	2,801,683	1
2	00200	Cap Rel Costs-Mvble Equip				4,053,525	4,053,525	2,289,018	6,342,543	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	81,175	28,562	109,737	13,435,076	13,544,813		13,544,813	4
4.01	00401	MAINTENANCE OF PERSONNEL	392,329	313,205	705,534	-49,268	656,266	-185	656,081	4.01
5.01	00540	NONPATIENT TELEPHONES						369,511	369,511	5.01
5.02	00560	PURCHASING RECEIVING & STORES	320,318	93,778	414,096	-7,899	406,197	-19,892	386,305	5.02
5.03	00570	ADMITTING	894,593	87,572	982,165	-36,334	945,831		945,831	5.03
5.04	00580	CASHIERING ACCOUNTS RECEIVABLE								5.04
5.05	00590	OTHER ADMIN & GENERAL	4,683,717	75,360,673	80,044,390	-17,505,902	62,538,488	-43,074,349	19,464,139	5.05
6	00600	Maintenance & Repairs	1,196,107	5,706,896	6,903,003	-55,791	6,847,212	-11,853	6,835,359	6
7	00700	Operation of Plant	558,526	1,400,616	1,959,142	-13,380	1,945,762	-41,870	1,903,892	7
8	00800	Laundry & Linen Service	88,412	508,710	597,122	-22,818	574,304	-52,626	521,678	8
9	00900	Housekeeping	1,689,164	419,053	2,108,217	-80,413	2,027,804	-1,435	2,026,369	9
10	01000	Dietary	1,516,431	1,346,390	2,862,821	-1,713,842	1,148,979		1,148,979	10
11	01100	Cafeteria				1,625,894	1,625,894	-786,581	839,313	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,103,737	222,805	1,326,542	-23,200	1,303,342	-21,677	1,281,665	13
14	01400	Central Services & Supply		5,207	5,207	-3,691	1,516		1,516	14
15	01500	Pharmacy	1,578,212	3,764,692	5,342,904	-3,556,140	1,786,764	-95	1,786,669	15
16	01600	Medical Records & Library	97,683	92,596	190,279	-3,058	187,221	1,605,347	1,792,568	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	11,928,961	2,593,342	14,522,303	-1,629,948	12,892,355	-16,363	12,875,992	30
31	03100	Intensive Care Unit	2,084,843	400,199	2,485,042	-102,321	2,382,721	-36,729	2,345,992	31
41	04100	Subprovider - IRF	2,172,496	1,185,714	3,358,210	-68,632	3,289,578		3,289,578	41
43	04300	Nursery				382,178	382,178		382,178	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	3,042,540	5,916,786	8,959,326	-3,441,243	5,518,083	-515,521	5,002,562	50
51	05100	Recovery Room	305,462	39,305	344,767	-7,540	337,227		337,227	51
52	05200	Delivery Room & Labor Room				758,181	758,181		758,181	52
53	05300	Anesthesiology	2,194,318	563,702	2,758,020	-62,723	2,695,297	-2,518,310	176,987	53
54	05400	Radiology-Diagnostic	1,615,138	278,477	1,893,615	-122,247	1,771,368	-29,833	1,741,535	54
54.01	05401	ULTRASOUND	379,414	14,852	394,266	-25,183	369,083		369,083	54.01
54.02	03040	AUDIOLOGY								54.02
56	05600	Radioisotope	458,444	309,324	767,768	-278,200	489,568		489,568	56
57	05700	CT Scan	400,711	153,564	554,275	-38,161	516,114	-751	515,363	57
59	05900	Cardiac Catheterization	1,121,812	3,912,246	5,034,058	-3,416,612	1,617,446	-8,014	1,609,432	59
60	06000	Laboratory	2,146,078	2,259,926	4,406,004	-53,350	4,352,654	-6,907	4,345,747	60
62	06200	Whole Blood & Packed Red Blood Cells	136,416	797,653	934,069	-4,297	929,772		929,772	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	06301	NONINVASIVE LAB	665,694	86,264	751,958	-45,662	706,296	-53,113	653,183	63.02
65	06500	Respiratory Therapy	1,165,009	186,832	1,351,841	-76,763	1,275,078	-10,324	1,264,754	65
66	06600	Physical Therapy	964,856	1,162,818	2,127,674	-55,470	2,072,204	-28,337	2,043,867	66
67	06700	Occupational Therapy	491,568	1,025,082	1,516,650	-12,234	1,504,416		1,504,416	67
68	06800	Speech Pathology	225,726	238,644	464,370	-3,594	460,776		460,776	68
70	07000	Electroencephalography	187,284	42,194	229,478	-7,100	222,378		222,378	70
71	07100	Medical Supplies Charged to Patients				3,107,746	3,107,746		3,107,746	71
72	07200	Impl. Dev. Charged to Patients				3,585,537	3,585,537		3,585,537	72
73	07300	Drugs Charged to Patients	284	284,034	284,318	3,890,371	4,174,689		4,174,689	73
74	07400	Renal Dialysis		668,245	668,245		668,245		668,245	74
75.01	03480	ONCOLOGY	112,086	61,070	173,156	-2,079	171,077	-42,355	128,722	75.01
76.97	07697	CARDIAC REHABILITATION	425,986	35,183	461,169	-15,367	445,802	-44,088	401,714	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	2,710,180	619,235	3,329,415	-102,095	3,227,320	-2,687,088	540,232	90
90.01	09001	OP PSYCH		6,682	6,682		6,682		6,682	90.01
91	09100	Emergency	2,683,102	947,008	3,630,110	-107,631	3,522,479	-133,505	3,388,974	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	1,176,864	525,646	1,702,510	-27,032	1,675,478	-2,735	1,672,743	101
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	52,995,676	113,664,782	166,660,458	322	166,660,780	-45,018,011	121,642,769	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices		215,191	215,191		215,191		215,191	192
194	07950	OTHER NON REIM COST CENTER		110,830	110,830	-40	110,790		110,790	194
194.01	07954	RETAIL PHARMACY	201,921	419,532	621,453		621,453		621,453	194.01
194.03	07951	ADVERTISING EXPENSE	39,335	416,113	455,448	-282	455,166		455,166	194.03

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194.04	07952	REGENCY HOSPITAL								194.04
194.05	07953	UNUSED SPACE								194.05
200		TOTAL (sum of lines 118-199)	53,236,932	114,826,448	168,063,380		168,063,380	-45,018,011	123,045,369	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		234,364	1
2			Impl. Dev. Charged to Patient	72		3,585,537	2
3			Medical Supplies Charged to P	71		2,873,382	3
4							4
5							5
6							6
500	Total reclassifications					6,693,283	500
	Code Letter - A						
1	DRUGS CHARGED TO PATIENTS	B	Drugs Charged to Patients	73		3,890,371	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					3,890,371	500
	Code Letter - B						
1	CAFETERIA RECLASS	C	Cafeteria	11	861,233	764,661	1
500	Total reclassifications				861,233	764,661	500
	Code Letter - C						
1	UNASSIGNED DEPRECIATION RECLASS	D	Cap Rel Costs-Mvble Equip	2		3,461,429	1
2			Cap Rel Costs-Bldg & Fixt	1		1,911,303	2
500	Total reclassifications					5,372,732	500
	Code Letter - D						
1	RECLASS BLDG RENT EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		19,600	1
500	Total reclassifications					19,600	500
	Code Letter - E						
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Delivery Room & Labor Room	52	637,296	120,885	1
2			Nursery	43	321,243	60,935	2
500	Total reclassifications				958,539	181,820	500
	Code Letter - F						
1	RECLASS RENTAL EQUIPMENT	G	Cap Rel Costs-Mvble Equip	2		592,096	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
500	Total reclassifications					592,096	500
	Code Letter - G						
1	RECLASS PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		8,131	1
500	Total reclassifications					8,131	500
	Code Letter - J						

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
			1	2	3	4	
1	RECLASS FRINGE BENEFITS	L	Employee Benefits Department	4		13,442,023	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
500	Total reclassifications					13,442,023	500
	Code Letter - L						
	GRAND TOTAL (Increases)					1,819,772	30,964,717

(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		118,910	1	
2			Subprovider - IRF	41		17,262	2	
3			Cardiac Catheterization	59		3,288,450	3	
4			Emergency	91		46,933	4	
5			Intensive Care Unit	31		51,259	5	
6			Operating Room	50		3,170,469	6	
500	Total reclassifications					6,693,283	500	
	Code letter - A							
1	DRUGS CHARGED TO PATIENTS	B	Pharmacy	15		3,501,258	1	
2			Anesthesiology	53		35,652	2	
3			Radioisotope	56		268,642	3	
4			Respiratory Therapy	65		40,406	4	
5			Clinic	90		36,895	5	
6			Employee Benefits Department	4		6,947	6	
7			Operating Room	50		246	7	
8			Maintenance & Repairs	6		325	8	
500	Total reclassifications					3,890,371	500	
	Code letter - B							
1	CAFETERIA RECLASS	C	Dietary	10	861,233	764,661	1	
500	Total reclassifications				861,233	764,661	500	
	Code letter - C							
1	UNASSIGNED DEPRECIATION RECLASS	D	OTHER ADMIN & GENERAL	5.05		3,461,429	9	
2			OTHER ADMIN & GENERAL	5.05		1,911,303	9	
500	Total reclassifications					5,372,732	500	
	Code letter - D							
1	RECLASS BLDG RENT EXPENSE	E	OTHER ADMIN & GENERAL	5.05		19,600	10	
500	Total reclassifications					19,600	500	
	Code letter - E							
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Adults & Pediatrics	30	637,296	120,885	1	
2			Adults & Pediatrics	30	321,243	60,935	2	
500	Total reclassifications				958,539	181,820	500	
	Code letter - F							
1	RECLASS RENTAL EQUIPMENT	G	ADMITTING	5.03		8	10	
2			MAINTENANCE OF PERSONNEL	4.01		4	2	
3			PURCHASING RECEIVING & STORES	5.02		4	3	
4			OTHER ADMIN & GENERAL	5.05		1,732	4	
5			Maintenance & Repairs	6		12,903	5	
6			Operation of Plant	7		122	6	
7			Laundry & Linen Service	8		18,927	7	
8			Housekeeping	9		276	8	
9			Dietary	10		20,755	9	
10			Nursing Administration	13		20	10	
11			Central Services & Supply	14		3,691	11	
12			Pharmacy	15		18,809	12	
13			Adults & Pediatrics	30		44,283	13	
14			Intensive Care Unit	31		4	14	
15			Subprovider - IRF	41		930	15	
16			Operating Room	50		193,458	16	
17			Radiology-Diagnostic	54		71,452	17	
18			ULTRASOUND	54.01		19,415	18	
19			Radioisotope	56		5,024	19	
20			CT Scan	57		28,574	20	
21			Cardiac Catheterization	59		101,870	21	
22			Laboratory	60		21	22	
23			NONINVASIVE LAB	63.02		16,839	23	
24			Respiratory Therapy	65		3,479	24	
25			Physical Therapy	66		26,330	25	
26			Occupational Therapy	67		180	26	
27			Electroencephalography	70		1,744	27	
28			Clinic	90		1,183	28	
29			Emergency	91		9	29	
30			Home Health Agency	101		6	30	
31			OTHER NON REIM COST CENTER	194		40	31	
32			ADVERTISING EXPENSE	194.03		4	32	
500	Total reclassifications					592,096	500	
	Code letter - G							
1	RECLASS PROPERTY INSURANCE	J	OTHER ADMIN & GENERAL	5.05		8,131	12	
500	Total reclassifications					8,131	500	

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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	
	Code letter - J							
1	RECLASS FRINGE BENEFITS	L	MAINTENANCE OF PERSONNEL	4.01		49,264	1	
2			PURCHASING RECEIVING & STORES	5.02		7,895	2	
3			ADMITTING	5.03		36,326	3	
4			OTHER ADMIN & GENERAL	5.05		12,103,707	4	
5			Maintenance & Repairs	6		42,563	5	
6			Operation of Plant	7		13,258	6	
7			Laundry & Linen Service	8		3,891	7	
8			Housekeeping	9		80,137	8	
9			Dietary	10		67,193	9	
10			Nursing Administration	13		23,180	10	
11			Pharmacy	15		36,073	11	
12			Medical Records & Library	16		3,058	12	
13			Adults & Pediatrics	30		326,396	13	
14			Intensive Care Unit	31		51,058	14	
15			Subprovider - IRF	41		50,440	15	
16			Operating Room	50		77,070	16	
17			Recovery Room	51		7,540	17	
18			Anesthesiology	53		27,071	18	
19			Radiology-Diagnostic	54		50,795	19	
20			ULTRASOUND	54.01		5,768	20	
21			Radioisotope	56		4,534	21	
22			CT Scan	57		9,587	22	
23			Cardiac Catheterization	59		26,292	23	
24			Laboratory	60		53,329	24	
25			Whole Blood & Packed Red Bloo	62		4,297	25	
26			NONINVASIVE LAB	63.02		28,823	26	
27			Respiratory Therapy	65		32,878	27	
28			Physical Therapy	66		29,140	28	
29			Occupational Therapy	67		12,054	29	
30			Speech Pathology	68		3,594	30	
31			Electroencephalography	70		5,356	31	
32			ONCOLOGY	75.01		2,079	32	
33			CARDIAC REHABILITATION	76.97		15,367	33	
34			Clinic	90		64,017	34	
35			Emergency	91		60,689	35	
36			Home Health Agency	101		27,026	36	
37			ADVERTISING EXPENSE	194.03		278	37	
500	Total reclassifications					13,442,023	500	
	Code letter - L							
	GRAND TOTAL (Decreases)				1,819,772	30,964,717		

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

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	251,413					251,413		1
2	Land Improvements	2,059,213	327,642		327,642		2,386,855		2
3	Buildings and Fixtures	49,077,260	46,500		46,500		49,123,760		3
4	Building Improvements	11,540,897	5,393,473		5,393,473		16,934,370		4
5	Fixed Equipment								5
6	Movable Equipment	105,346,032	2,548,284		2,548,284	763,758	107,130,558		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	168,274,815	8,315,899		8,315,899	763,758	175,826,956		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	168,274,815	8,315,899		8,315,899	763,758	175,826,956		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		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

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	68,696,398		68,696,398	0.390705					1
2	Cap Rel Costs-Mvble Equip	107,130,558		107,130,558	0.609295					2
3	Total (sum of lines 1-2)	175,826,956		175,826,956	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	2,773,952	19,600		8,131				2,801,683	1
2	Cap Rel Costs-Mvble Equip	5,750,447	592,096						6,342,543	2
3	Total (sum of lines 1-2)	8,524,399	611,696		8,131				9,144,226	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

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref. 5
				COST CENTER	LINE#		
		1	2	3	4		
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-2,646	Adults & Pediatrics	30		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	-93,001	NONPATIENT TELEPHONES	5.01		7
8	Television and radio service (chapter 21)	A	-3,154	Cap Rel Costs-Mvble Equip	2	9	8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,389,168				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-1,975,242				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	-95	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	758,607	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	108,350	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	OTHER OPERATING REVENUE	B	-36,664	CARDIAC REHABILITATION	76.97		33
33.07	LAB REVENUE	B	-1,849	Laboratory	60		33.07
33.08	OFFSET OTHER INCOME	B	-1,435	Housekeeping	9		33.08
33.09	OFFSET OTHER INCOME	B	-9,732	Operating Room	50		33.09
33.10	OFFSET OTHER INCOME	B	-751	CT Scan	57		33.10
33.11	OFFSET OTHER INCOME	B	-17,420	Physical Therapy	66		33.11
33.12	OTHER RELEASED TEMP REST OP	B	-1,072	Emergency	91		33.12
33.13	OTHER OPERATING REVENUE	B	-185	MAINTENANCE OF PERSONNEL	4.01		33.13
33.14	OTHER INCOME	B	-4,902	Clinic	90		33.14
33.15	OFFSET OCC HEALTH COSTS FOR BP/US	A	-1,920,279	Clinic	90		33.15
33.16	OFFSET INTERCO REVENUE	B	-53,113	NONINVASIVE LAB	63.02		33.16
33.19	OTHER OPERATING REVENUE	B	-101,610	OTHER ADMIN & GENERAL	5.05		33.19
33.23	OTHER OPER REV	B	-19,892	PURCHASING RECEIVING & STORES	5.02		33.23
33.26	CAFETERIA REVENUE	B	-786,581	Cafeteria	11		33.26
33.28	OTHER OPER REVENUE	B	-41,870	Operation of Plant	7		33.28
33.29	OTHER OPERATING REVENUE	B	-11,853	Maintenance & Repairs	6		33.29
33.30	OTHER OPERATING REVENUE	B	-52,626	Laundry & Linen Service	8		33.30
34	OFFSET TELEPHONE DEPRECIATION	A	-485	Cap Rel Costs-Mvble Equip	2	9	34
34.01	OFFSET CONTRIBUTIONS	A	-18,300	OTHER ADMIN & GENERAL	5.05		34.01
34.03	OFFSET CAPITATION EXPENSE	A	-28,360,031	OTHER ADMIN & GENERAL	5.05		34.03
35	CRNA SALARIES	A	-645,161	Anesthesiology	53		35
36	OFFSET CONTRIBUTIONS	A	-350	Nursing Administration	13		36
37	OFFSET PHYSICIAN RECRUITMENT	A	-4	OTHER ADMIN & GENERAL	5.05		37
38	OFFSET NONWAGE CRNA/ANEST COSTS	A	-323,992	Anesthesiology	53		38
39	OFFSET FEES FOR ON CALL SURGEONS	A	-490,000	Operating Room	50		39
40	MDWISE ADD BACK	A	2,337,385	OTHER ADMIN & GENERAL	5.05		40
41	OFFSET MEDICAID ASSESSMENT	A	-4,082,711	OTHER ADMIN & GENERAL	5.05		41
42	OFFSET MAMMO READS	A	-27,689	Radiology-Diagnostic	54		42
43	OFFSET EKG READS AT CLINIC	A	-6,874	Clinic	90		43
44	OFFSET OTHER INCOME	B	-330	Radiology-Diagnostic	54		44
45	OFFSET PHYSICIAN BLG RENT	A	-19,600	Cap Rel Costs-Bldg & Fixt	1	9	45
46	ELIMINATE PHYSICIAN COSTS	A	-6,273,439	OTHER ADMIN & GENERAL	5.05		46
46.02	OFFSET OCC HEALTH PHYS PART B	A	-193,080	Clinic	90		46.02

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref. 5	
				COST CENTER	LINE#		
		1	2	3	4		
46.03	OFFSET ADMIN PHYS PART B	A	-210,077	OTHER ADMIN & GENERAL	5.05		46.03
46.04	OFFSET ONCOLOGY PHYSICIAN COSTS	A	-42,355	ONCOLOGY	75.01		46.04
47	HHA MARKETING EXPENSE	A	-2,735	Home Health Agency	101		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-45,018,011				50

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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	DEPRECIATION BLDG	123,642		123,642	9	1
2	2	Cap Rel Costs-Mvble Equip	DEPRECIATION EQUIP	2,184,307		2,184,307	9	2
3	5.05	OTHER ADMIN & GENERAL	A&G OTHER	12,345,833	18,696,883	-6,351,050		3
3.01	5.01	NONPATIENT TELEPHONES	TELECOMMUNICATIONS	462,512		462,512		3.01
3.02	16	Medical Records & Library	MEDICAL RECORDS	1,605,347		1,605,347		3.02
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			16,721,641	18,696,883	-1,975,242		5

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5.05	OTHER ADMIN & GENERA	78,064		78,064	211,500	625	63,552	3,178	1
2	13	Nursing Administrati AGGREGATE	35,766	11,559	24,207	211,500	142	14,439	722	2
3	16	Medical Records & Li	23,411		23,411	211,500	247	25,116	1,256	3
4	30	Adults & Pediatrics AGGREGATE	26,983	13,717	13,266	211,500	131	13,320	666	4
5	31	Intensive Care Unit AGGREGATE	36,729	36,729						5
6	50	Operating Room	33,440		33,440	246,400	149	17,651	883	6
7	54	Radiology-Diagnostic	4,167		4,167	271,900	18	2,353	118	7
8	59	Cardiac Catheterizat	16,250		16,250	211,500	81	8,236	412	8
9	60	Laboratory	27,083		27,083	260,300	176	22,025	1,101	9
10	65	Respiratory Therapy AGGREGATE	18,052	9,828	8,224	211,500	76	7,728	386	10
11	66	Physical Therapy AGGREGATE	10,917	10,917						11
12										12
13	76.97	CARDIAC REHABILITATI	15,050		15,050	211,500	75	7,626	381	13
14	90	Clinic AGGREGATE	36,966	36,966						14
15	53	Anesthesiology AGGREGATE	1,549,157	1,549,157						15
16	91	Emergency	269,400		269,400	211,500	1,347	136,967	6,848	16
17	90	Clinic OCC HEALTH SALA	524,987	524,987						17
18										18
19										19
20										20
200		TOTAL	2,706,422	2,193,860	512,562		3,067	319,013	15,951	200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.05	OTHER ADMIN & GENERA					63,552	14,512	14,512	1
2	13	Nursing Administrati AGGREGATE					14,439	9,768	21,327	2
3	16	Medical Records & Li					25,116			3
4	30	Adults & Pediatrics AGGREGATE					13,320		13,717	4
5	31	Intensive Care Unit AGGREGATE							36,729	5
6	50	Operating Room					17,651	15,789	15,789	6
7	54	Radiology-Diagnostic					2,353	1,814	1,814	7
8	59	Cardiac Catheterizat					8,236	8,014	8,014	8
9	60	Laboratory					22,025	5,058	5,058	9
10	65	Respiratory Therapy AGGREGATE					7,728	496	10,324	10
11	66	Physical Therapy AGGREGATE							10,917	11
12										12
13	76.97	CARDIAC REHABILITATI					7,626	7,424	7,424	13
14	90	Clinic AGGREGATE							36,966	14
15	53	Anesthesiology AGGREGATE							1,549,157	15
16	91	Emergency					136,967	132,433	132,433	16
17	90	Clinic OCC HEALTH SALA							524,987	17
18										18
19										19
20										20
200		TOTAL					319,013	195,308	2,389,168	200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,801,683	2,801,683					1
2	Cap Rel Costs-Mvble Equip	6,342,543		6,342,543				2
4	Employee Benefits Department	13,544,813	1,104		13,545,917			4
4.01	MAINTENANCE OF PERSONNEL	656,081	14,321		104,039	774,441		4.01
5.01	NONPATIENT TELEPHONES	369,511	5,388				374,899	5.01
5.02	PURCHASING RECEIVING & STORES	386,305	53,837	2,361	84,943	8,121	1,417	5.02
5.03	ADMITTING	945,831	20,846	1,055	237,230	25,176	10,768	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	19,464,139	278,658	209,858	1,242,037	40,287	115,614	5.05
6	Maintenance & Repairs	6,835,359	382,914	436,215	317,186	17,869	3,400	6
7	Operation of Plant	1,903,892	105,400	68,838	148,111	7,262	5,951	7
8	Laundry & Linen Service	521,678	10,855	1,975	23,445	2,686	567	8
9	Housekeeping	2,026,369	49,733	33,265	447,936	46,581	3,400	9
10	Dietary	1,148,979	75,621	65,392	173,747	17,453	7,084	10
11	Cafeteria	839,313	24,192		228,383	22,934		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,281,665	11,261	144,756	292,691	11,828	3,967	13
14	Central Services & Supply	1,516					3,117	14
15	Pharmacy	1,786,669	25,801	308,112	418,513	17,878	8,218	15
16	Medical Records & Library	1,792,568	35,399	1,827	25,904	1,564	6,518	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,875,992	428,373	577,752	2,909,154	181,146	44,206	30
31	Intensive Care Unit	2,345,992	60,003	173,709	552,863	26,026	5,101	31
41	Subprovider - IRF	3,289,578	97,125	83,574	576,107	35,323	9,918	41
43	Nursery	382,178	14,826		85,188	4,205		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,002,562	210,813	1,034,378	806,827	41,373	15,019	50
51	Recovery Room	337,227	8,075	6,149	81,003	3,699	1,417	51
52	Delivery Room & Labor Room	758,181	24,285		168,999	8,329		52
53	Anesthesiology	176,987	2,128	121,563	171,085	7,072	1,700	53
54	Radiology-Diagnostic	1,741,535	62,404	806,485	428,306	28,414	11,335	54
54.01	ULTRASOUND	369,083	7,237	83,479	100,614	3,889	1,133	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	489,568	11,314	64,930	121,571	4,196	2,550	56
57	CT Scan	515,363	8,068	628,207	106,261	5,209	2,550	57
59	Cardiac Catheterization	1,609,432	43,082	616,933	297,484	12,299	11,618	59
60	Laboratory	4,345,747	79,811	159,954	569,101	36,534	20,686	60
62	Whole Blood & Packed Red Blood Cells	929,772	4,896	31,519	36,175	1,890	1,984	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	653,183	18,697	244,788	176,530	10,779	5,384	63.02
65	Respiratory Therapy	1,264,754	15,930	60,307	308,939	17,417	4,534	65
66	Physical Therapy	2,043,867	58,540	29,930	255,862	11,304	11,618	66
67	Occupational Therapy	1,504,416	16,250	2,018	130,355	6,538	8,784	67
68	Speech Pathology	460,776	5,102	15,224	59,858	1,863	283	68
70	Electroencephalography	222,378	27,464	60,488	49,664	2,831	3,967	70
71	Medical Supplies Charged to Patients	3,107,746						71
72	Impl. Dev. Charged to Patients	3,585,537						72
73	Drugs Charged to Patients	4,174,689			75			73
74	Renal Dialysis	668,245	2,508					74
75.01	ONCOLOGY	128,722	6,671	1,478	29,723	1,338	3,684	75.01
76.97	CARDIAC REHABILITATION	401,714	37,588	33,714	112,964	6,077	5,101	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	540,232	61,460	10,710	579,474	44,212	4,251	90
90.01	OP PSYCH	6,682	3,678					90.01
91	Emergency	3,388,974	65,484	219,435	711,510	38,759	1,984	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,672,743	21,005	164	312,083	14,053	4,251	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	121,642,769	2,498,147	6,340,542	13,481,940	774,414	353,079	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		7,430					190
192	Physicians' Private Offices	215,191	173,046			27	2,267	192
194	OTHER NON REIM COST CENTER	110,790		2,001				194
194.01	RETAIL PHARMACY	621,453	6,938		53,546			194.01
194.03	ADVERTISING EXPENSE	455,166	6,352		10,431		2,267	194.03
194.04	REGENCY HOSPITAL		109,770				17,286	194.04
194.05	UNUSED SPACE							194.05

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	123,045,369	2,801,683	6,342,543	13,545,917	774,441	374,899	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES 5.02	ADMITTING 5.03	SUBTOTAL (cols.0-4) 4A	OTHER ADMIN GENERAL 5.05	MAIN-TENANCE + REPAIRS 6	OPERATION OF PLANT 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	536,984						5.02
5.03	ADMITTING	8,778	1,249,684					5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	11,686		21,362,279	21,362,279			5.05
6	Maintenance & Repairs	100,754		8,093,697	1,700,381	9,794,078		6
7	Operation of Plant	24,245		2,263,699	475,574	504,885	3,244,158	7
8	Laundry & Linen Service	47,499		608,705	127,881	51,999	18,160	8
9	Housekeeping	65,601		2,672,885	561,538	238,232	83,200	9
10	Dietary	64,672		1,552,948	326,254	362,239	126,508	10
11	Cafeteria			1,114,822	234,210	115,882	40,471	11
12	Maintenance of Personnel							12
13	Nursing Administration	4,138		1,750,306	367,717	53,942	18,839	13
14	Central Services & Supply	321		4,954	1,041			14
15	Pharmacy	4,101		2,569,292	539,775	123,593	43,163	15
16	Medical Records & Library	1,755		1,865,535	391,925	169,569	59,220	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,315	154,807	17,205,745	3,614,687	2,051,971	716,631	30
31	Intensive Care Unit	5,803	14,970	3,184,467	669,015	287,427	100,381	31
41	Subprovider - IRF	11,202	25,080	4,127,907	867,220	465,248	162,483	41
43	Nursery		3,885	490,282	103,002	71,020	24,803	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	75,751	111,155	7,297,878	1,533,189	1,009,833	352,674	50
51	Recovery Room	303	7,929	445,802	93,657	38,680	13,509	51
52	Delivery Room & Labor Room		7,577	967,371	203,232	116,328	40,626	52
53	Anesthesiology	1,181	15,559	497,275	104,471	10,196	3,561	53
54	Radiology-Diagnostic	5,792	69,572	3,153,843	662,581	298,929	104,398	54
54.01	ULTRASOUND	644	16,558	582,637	122,404	34,666	12,107	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	671	23,975	718,775	151,005	54,197	18,928	56
57	CT Scan	745	88,304	1,354,707	284,606	38,649	13,498	57
59	Cardiac Catheterization	6,564	52,340	2,649,752	556,678	206,370	72,073	59
60	Laboratory	12,223	193,536	5,417,592	1,138,166	382,312	133,519	60
62	Whole Blood & Packed Red Blood Cells	1,016	9,620	1,016,872	213,632	23,450	8,190	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	1,692	36,603	1,147,656	241,108	89,564	31,279	63.02
65	Respiratory Therapy	627	31,211	1,703,719	357,929	76,309	26,650	65
66	Physical Therapy	3,019	29,561	2,443,701	513,390	280,417	97,933	66
67	Occupational Therapy	1,481	20,154	1,689,996	355,046	77,839	27,184	67
68	Speech Pathology	419	4,573	548,098	115,148	24,438	8,535	68
70	Electroencephalography	235	13,556	380,583	79,956	131,558	45,945	70
71	Medical Supplies Charged to Patients		27,946	3,135,692	658,768			71
72	Impl. Dev. Charged to Patients		25,146	3,610,683	758,558			72
73	Drugs Charged to Patients		100,391	4,275,155	898,154			73
74	Renal Dialysis		10,627	681,380	143,149	12,012	4,195	74
75.01	ONCOLOGY	264	2,373	174,253	36,608	31,958	11,161	75.01
76.97	CARDIAC REHABILITATION	3,525	1,545	602,228	126,520	180,052	62,881	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	14,094	5,415	1,259,848	264,678	294,404	102,818	90
90.01	OP PSYCH		90	10,450	2,195	17,620	6,153	90.01
91	Emergency	10,909	137,747	4,574,802	961,106	313,681	109,550	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	6,090	7,879	2,038,268	428,214	100,620	35,141	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	532,115	1,249,684	121,246,539	20,984,368	8,340,089	2,736,367	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			7,430	1,561	35,590	12,429	190
192	Physicians' Private Offices			390,531	82,045	828,921	289,492	192
194	OTHER NON REIM COST CENTER	113		112,904	23,720			194
194.01	RETAIL PHARMACY			681,937	143,266	33,232	11,606	194.01
194.03	ADVERTISING EXPENSE	2,708		476,924	100,196	30,428	10,627	194.03
194.04	REGENCY HOSPITAL	2,048		129,104	27,123	525,818	183,637	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES	ADMITTING	SUBTOTAL (cols.0-4)	OTHER ADMIN GENERAL	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	
		5.02	5.03	4A	5.05	6	7	
202	TOTAL (sum of lines 118-201)	536,984	1,249,684	123,045,369	21,362,279	9,794,078	3,244,158	202

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	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	806,745						8
9	Housekeeping		3,555,855					9
10	Dietary		143,135	2,511,084				10
11	Cafeteria		45,790		1,551,175			11
12	Maintenance of Personnel							12
13	Nursing Administration		21,315		32,076	2,244,195		13
14	Central Services & Supply						5,995	14
15	Pharmacy		48,836		48,482			15
16	Medical Records & Library		67,004		4,242			16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	263,756	810,819	1,690,922	491,219	1,012,620		30
31	Intensive Care Unit	29,022	113,574	70,655	70,577	145,470		31
41	Subprovider - IRF	63,607	183,838	461,942	95,787	197,452		41
43	Nursery		28,063		11,403	23,517		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	105,687	399,026		112,193	231,257		50
51	Recovery Room	16,862	15,284		10,030	20,686		51
52	Delivery Room & Labor Room		45,966		22,586	46,560		52
53	Anesthesiology		4,029		19,177			53
54	Radiology-Diagnostic	16,742	118,119		77,051			54
54.01	ULTRASOUND	14,781	13,698		10,545			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	3,931	21,416		11,379			56
57	CT Scan		15,272		14,125			57
59	Cardiac Catheterization	14,946	81,545		33,351	68,777		59
60	Laboratory		151,067		99,073			60
62	Whole Blood & Packed Red Blood Cells		9,266		5,125			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	8,385	35,390		29,231			63.02
65	Respiratory Therapy		30,153		47,231			65
66	Physical Therapy	18,181	110,804		30,654			66
67	Occupational Therapy		30,757		17,730			67
68	Speech Pathology		9,656		5,052			68
70	Electroencephalography	9,155	51,984		7,676			70
71	Medical Supplies Charged to Patients						2,666	71
72	Impl. Dev. Charged to Patients						3,329	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		4,746					74
75.01	ONCOLOGY		12,628		3,629			75.01
76.97	CARDIAC REHABILITATION	8,752	71,146		16,479	33,985		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	14,699	116,331		119,893	247,177		90
90.01	OP PSYCH		6,962					90.01
91	Emergency	169,221	123,948	43,077	105,105	216,694		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		39,759					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	757,727	2,981,326	2,266,596	1,551,101	2,244,195	5,995	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		14,063					190
192	Physicians' Private Offices		327,540		74			192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		13,131					194.01
194.03	ADVERTISING EXPENSE		12,023					194.03
194.04	REGENCY HOSPITAL	49,018	207,772	244,488				194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
202	TOTAL (sum of lines 118-201)	806,745	3,555,855	2,511,084	1,551,175	2,244,195	5,995	202

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NONPATIENT TELEPHONES						5.01
5.02	PURCHASING RECEIVING & STORES						5.02
5.03	ADMITTING						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMIN & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	3,373,141					15
16	Medical Records & Library		2,557,495				16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		316,873	28,175,243		28,175,243	30
31	Intensive Care Unit		30,642	4,701,230		4,701,230	31
41	Subprovider - IRF		51,335	6,676,819		6,676,819	41
43	Nursery		7,951	760,041		760,041	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		227,522	11,269,259		11,269,259	50
51	Recovery Room		16,231	670,741		670,741	51
52	Delivery Room & Labor Room		15,509	1,458,178		1,458,178	52
53	Anesthesiology		31,847	670,556		670,556	53
54	Radiology-Diagnostic		142,406	4,574,069		4,574,069	54
54.01	ULTRASOUND		33,893	824,731		824,731	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope		49,074	1,028,705		1,028,705	56
57	CT Scan		180,748	1,901,605		1,901,605	57
59	Cardiac Catheterization		107,134	3,790,626		3,790,626	59
60	Laboratory		395,678	7,717,407		7,717,407	60
62	Whole Blood & Packed Red Blood Cells		19,692	1,296,227		1,296,227	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB		74,921	1,657,534		1,657,534	63.02
65	Respiratory Therapy		63,885	2,305,876		2,305,876	65
66	Physical Therapy		60,508	3,555,588		3,555,588	66
67	Occupational Therapy		41,254	2,239,806		2,239,806	67
68	Speech Pathology		9,360	720,287		720,287	68
70	Electroencephalography		27,747	734,604		734,604	70
71	Medical Supplies Charged to Patients		57,203	3,854,329		3,854,329	71
72	Impl. Dev. Charged to Patients		51,470	4,424,040		4,424,040	72
73	Drugs Charged to Patients	3,373,141	205,490	8,751,940		8,751,940	73
74	Renal Dialysis		21,753	867,235		867,235	74
75.01	ONCOLOGY		4,857	275,094		275,094	75.01
76.97	CARDIAC REHABILITATION		3,163	1,105,206		1,105,206	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		11,084	2,430,932		2,430,932	90
90.01	OP PSYCH		184	43,564		43,564	90.01
91	Emergency		281,953	6,899,137		6,899,137	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		16,128	2,658,130		2,658,130	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	3,373,141	2,557,495	118,038,739		118,038,739	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			71,073		71,073	190
192	Physicians' Private Offices			1,918,603		1,918,603	192
194	OTHER NON REIM COST CENTER			136,624		136,624	194
194.01	RETAIL PHARMACY			883,172		883,172	194.01
194.03	ADVERTISING EXPENSE			630,198		630,198	194.03
194.04	REGENCY HOSPITAL			1,366,960		1,366,960	194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		15	16	24	25	26		
202	TOTAL (sum of lines 118-201)	3,373,141	2,557,495	123,045,369		123,045,369		202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	
		0	1	2	2A	4	4.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		1,104		1,104	1,104		4
4.01	MAINTENANCE OF PERSONNEL		14,321		14,321	9	14,330	4.01
5.01	NONPATIENT TELEPHONES		5,388		5,388			5.01
5.02	PURCHASING RECEIVING & STORES		53,837	2,361	56,198	7	150	5.02
5.03	ADMITTING		20,846	1,055	21,901	20	466	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL		278,658	209,858	488,516	103	745	5.05
6	Maintenance & Repairs		382,914	436,215	819,129	26	331	6
7	Operation of Plant		105,400	68,838	174,238	12	134	7
8	Laundry & Linen Service		10,855	1,975	12,830	2	50	8
9	Housekeeping		49,733	33,265	82,998	37	862	9
10	Dietary		75,621	65,392	141,013	14	323	10
11	Cafeteria		24,192		24,192	19	424	11
12	Maintenance of Personnel							12
13	Nursing Administration		11,261	144,756	156,017	24	219	13
14	Central Services & Supply							14
15	Pharmacy		25,801	308,112	333,913	35	331	15
16	Medical Records & Library		35,399	1,827	37,226	2	29	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		428,373	577,752	1,006,125	222	3,352	30
31	Intensive Care Unit		60,003	173,709	233,712	46	482	31
41	Subprovider - IRF		97,125	83,574	180,699	48	654	41
43	Nursery		14,826		14,826	7	78	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		210,813	1,034,378	1,245,191	67	766	50
51	Recovery Room		8,075	6,149	14,224	7	68	51
52	Delivery Room & Labor Room		24,285		24,285	14	154	52
53	Anesthesiology		2,128	121,563	123,691	14	131	53
54	Radiology-Diagnostic		62,404	806,485	868,889	36	526	54
54.01	ULTRASOUND		7,237	83,479	90,716	8	72	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		11,314	64,930	76,244	10	78	56
57	CT Scan		8,068	628,207	636,275	9	96	57
59	Cardiac Catheterization		43,082	616,933	660,015	25	228	59
60	Laboratory		79,811	159,954	239,765	47	676	60
62	Whole Blood & Packed Red Blood Cells		4,896	31,519	36,415	3	35	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		18,697	244,788	263,485	15	199	63.02
65	Respiratory Therapy		15,930	60,307	76,237	26	322	65
66	Physical Therapy		58,540	29,930	88,470	21	209	66
67	Occupational Therapy		16,250	2,018	18,268	11	121	67
68	Speech Pathology		5,102	15,224	20,326	5	34	68
70	Electroencephalography		27,464	60,488	87,952	4	52	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis		2,508		2,508			74
75.01	ONCOLOGY		6,671	1,478	8,149	2	25	75.01
76.97	CARDIAC REHABILITATION		37,588	33,714	71,302	9	112	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		61,460	10,710	72,170	48	818	90
90.01	OP PSYCH		3,678		3,678			90.01
91	Emergency		65,484	219,435	284,919	59	717	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		21,005	164	21,169	26	260	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,498,147	6,340,542	8,838,689	1,099	14,329	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		7,430		7,430			190
192	Physicians' Private Offices		173,046		173,046		1	192
194	OTHER NON REIM COST CENTER			2,001	2,001			194
194.01	RETAIL PHARMACY		6,938		6,938	4		194.01
194.03	ADVERTISING EXPENSE		6,352		6,352	1		194.03
194.04	REGENCY HOSPITAL		109,770		109,770			194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	
		0	1	2	2A	4	4.01	
202	TOTAL (sum of lines 118-201)		2,801,683	6,342,543	9,144,226	1,104	14,330	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	OTHER ADMIN GENERAL	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES	5,388						5.01
5.02	PURCHASING RECEIVING & STORES	20	56,375					5.02
5.03	ADMITTING	155	922	23,464				5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	1,661	1,227		492,252			5.05
6	Maintenance & Repairs	49	10,575		39,182	869,292		6
7	Operation of Plant	86	2,545		10,959	44,812	232,786	7
8	Laundry & Linen Service	8	4,987		2,947	4,615	1,303	8
9	Housekeeping	49	6,887		12,939	21,145	5,970	9
10	Dietary	102	6,790		7,518	32,151	9,078	10
11	Cafeteria				5,397	10,285	2,904	11
12	Maintenance of Personnel							12
13	Nursing Administration	57	434		8,473	4,788	1,352	13
14	Central Services & Supply	45	34		24			14
15	Pharmacy	118	431		12,438	10,970	3,097	15
16	Medical Records & Library	94	184		9,031	15,050	4,249	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	635	3,603	2,924	83,295	182,127	51,419	30
31	Intensive Care Unit	73	609	283	15,416	25,511	7,203	31
41	Subprovider - IRF	143	1,176	474	19,983	41,294	11,659	41
43	Nursery			73	2,373	6,304	1,780	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	216	7,953	2,099	35,329	89,630	25,306	50
51	Recovery Room	20	32	150	2,158	3,433	969	51
52	Delivery Room & Labor Room			143	4,683	10,325	2,915	52
53	Anesthesiology	24	124	294	2,407	905	256	53
54	Radiology-Diagnostic	163	608	1,314	15,268	26,532	7,491	54
54.01	ULTRASOUND	16	68	313	2,821	3,077	869	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	37	70	453	3,480	4,810	1,358	56
57	CT Scan	37	78	1,668	6,558	3,430	969	57
59	Cardiac Catheterization	167	689	989	12,827	18,317	5,172	59
60	Laboratory	297	1,283	3,515	26,227	33,933	9,581	60
62	Whole Blood & Packed Red Blood Cells	29	107	182	4,923	2,081	588	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	77	178	691	5,556	7,949	2,244	63.02
65	Respiratory Therapy	65	66	589	8,248	6,773	1,912	65
66	Physical Therapy	167	317	558	11,830	24,889	7,027	66
67	Occupational Therapy	126	156	381	8,181	6,909	1,951	67
68	Speech Pathology	4	44	86	2,653	2,169	612	68
70	Electroencephalography	57	25	256	1,842	11,677	3,297	70
71	Medical Supplies Charged to Patients			528	15,180			71
72	Impl. Dev. Charged to Patients			475	17,479			72
73	Drugs Charged to Patients			1,896	20,696			73
74	Renal Dialysis			201	3,299	1,066	301	74
75.01	ONCOLOGY	53	28	45	844	2,836	801	75.01
76.97	CARDIAC REHABILITATION	73	370	29	2,915	15,981	4,512	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	61	1,480	102	6,099	26,130	7,378	90
90.01	OP PSYCH			2	51	1,564	442	90.01
91	Emergency	29	1,145	2,602	22,147	27,841	7,861	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	61	639	149	9,867	8,931	2,522	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,074	55,864	23,464	483,543	740,240	196,348	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				36	3,159	892	190
192	Physicians' Private Offices	33			1,891	73,572	20,773	192
194	OTHER NON REIM COST CENTER		12		547			194
194.01	RETAIL PHARMACY				3,301	2,950	833	194.01
194.03	ADVERTISING EXPENSE	33	284		2,309	2,701	763	194.03
194.04	REGENCY HOSPITAL	248	215		625	46,670	13,177	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	OTHER ADMIN GENERAL	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
202	TOTAL (sum of lines 118-201)	5,388	56,375	23,464	492,252	869,292	232,786	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	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	26,742						8
9	Housekeeping		130,887					9
10	Dietary		5,269	202,258				10
11	Cafeteria		1,685			44,906		11
12	Maintenance of Personnel							12
13	Nursing Administration		785			929	173,078	13
14	Central Services & Supply							103
15	Pharmacy		1,798			1,404		15
16	Medical Records & Library		2,466			123		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,745	29,844	136,196	14,222	78,096		30
31	Intensive Care Unit	962	4,181	5,691	2,043	11,219		31
41	Subprovider - IRF	2,108	6,767	37,208	2,773	15,228		41
43	Nursery		1,033		330	1,814		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,503	14,688		3,248	17,835		50
51	Recovery Room	559	563		290	1,595		51
52	Delivery Room & Labor Room		1,692		654	3,591		52
53	Anesthesiology		148		555			53
54	Radiology-Diagnostic	555	4,348		2,231			54
54.01	ULTRASOUND	490	504		305			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	130	788		329			56
57	CT Scan		562		409			57
59	Cardiac Catheterization	495	3,002		966	5,304		59
60	Laboratory		5,561		2,868			60
62	Whole Blood & Packed Red Blood Cells		341		148			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	278	1,303		846			63.02
65	Respiratory Therapy		1,110		1,367			65
66	Physical Therapy	603	4,079		887			66
67	Occupational Therapy		1,132		513			67
68	Speech Pathology		355		146			68
70	Electroencephalography	303	1,913		222			70
71	Medical Supplies Charged to Patients						46	71
72	Impl. Dev. Charged to Patients						57	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		175					74
75.01	ONCOLOGY		465		105			75.01
76.97	CARDIAC REHABILITATION	290	2,619		477	2,621		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	487	4,282		3,471	19,063		90
90.01	OP PSYCH		256					90.01
91	Emergency	5,609	4,562	3,470	3,043	16,712		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,463					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	25,117	109,739	182,565	44,904	173,078	103	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		518					190
192	Physicians' Private Offices		12,056		2			192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		483					194.01
194.03	ADVERTISING EXPENSE		443					194.03
194.04	REGENCY HOSPITAL	1,625	7,648	19,693				194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
202	TOTAL (sum of lines 118-201)	26,742	130,887	202,258	44,906	173,078	103	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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	364,535					15
16	Medical Records & Library		68,454				16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		8,469	1,609,274		1,609,274	30
31	Intensive Care Unit		819	308,250		308,250	31
41	Subprovider - IRF		1,372	321,586		321,586	41
43	Nursery		213	28,831		28,831	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		6,081	1,451,912		1,451,912	50
51	Recovery Room		434	24,502		24,502	51
52	Delivery Room & Labor Room		414	48,870		48,870	52
53	Anesthesiology		851	129,400		129,400	53
54	Radiology-Diagnostic		3,806	931,767		931,767	54
54.01	ULTRASOUND		906	100,165		100,165	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope		1,312	89,099		89,099	56
57	CT Scan		4,831	654,922		654,922	57
59	Cardiac Catheterization		2,863	711,059		711,059	59
60	Laboratory		10,676	334,429		334,429	60
62	Whole Blood & Packed Red Blood Cells		526	45,378		45,378	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB		2,002	284,823		284,823	63.02
65	Respiratory Therapy		1,707	98,422		98,422	65
66	Physical Therapy		1,617	140,674		140,674	66
67	Occupational Therapy		1,103	38,852		38,852	67
68	Speech Pathology		250	26,684		26,684	68
70	Electroencephalography		742	108,342		108,342	70
71	Medical Supplies Charged to Patients		1,529	17,283		17,283	71
72	Impl. Dev. Charged to Patients		1,376	19,387		19,387	72
73	Drugs Charged to Patients	364,535	5,492	392,619		392,619	73
74	Renal Dialysis		581	8,131		8,131	74
75.01	ONCOLOGY		130	13,483		13,483	75.01
76.97	CARDIAC REHABILITATION		85	101,395		101,395	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic		296	141,885		141,885	90
90.01	OP PSYCH		5	5,998		5,998	90.01
91	Emergency		7,535	388,251		388,251	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		431	45,518		45,518	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	364,535	68,454	8,621,191		8,621,191	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			12,035		12,035	190
192	Physicians' Private Offices			281,374		281,374	192
194	OTHER NON REIM COST CENTER			2,560		2,560	194
194.01	RETAIL PHARMACY			14,509		14,509	194.01
194.03	ADVERTISING EXPENSE			12,886		12,886	194.03
194.04	REGENCY HOSPITAL			199,671		199,671	194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201

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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		
202	TOTAL (sum of lines 118-201)	364,535	68,454	9,144,226		9,144,226		202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DEPRECIATION EXPENSE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINT OF PERSONNEL FTE'S	NONPATIENT TELEPHONES NUMBER OF TELEPHONES	PURCHASING RECEIVING & STORES COSTED REQ	
		1	2	4	4.01	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	421,210						1
2	Cap Rel Costs-Mvble Equip		3,432,581					2
4	Employee Benefits Department	166		51,081,613				4
4.01	MAINTENANCE OF PERSONNEL	2,153		392,329	85,638			4.01
5.01	NONPATIENT TELEPHONES	810				1,323		5.01
5.02	PURCHASING RECEIVING & STORES	8,094	1,278	320,318	898		1,350,270	5.02
5.03	ADMITTING	3,134	571	894,593	2,784	38	22,073	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	41,894	113,575	4,683,717	4,455	408	29,386	5.05
6	Maintenance & Repairs	57,568	236,079	1,196,107	1,976	12	253,347	6
7	Operation of Plant	15,846	37,255	558,526	803	21	60,964	7
8	Laundry & Linen Service	1,632	1,069	88,412	297	2	119,439	8
9	Housekeeping	7,477	18,003	1,689,164	5,151	12	164,957	9
10	Dietary	11,369	35,390	655,198	1,930	25	162,621	10
11	Cafeteria	3,637		861,233	2,536			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,693	78,342	1,103,737	1,308	14	10,406	13
14	Central Services & Supply					11	806	14
15	Pharmacy	3,879	166,750	1,578,212	1,977	29	10,312	15
16	Medical Records & Library	5,322	989	97,683	173	23	4,414	16
17	Social Service							17
19	Nonphysician Anesthetists							19
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	64,402	312,679	10,970,422	20,031	156	86,286	30
31	Intensive Care Unit	9,021	94,011	2,084,843	2,878	18	14,593	31
41	Subprovider - IRF	14,602	45,230	2,172,496	3,906	35	28,167	41
43	Nursery	2,229		321,243	465			43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	31,694	559,806	3,042,540	4,575	53	190,479	50
51	Recovery Room	1,214	3,328	305,462	409	5	761	51
52	Delivery Room & Labor Room	3,651		637,296	921			52
53	Anesthesiology	320	65,790	645,161	782	6	2,970	53
54	Radiology-Diagnostic	9,382	436,469	1,615,138	3,142	40	14,565	54
54.01	ULTRASOUND	1,088	45,179	379,414	430	4	1,620	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,701	35,140	458,444	464	9	1,687	56
57	CT Scan	1,213	339,985	400,711	576	9	1,874	57
59	Cardiac Catheterization	6,477	333,884	1,121,812	1,360	41	16,505	59
60	Laboratory	11,999	86,567	2,146,078	4,040	73	30,736	60
62	Whole Blood & Packed Red Blood Cells	736	17,058	136,416	209	7	2,555	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,811	132,479	665,694	1,192	19	4,255	63.02
65	Respiratory Therapy	2,395	32,638	1,165,009	1,926	16	1,577	65
66	Physical Therapy	8,801	16,198	964,856	1,250	41	7,591	66
67	Occupational Therapy	2,443	1,092	491,568	723	31	3,725	67
68	Speech Pathology	767	8,239	225,726	206	1	1,054	68
70	Electroencephalography	4,129	32,736	187,284	313	14	592	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			284				73
74	Renal Dialysis	377						74
75.01	ONCOLOGY	1,003	800	112,086	148	13	664	75.01
76.97	CARDIAC REHABILITATION	5,651	18,246	425,986	672	18	8,865	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	9,240	5,796	2,185,193	4,889	15	35,439	90
90.01	OP PSYCH	553						90.01
91	Emergency	9,845	118,758	2,683,102	4,286	7	27,430	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency	3,158	89	1,176,864	1,554	15	15,313	101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	375,576	3,431,498	50,840,357	85,635	1,246	1,338,028	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen	1,117						190
192	Physicians' Private Offices	26,016			3	8		192
194	OTHER NON REIM COST CENTER		1,083				284	194
194.01	RETAIL PHARMACY	1,043		201,921				194.01
194.03	ADVERTISING EXPENSE	955		39,335		8	6,809	194.03
194.04	REGENCY HOSPITAL	16,503				61	5,149	194.04
194.05	UNUSED SPACE							194.05
200	Cross foot adjustments							200

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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	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,801,683	6,342,543	13,545,917	774,441	374,899	536,984	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.651511	1.847748	0.265182	9.043193	283.370370	0.397686	203
204	Cost to be allocated (Per Wkst. B, Part II)			1,104	14,330	5,388	56,375	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000022	0.167332	4.072562	0.041751	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING GROSS REVENUE	RECON- CILIATION	OTHER ADMIN GENERAL ACCUM COST	MAIN- TENANCE + REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.03	5A.05	5.05	6	7	8	
	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	406,887,713						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL		-21,362,279	101,683,090				5.05
6	Maintenance & Repairs			8,093,697	307,391			6
7	Operation of Plant			2,263,699	15,846	291,545		7
8	Laundry & Linen Service			608,705	1,632	1,632	176,070	8
9	Housekeeping			2,672,885	7,477	7,477		9
10	Dietary			1,552,948	11,369	11,369		10
11	Cafeteria			1,114,822	3,637	3,637		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,750,306	1,693	1,693		13
14	Central Services & Supply			4,954				14
15	Pharmacy			2,569,292	3,879	3,879		15
16	Medical Records & Library			1,865,535	5,322	5,322		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	50,409,269		17,205,745	64,402	64,402	57,564	30
31	Intensive Care Unit	4,874,640		3,184,467	9,021	9,021	6,334	31
41	Subprovider - IRF	8,166,618		4,127,907	14,602	14,602	13,882	41
43	Nursery	1,264,904		490,282	2,229	2,229		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,195,069		7,297,878	31,694	31,694	23,066	50
51	Recovery Room	2,582,034		445,802	1,214	1,214	3,680	51
52	Delivery Room & Labor Room	2,467,167		967,371	3,651	3,651		52
53	Anesthesiology	5,066,276		497,275	320	320		53
54	Radiology-Diagnostic	22,654,543		3,153,843	9,382	9,382	3,654	54
54.01	ULTRASOUND	5,391,784		582,637	1,088	1,088	3,226	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	7,806,893		718,775	1,701	1,701	858	56
57	CT Scan	28,754,123		1,354,707	1,213	1,213		57
59	Cardiac Catheterization	17,043,192		2,649,752	6,477	6,477	3,262	59
60	Laboratory	62,977,928		5,417,592	11,999	11,999		60
62	Whole Blood & Packed Red Blood Cells	3,132,681		1,016,872	736	736		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	11,918,782		1,147,656	2,811	2,811	1,830	63.02
65	Respiratory Therapy	10,163,066		1,703,719	2,395	2,395		65
66	Physical Therapy	9,625,886		2,443,701	8,801	8,801	3,968	66
67	Occupational Therapy	6,562,763		1,689,996	2,443	2,443		67
68	Speech Pathology	1,488,979		548,098	767	767		68
70	Electroencephalography	4,414,102		380,583	4,129	4,129	1,998	70
71	Medical Supplies Charged to Patients	9,100,079		3,135,692				71
72	Impl. Dev. Charged to Patients	8,188,103		3,610,683				72
73	Drugs Charged to Patients	32,690,082		4,275,155				73
74	Renal Dialysis	3,460,505		681,380	377	377		74
75.01	ONCOLOGY	772,650		174,253	1,003	1,003		75.01
76.97	CARDIAC REHABILITATION	503,194		602,228	5,651	5,651	1,910	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,763,322		1,259,848	9,240	9,240	3,208	90
90.01	OP PSYCH	29,253		10,450	553	553		90.01
91	Emergency	44,854,064		4,574,802	9,845	9,845	36,932	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,565,762		2,038,268	3,158	3,158		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	406,887,713	-21,362,279	99,884,260	261,757	245,911	165,372	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			7,430	1,117	1,117		190
192	Physicians' Private Offices			390,531	26,016	26,016		192
194	OTHER NON REIM COST CENTER			112,904				194
194.01	RETAIL PHARMACY			681,937	1,043	1,043		194.01
194.03	ADVERTISING EXPENSE			476,924	955	955		194.03
194.04	REGENCY HOSPITAL			129,104	16,503	16,503	10,698	194.04
194.05	UNUSED SPACE							194.05
200	Cross foot adjustments							200

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING GROSS REVENUE	RECON- CILIATION	OTHER ADMIN GENERAL ACCUM COST	MAIN- TENANCE + REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.03	5A.05	5.05	6	7	8	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,249,684		21,362,279	9,794,078	3,244,158	806,745	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.003071		0.210087	31,861,954	11,127,469	4,581,956	203
204	Cost to be allocated (Per Wkst. B, Part II)	23,464		492,252	869,292	232,786	26,742	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000058		0.004841	2,827,968	0,798,456	0,151,883	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		9	10	11	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	282,436						9
10	Dietary	11,369	143,226					10
11	Cafeteria	3,637		63,254				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,693		1,308	923,366			13
14	Central Services & Supply					6,458,919		14
15	Pharmacy	3,879		1,977			10,000	15
16	Medical Records & Library	5,322		173				16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,402	96,446	20,031	416,639			30
31	Intensive Care Unit	9,021	4,030	2,878	59,853			31
41	Subprovider - IRF	14,602	26,348	3,906	81,241			41
43	Nursery	2,229		465	9,676			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,694		4,575	95,150			50
51	Recovery Room	1,214		409	8,511			51
52	Delivery Room & Labor Room	3,651		921	19,157			52
53	Anesthesiology	320		782				53
54	Radiology-Diagnostic	9,382		3,142				54
54.01	ULTRASOUND	1,088		430				54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,701		464				56
57	CT Scan	1,213		576				57
59	Cardiac Catheterization	6,477		1,360	28,298			59
60	Laboratory	11,999		4,040				60
62	Whole Blood & Packed Red Blood Cells	736		209				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,811		1,192				63.02
65	Respiratory Therapy	2,395		1,926				65
66	Physical Therapy	8,801		1,250				66
67	Occupational Therapy	2,443		723				67
68	Speech Pathology	767		206				68
70	Electroencephalography	4,129		313				70
71	Medical Supplies Charged to Patients					2,873,382		71
72	Impl. Dev. Charged to Patients					3,585,537		72
73	Drugs Charged to Patients						10,000	73
74	Renal Dialysis	377						74
75.01	ONCOLOGY	1,003		148				75.01
76.97	CARDIAC REHABILITATION	5,651		672	13,983			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	9,240		4,889	101,700			90
90.01	OP PSYCH	553						90.01
91	Emergency	9,845	2,457	4,286	89,158			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,158						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	236,802	129,281	63,251	923,366	6,458,919	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,117						190
192	Physicians' Private Offices	26,016		3				192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY	1,043						194.01
194.03	ADVERTISING EXPENSE	955						194.03
194.04	REGENCY HOSPITAL	16,503	13,945					194.04
194.05	UNUSED SPACE							194.05
200	Cross foot adjustments							200

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		9	10	11	13	14	15	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,555,855	2,511,084	1,551,175	2,244,195	5,995	3,373,141	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.589950	17.532320	24.522955	2.430450	0.000928	337.314100	203
204	Cost to be allocated (Per Wkst. B, Part II)	130,887	202,258	44,906	173,078	103	364,535	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.463422	1.412160	0.709931	0.187442	0.000016	36.453500	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE						
		16						

GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	406,887,713						16
17	Social Service							17
19	Nonphysician Anesthetists							19
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	50,409,269						30
31	Intensive Care Unit	4,874,640						31
41	Subprovider - IRF	8,166,618						41
43	Nursery	1,264,904						43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	36,195,069						50
51	Recovery Room	2,582,034						51
52	Delivery Room & Labor Room	2,467,167						52
53	Anesthesiology	5,066,276						53
54	Radiology-Diagnostic	22,654,543						54
54.01	ULTRASOUND	5,391,784						54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	7,806,893						56
57	CT Scan	28,754,123						57
59	Cardiac Catheterization	17,043,192						59
60	Laboratory	62,977,928						60
62	Whole Blood & Packed Red Blood Cells	3,132,681						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	11,918,782						63.02
65	Respiratory Therapy	10,163,066						65
66	Physical Therapy	9,625,886						66
67	Occupational Therapy	6,562,763						67
68	Speech Pathology	1,488,979						68
70	Electroencephalography	4,414,102						70
71	Medical Supplies Charged to Patients	9,100,079						71
72	Impl. Dev. Charged to Patients	8,188,103						72
73	Drugs Charged to Patients	32,690,082						73
74	Renal Dialysis	3,460,505						74
75.01	ONCOLOGY	772,650						75.01
76.97	CARDIAC REHABILITATION	503,194						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,763,322						90
90.01	OP PSYCH	29,253						90.01
91	Emergency	44,854,064						91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency	2,565,762						101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	406,887,713						118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY							194.01
194.03	ADVERTISING EXPENSE							194.03
194.04	REGENCY HOSPITAL							194.04

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY GROSS REVENUE						
		16						
194.05	UNUSED SPACE							194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,557,495						202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.006286						203
204	Cost to be allocated (Per Wkst. B, Part II)	68,454						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000168						205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	28,175,243		28,175,243		28,175,243	30
31	Intensive Care Unit	4,701,230		4,701,230		4,701,230	31
41	Subprovider - IRF	6,676,819		6,676,819		6,676,819	41
43	Nursery	760,041		760,041		760,041	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	11,269,259		11,269,259	15,789	11,285,048	50
51	Recovery Room	670,741		670,741		670,741	51
52	Delivery Room & Labor Room	1,458,178		1,458,178		1,458,178	52
53	Anesthesiology	670,556		670,556		670,556	53
54	Radiology-Diagnostic	4,574,069		4,574,069	1,814	4,575,883	54
54.01	ULTRASOUND	824,731		824,731		824,731	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,028,705		1,028,705		1,028,705	56
57	CT Scan	1,901,605		1,901,605		1,901,605	57
59	Cardiac Catheterization	3,790,626		3,790,626	8,014	3,798,640	59
60	Laboratory	7,717,407		7,717,407	5,058	7,722,465	60
62	Whole Blood & Packed Red Blood Cells	1,296,227		1,296,227		1,296,227	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,657,534		1,657,534		1,657,534	63.02
65	Respiratory Therapy	2,305,876		2,305,876	496	2,306,372	65
66	Physical Therapy	3,555,588		3,555,588		3,555,588	66
67	Occupational Therapy	2,239,806		2,239,806		2,239,806	67
68	Speech Pathology	720,287		720,287		720,287	68
70	Electroencephalography	734,604		734,604		734,604	70
71	Medical Supplies Charged to Patients	3,854,329		3,854,329		3,854,329	71
72	Impl. Dev. Charged to Patients	4,424,040		4,424,040		4,424,040	72
73	Drugs Charged to Patients	8,751,940		8,751,940		8,751,940	73
74	Renal Dialysis	867,235		867,235		867,235	74
75.01	ONCOLOGY	275,094		275,094		275,094	75.01
76.97	CARDIAC REHABILITATION	1,105,206		1,105,206	7,424	1,112,630	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,430,932		2,430,932		2,430,932	90
90.01	OP PSYCH	43,564		43,564		43,564	90.01
91	Emergency	6,899,137		6,899,137	132,433	7,031,570	91
92	Observation Beds (Non-Distinct Part)	3,478,781		3,478,781		3,478,781	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,658,130		2,658,130		2,658,130	101
200	Subtotal (sum of lines 30 thru 199)	121,517,520		121,517,520	171,028	121,688,548	200
201	Less Observation Beds	3,478,781		3,478,781		3,478,781	201
202	Total (line 200 minus line 201)	118,038,739		118,038,739		118,209,767	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	42,358,329		42,358,329				30
31	Intensive Care Unit	4,874,640		4,874,640				31
41	Subprovider - IRF	8,166,618		8,166,618				41
43	Nursery	1,264,904		1,264,904				43
	ANCLLARY SERVICE COST CENTERS							
50	Operating Room	13,038,845	23,156,224	36,195,069	0.311348	0.311348	0.311784	50
51	Recovery Room	1,028,560	1,553,474	2,582,034	0.259772	0.259772	0.259772	51
52	Delivery Room & Labor Room	2,106,447	360,720	2,467,167	0.591033	0.591033	0.591033	52
53	Anesthesiology	2,101,188	2,965,088	5,066,276	0.132357	0.132357	0.132357	53
54	Radiology-Diagnostic	5,926,349	16,728,194	22,654,543	0.201905	0.201905	0.201985	54
54.01	ULTRASOUND	855,190	4,536,594	5,391,784	0.152961	0.152961	0.152961	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,825,163	5,981,730	7,806,893	0.131769	0.131769	0.131769	56
57	CT Scan	9,149,177	19,604,946	28,754,123	0.066133	0.066133	0.066133	57
59	Cardiac Catheterization	9,544,990	7,498,202	17,043,192	0.222413	0.222413	0.222883	59
60	Laboratory	25,349,109	37,628,819	62,977,928	0.122541	0.122541	0.122622	60
62	Whole Blood & Packed Red Blood Cells	2,498,966	633,715	3,132,681	0.413776	0.413776	0.413776	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	4,880,653	7,038,129	11,918,782	0.139069	0.139069	0.139069	63.02
65	Respiratory Therapy	8,419,013	1,744,053	10,163,066	0.226888	0.226888	0.226937	65
66	Physical Therapy	6,167,557	3,458,329	9,625,886	0.369378	0.369378	0.369378	66
67	Occupational Therapy	4,999,396	1,563,367	6,562,763	0.341290	0.341290	0.341290	67
68	Speech Pathology	910,370	578,609	1,488,979	0.483746	0.483746	0.483746	68
70	Electroencephalography	1,531,890	2,882,212	4,414,102	0.166422	0.166422	0.166422	70
71	Medical Supplies Charged to Patients	4,926,800	4,173,279	9,100,079	0.423549	0.423549	0.423549	71
72	Impl. Dev. Charged to Patients	6,158,612	2,029,491	8,188,103	0.540301	0.540301	0.540301	72
73	Drugs Charged to Patients	21,478,139	11,211,943	32,690,082	0.267725	0.267725	0.267725	73
74	Renal Dialysis	3,255,300	205,205	3,460,505	0.250609	0.250609	0.250609	74
75.01	ONCOLOGY	436	772,214	772,650	0.356040	0.356040	0.356040	75.01
76.97	CARDIAC REHABILITATION	137,837	365,357	503,194	2.196382	2.196382	2.211135	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	226,779	1,536,543	1,763,322	1.378609	1.378609	1.378609	90
90.01	OP PSYCH		29,253	29,253	1.489215	1.489215	1.489215	90.01
91	Emergency	10,691,877	34,162,187	44,854,064	0.153813	0.153813	0.156766	91
92	Observation Beds (Non-Distinct Part)	902,824	7,148,116	8,050,940	0.432096	0.432096	0.432096	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,565,762	2,565,762				101
200	Subtotal (sum of lines 30 thru 199)	204,775,958	202,111,755	406,887,713				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	204,775,958	202,111,755	406,887,713				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	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)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,609,274		1,609,274	30,712	52.40	11,287	591,439	30
31	Intensive Care Unit	308,250		308,250	2,469	124.85	1,244	155,313	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	321,586		321,586	9,018	35.66	7,352	262,172	41
42	Subprovider I								42
43	Nursery	28,831		28,831	1,236	23.33			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,267,941		2,267,941	43,435		19,883	1,008,924	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0008

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,451,912	36,195,069	0.040114	5,052,164	202,663	50
51	Recovery Room	24,502	2,582,034	0.009489	328,836	3,120	51
52	Delivery Room & Labor Room	48,870	2,467,167	0.019808			52
53	Anesthesiology	129,400	5,066,276	0.025541	754,005	19,258	53
54	Radiology-Diagnostic	931,767	22,654,543	0.041129	2,289,944	94,183	54
54.01	ULTRASOUND	100,165	5,391,784	0.018577	347,083	6,448	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,099	7,806,893	0.011413	813,298	9,282	56
57	CT Scan	654,922	28,754,123	0.022777	3,852,667	87,752	57
59	Cardiac Catheterization	711,059	17,043,192	0.041721	4,582,715	191,195	59
60	Laboratory	334,429	62,977,928	0.005310	9,700,389	51,509	60
62	Whole Blood & Packed Red Blood	45,378	3,132,681	0.014485	980,684	14,205	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	284,823	11,918,782	0.023897	2,460,423	58,797	63.02
65	Respiratory Therapy	98,422	10,163,066	0.009684	4,984,526	48,270	65
66	Physical Therapy	140,674	9,625,886	0.014614	1,058,822	15,474	66
67	Occupational Therapy	38,852	6,562,763	0.005920	513,842	3,042	67
68	Speech Pathology	26,684	1,488,979	0.017921	234,160	4,196	68
70	Electroencephalography	108,342	4,414,102	0.024545	408,690	10,031	70
71	Medical Supplies Charged to Pat	17,283	9,100,079	0.001899	1,218,202	2,313	71
72	Impl. Dev. Charged to Patients	19,387	8,188,103	0.002368	3,485,122	8,253	72
73	Drugs Charged to Patients	392,619	32,690,082	0.012010	8,164,557	98,056	73
74	Renal Dialysis	8,131	3,460,505	0.002350	1,570,702	3,691	74
75.01	ONCOLOGY	13,483	772,650	0.017450			75.01
76.97	CARDIAC REHABILITATION	101,395	503,194	0.201503	64,185	12,933	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	141,885	1,763,322	0.080465	10,736	864	90
90.01	OP PSYCH	5,998	29,253	0.205039			90.01
91	Emergency	388,251	44,854,064	0.008656	4,225,896	36,579	91
92	Observation Beds (Non-Distinct	198,698	8,050,940	0.024680	395,103	9,751	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	6,506,430	347,657,460		57,496,751	991,865	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	30,712		11,287		30
31	Intensive Care Unit	2,469		1,244		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	9,018		7,352		41
42	Subprovider I					42
43	Nursery	1,236				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	43,435		19,883		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OP PSYCH							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	36,195,069			5,052,164		8,028,426		50
51	Recovery Room	2,582,034			328,836		270,178		51
52	Delivery Room & Labor Room	2,467,167							52
53	Anesthesiology	5,066,276			754,005		652,296		53
54	Radiology-Diagnostic	22,654,543			2,289,944		4,074,765		54
54.01	ULTRASOUND	5,391,784			347,083		574,472		54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	7,806,893			813,298		2,961,509		56
57	CT Scan	28,754,123			3,852,667		5,404,805		57
59	Cardiac Catheterization	17,043,192			4,582,715		4,170,838		59
60	Laboratory	62,977,928			9,700,389		4,295,450		60
62	Whole Blood & Packed Red Blood	3,132,681			980,684		145,104		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,918,782			2,460,423		3,079,285		63.02
65	Respiratory Therapy	10,163,066			4,984,526		654,365		65
66	Physical Therapy	9,625,886			1,058,822		69,396		66
67	Occupational Therapy	6,562,763			513,842		815		67
68	Speech Pathology	1,488,979			234,160		49,949		68
70	Electroencephalography	4,414,102			408,690		866,324		70
71	Medical Supplies Charged to Pat	9,100,079			1,218,202		1,978,772		71
72	Impl. Dev. Charged to Patients	8,188,103			3,485,122		726,427		72
73	Drugs Charged to Patients	32,690,082			8,164,557		4,405,663		73
74	Renal Dialysis	3,460,505			1,570,702		205,205		74
75.01	ONCOLOGY	772,650					403,543		75.01
76.97	CARDIAC REHABILITATION	503,194			64,185		142,518		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,763,322			10,736		244,369		90
90.01	OP PSYCH	29,253							90.01
91	Emergency	44,854,064			4,225,896		5,209,855		91
92	Observation Beds (Non-Distinct	8,050,940			395,103		1,751,556		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	347,657,460			57,496,751		50,365,885		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.311348	8,028,426			2,499,634			50
51	Recovery Room	0.259772	270,178			70,185			51
52	Delivery Room & Labor Room	0.591033							52
53	Anesthesiology	0.132357	652,296			86,336			53
54	Radiology-Diagnostic	0.201905	4,074,765			822,715			54
54.01	ULTRASOUND	0.152961	574,472			87,872			54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.131769	2,961,509			390,235			56
57	CT Scan	0.066133	5,404,805			357,436			57
59	Cardiac Catheterization	0.222413	4,170,838			927,649			59
60	Laboratory	0.122541	4,295,450			526,369			60
62	Whole Blood & Packed Red Blood	0.413776	145,104			60,041			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.139069	3,079,285			428,233			63.02
65	Respiratory Therapy	0.226888	654,365			148,468			65
66	Physical Therapy	0.369378	69,396			25,633			66
67	Occupational Therapy	0.341290	815			278			67
68	Speech Pathology	0.483746	49,949			24,163			68
70	Electroencephalography	0.166422	866,324			144,175			70
71	Medical Supplies Charged to Pat	0.423549	1,978,772			838,107			71
72	Impl. Dev. Charged to Patients	0.540301	726,427			392,489			72
73	Drugs Charged to Patients	0.267725	4,405,663		29,423	1,179,506		7,877	73
74	Renal Dialysis	0.250609	205,205			51,426			74
75.01	ONCOLOGY	0.356040	403,543			143,677			75.01
76.97	CARDIAC REHABILITATION	2.196382	142,518			313,024			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.378609	244,369			336,889			90
90.01	OP PSYCH	1.489215							90.01
91	Emergency	0.153813	5,209,855			801,343			91
92	Observation Beds (Non-Distinct	0.432096	1,751,556			756,840			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		50,365,885		29,423	11,412,723		7,877	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		50,365,885		29,423	11,412,723		7,877	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T008

**WORKSHEET D
PART II**

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

(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	1,451,912	36,195,069	0.040114	159,960	6,417	50
51	Recovery Room	24,502	2,582,034	0.009489	32,303	307	51
52	Delivery Room & Labor Room	48,870	2,467,167	0.019808			52
53	Anesthesiology	129,400	5,066,276	0.025541	41,839	1,069	53
54	Radiology-Diagnostic	931,767	22,654,543	0.041129	364,215	14,980	54
54.01	ULTRASOUND	100,165	5,391,784	0.018577	26,593	494	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,099	7,806,893	0.011413	58,078	663	56
57	CT Scan	654,922	28,754,123	0.022777	261,376	5,953	57
59	Cardiac Catheterization	711,059	17,043,192	0.041721	61,040	2,547	59
60	Laboratory	334,429	62,977,928	0.005310	1,787,122	9,490	60
62	Whole Blood & Packed Red Blood	45,378	3,132,681	0.014485	140,616	2,037	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	284,823	11,918,782	0.023897	472,101	11,282	63.02
65	Respiratory Therapy	98,422	10,163,066	0.009684	744,696	7,212	65
66	Physical Therapy	140,674	9,625,886	0.014614	3,402,535	49,725	66
67	Occupational Therapy	38,852	6,562,763	0.005920	3,341,225	19,780	67
68	Speech Pathology	26,684	1,488,979	0.017921	408,946	7,329	68
70	Electroencephalography	108,342	4,414,102	0.024545	525,104	12,889	70
71	Medical Supplies Charged to Pat	17,283	9,100,079	0.001899	642,449	1,220	71
72	Impl. Dev. Charged to Patients	19,387	8,188,103	0.002368	32,515	77	72
73	Drugs Charged to Patients	392,619	32,690,082	0.012010	3,073,042	36,907	73
74	Renal Dialysis	8,131	3,460,505	0.002350	752,114	1,767	74
75.01	ONCOLOGY	13,483	772,650	0.017450			75.01
76.97	CARDIAC REHABILITATION	101,395	503,194	0.201503	401	81	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	141,885	1,763,322	0.080465	1,220	98	90
90.01	OP PSYCH	5,998	29,253	0.205039			90.01
91	Emergency	388,251	44,854,064	0.008656	15,268	132	91
92	Observation Beds (Non-Distinct		8,050,940				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	6,307,732	347,657,460		16,344,758	192,456	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OP PSYCH							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	36,195,069			159,960				50
51	Recovery Room	2,582,034			32,303				51
52	Delivery Room & Labor Room	2,467,167							52
53	Anesthesiology	5,066,276			41,839				53
54	Radiology-Diagnostic	22,654,543			364,215				54
54.01	ULTRASOUND	5,391,784			26,593				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	7,806,893			58,078				56
57	CT Scan	28,754,123			261,376				57
59	Cardiac Catheterization	17,043,192			61,040				59
60	Laboratory	62,977,928			1,787,122				60
62	Whole Blood & Packed Red Blood	3,132,681			140,616				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,918,782			472,101				63.02
65	Respiratory Therapy	10,163,066			744,696				65
66	Physical Therapy	9,625,886			3,402,535				66
67	Occupational Therapy	6,562,763			3,341,225				67
68	Speech Pathology	1,488,979			408,946				68
70	Electroencephalography	4,414,102			525,104				70
71	Medical Supplies Charged to Pat	9,100,079			642,449				71
72	Impl. Dev. Charged to Patients	8,188,103			32,515				72
73	Drugs Charged to Patients	32,690,082			3,073,042		297		73
74	Renal Dialysis	3,460,505			752,114				74
75.01	ONCOLOGY	772,650							75.01
76.97	CARDIAC REHABILITATION	503,194			401				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	1,763,322			1,220				90
90.01	OP PSYCH	29,253							90.01
91	Emergency	44,854,064			15,268				91
92	Observation Beds (Non-Distinct	8,050,940							92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	347,657,460			16,344,758		297		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T008

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.311348							50
51	Recovery Room	0.259772							51
52	Delivery Room & Labor Room	0.591033							52
53	Anesthesiology	0.132357							53
54	Radiology-Diagnostic	0.201905							54
54.01	ULTRASOUND	0.152961							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.131769							56
57	CT Scan	0.066133							57
59	Cardiac Catheterization	0.222413							59
60	Laboratory	0.122541							60
62	Whole Blood & Packed Red Blood	0.413776							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.139069							63.02
65	Respiratory Therapy	0.226888							65
66	Physical Therapy	0.369378							66
67	Occupational Therapy	0.341290							67
68	Speech Pathology	0.483746							68
70	Electroencephalography	0.166422							70
71	Medical Supplies Charged to Pat	0.423549							71
72	Impl. Dev. Charged to Patients	0.540301							72
73	Drugs Charged to Patients	0.267725	297		966	80		259	73
74	Renal Dialysis	0.250609							74
75.01	ONCOLOGY	0.356040							75.01
76.97	CARDIAC REHABILITATION	2.196382							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.378609							90
90.01	OP PSYCH	1.489215							90.01
91	Emergency	0.153813							91
92	Observation Beds (Non-Distinct	0.432096							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		297		966	80		259	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		297		966	80		259	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: 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)	1	2	3	4	5	6	7		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,609,274		1,609,274	30,712	52.40	4,299	225,268	30
31	Intensive Care Unit	308,250		308,250	2,469	124.85	327	40,826	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	321,586		321,586	9,018	35.66	516	18,401	41
42	Subprovider I								42
43	Nursery	28,831		28,831	1,236	23.33	270	6,299	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,267,941		2,267,941	43,435		5,412	290,794	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0008

**WORKSHEET D
PART II**

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

(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	1,451,912	36,195,069	0.040114	1,093,595	43,868	50
51	Recovery Room	24,502	2,582,034	0.009489	124,479	1,181	51
52	Delivery Room & Labor Room	48,870	2,467,167	0.019808	329,175	6,520	52
53	Anesthesiology	129,400	5,066,276	0.025541	234,838	5,998	53
54	Radiology-Diagnostic	931,767	22,654,543	0.041129	835,302	34,355	54
54.01	ULTRASOUND	100,165	5,391,784	0.018577	99,690	1,852	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,099	7,806,893	0.011413	259,814	2,965	56
57	CT Scan	654,922	28,754,123	0.022777	1,159,230	26,404	57
59	Cardiac Catheterization	711,059	17,043,192	0.041721	1,015,443	42,365	59
60	Laboratory	334,429	62,977,928	0.005310	3,350,205	17,790	60
62	Whole Blood & Packed Red Blood	45,378	3,132,681	0.014485	156,486	2,267	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	284,823	11,918,782	0.023897	859,633	20,543	63.02
65	Respiratory Therapy	98,422	10,163,066	0.009684	707,061	6,847	65
66	Physical Therapy	140,674	9,625,886	0.014614	261,927	3,828	66
67	Occupational Therapy	38,852	6,562,763	0.005920	110,409	654	67
68	Speech Pathology	26,684	1,488,979	0.017921	76,033	1,363	68
70	Electroencephalography	108,342	4,414,102	0.024545	118,976	2,920	70
71	Medical Supplies Charged to Pat	17,283	9,100,079	0.001899	860,185	1,633	71
72	Impl. Dev. Charged to Patients	19,387	8,188,103	0.002368	539,578	1,278	72
73	Drugs Charged to Patients	392,619	32,690,082	0.012010	3,145,560	37,778	73
74	Renal Dialysis	8,131	3,460,505	0.002350	383,236	901	74
75.01	ONCOLOGY	13,483	772,650	0.017450			75.01
76.97	CARDIAC REHABILITATION	101,395	503,194	0.201503	15,501	3,123	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	141,885	1,763,322	0.080465	2,684	216	90
90.01	OP PSYCH	5,998	29,253	0.205039			90.01
91	Emergency	388,251	44,854,064	0.008656	1,115,005	9,651	91
92	Observation Beds (Non-Distinct	198,698	8,050,940	0.024680	164,230	4,053	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	6,506,430	347,657,460		17,018,275	280,353	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	30,712		4,299		30
31	Intensive Care Unit	2,469		327		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	9,018		516		41
42	Subprovider I					42
43	Nursery	1,236		270		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	43,435		5,412		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OP PSYCH							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-0008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	36,195,069			1,093,595				50
51	Recovery Room	2,582,034			124,479				51
52	Delivery Room & Labor Room	2,467,167			329,175				52
53	Anesthesiology	5,066,276			234,838				53
54	Radiology-Diagnostic	22,654,543			835,302				54
54.01	ULTRASOUND	5,391,784			99,690				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	7,806,893			259,814				56
57	CT Scan	28,754,123			1,159,230				57
59	Cardiac Catheterization	17,043,192			1,015,443				59
60	Laboratory	62,977,928			3,350,205				60
62	Whole Blood & Packed Red Blood	3,132,681			156,486				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,918,782			859,633				63.02
65	Respiratory Therapy	10,163,066			707,061				65
66	Physical Therapy	9,625,886			261,927				66
67	Occupational Therapy	6,562,763			110,409				67
68	Speech Pathology	1,488,979			76,033				68
70	Electroencephalography	4,414,102			118,976				70
71	Medical Supplies Charged to Pat	9,100,079			860,185				71
72	Impl. Dev. Charged to Patients	8,188,103			539,578				72
73	Drugs Charged to Patients	32,690,082			3,145,560				73
74	Renal Dialysis	3,460,505			383,236				74
75.01	ONCOLOGY	772,650							75.01
76.97	CARDIAC REHABILITATION	503,194			15,501				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,763,322			2,684				90
90.01	OP PSYCH	29,253							90.01
91	Emergency	44,854,064			1,115,005				91
92	Observation Beds (Non-Distinct	8,050,940			164,230				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	347,657,460			17,018,275				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0008

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.311348							50
51	Recovery Room	0.259772							51
52	Delivery Room & Labor Room	0.591033							52
53	Anesthesiology	0.132357							53
54	Radiology-Diagnostic	0.201905							54
54.01	ULTRASOUND	0.152961							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.131769							56
57	CT Scan	0.066133							57
59	Cardiac Catheterization	0.222413							59
60	Laboratory	0.122541							60
62	Whole Blood & Packed Red Blood	0.413776							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.139069							63.02
65	Respiratory Therapy	0.226888							65
66	Physical Therapy	0.369378							66
67	Occupational Therapy	0.341290							67
68	Speech Pathology	0.483746							68
70	Electroencephalography	0.166422							70
71	Medical Supplies Charged to Pat	0.423549							71
72	Impl. Dev. Charged to Patients	0.540301							72
73	Drugs Charged to Patients	0.267725							73
74	Renal Dialysis	0.250609							74
75.01	ONCOLOGY	0.356040							75.01
76.97	CARDIAC REHABILITATION	2.196382							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.378609							90
90.01	OP PSYCH	1.489215							90.01
91	Emergency	0.153813							91
92	Observation Beds (Non-Distinct	0.432096							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-T008

**WORKSHEET D
PART II**

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

(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	1,451,912	36,195,069	0.040114	10,062	404	50
51	Recovery Room	24,502	2,582,034	0.009489	1,032	10	51
52	Delivery Room & Labor Room	48,870	2,467,167	0.019808			52
53	Anesthesiology	129,400	5,066,276	0.025541	2,226	57	53
54	Radiology-Diagnostic	931,767	22,654,543	0.041129	16,811	691	54
54.01	ULTRASOUND	100,165	5,391,784	0.018577			54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	89,099	7,806,893	0.011413	2,054	23	56
57	CT Scan	654,922	28,754,123	0.022777	21,510	490	57
59	Cardiac Catheterization	711,059	17,043,192	0.041721	8,532	356	59
60	Laboratory	334,429	62,977,928	0.005310	110,849	589	60
62	Whole Blood & Packed Red Blood	45,378	3,132,681	0.014485	4,080	59	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	284,823	11,918,782	0.023897	7,469	178	63.02
65	Respiratory Therapy	98,422	10,163,066	0.009684	61,556	596	65
66	Physical Therapy	140,674	9,625,886	0.014614	256,939	3,755	66
67	Occupational Therapy	38,852	6,562,763	0.005920	242,578	1,436	67
68	Speech Pathology	26,684	1,488,979	0.017921	32,556	583	68
70	Electroencephalography	108,342	4,414,102	0.024545	57,733	1,417	70
71	Medical Supplies Charged to Pat	17,283	9,100,079	0.001899	32,381	61	71
72	Impl. Dev. Charged to Patients	19,387	8,188,103	0.002368			72
73	Drugs Charged to Patients	392,619	32,690,082	0.012010	217,498	2,612	73
74	Renal Dialysis	8,131	3,460,505	0.002350	25,200	59	74
75.01	ONCOLOGY	13,483	772,650	0.017450			75.01
76.97	CARDIAC REHABILITATION	101,395	503,194	0.201503			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	141,885	1,763,322	0.080465	366	29	90
90.01	OP PSYCH	5,998	29,253	0.205039			90.01
91	Emergency	388,251	44,854,064	0.008656			91
92	Observation Beds (Non-Distinct		8,050,940				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	6,307,732	347,657,460		1,111,432	13,405	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	ULTRASOUND						54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope						56
57	CT Scan						57
59	Cardiac Catheterization						59
60	Laboratory						60
62	Whole Blood & Packed Red Blood						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB						63.02
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
70	Electroencephalography						70
71	Medical Supplies Charged to Pat						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75.01	ONCOLOGY						75.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.01	OP PSYCH						90.01
91	Emergency						91
92	Observation Beds (Non-Distinct)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-T008

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	36,195,069			10,062				50
51	Recovery Room	2,582,034			1,032				51
52	Delivery Room & Labor Room	2,467,167							52
53	Anesthesiology	5,066,276			2,226				53
54	Radiology-Diagnostic	22,654,543			16,811				54
54.01	ULTRASOUND	5,391,784							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	7,806,893			2,054				56
57	CT Scan	28,754,123			21,510				57
59	Cardiac Catheterization	17,043,192			8,532				59
60	Laboratory	62,977,928			110,849				60
62	Whole Blood & Packed Red Blood	3,132,681			4,080				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	11,918,782			7,469				63.02
65	Respiratory Therapy	10,163,066			61,556				65
66	Physical Therapy	9,625,886			256,939				66
67	Occupational Therapy	6,562,763			242,578				67
68	Speech Pathology	1,488,979			32,556				68
70	Electroencephalography	4,414,102			57,733				70
71	Medical Supplies Charged to Pat	9,100,079			32,381				71
72	Impl. Dev. Charged to Patients	8,188,103							72
73	Drugs Charged to Patients	32,690,082			217,498				73
74	Renal Dialysis	3,460,505			25,200				74
75.01	ONCOLOGY	772,650							75.01
76.97	CARDIAC REHABILITATION	503,194							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	1,763,322			366				90
90.01	OP PSYCH	29,253							90.01
91	Emergency	44,854,064							91
92	Observation Beds (Non-Distinct	8,050,940							92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	347,657,460			1,111,432				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-T008

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.311348							50
51	Recovery Room	0.259772							51
52	Delivery Room & Labor Room	0.591033							52
53	Anesthesiology	0.132357							53
54	Radiology-Diagnostic	0.201905							54
54.01	ULTRASOUND	0.152961							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.131769							56
57	CT Scan	0.066133							57
59	Cardiac Catheterization	0.222413							59
60	Laboratory	0.122541							60
62	Whole Blood & Packed Red Blood	0.413776							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.139069							63.02
65	Respiratory Therapy	0.226888							65
66	Physical Therapy	0.369378							66
67	Occupational Therapy	0.341290							67
68	Speech Pathology	0.483746							68
70	Electroencephalography	0.166422							70
71	Medical Supplies Charged to Pat	0.423549							71
72	Impl. Dev. Charged to Patients	0.540301							72
73	Drugs Charged to Patients	0.267725							73
74	Renal Dialysis	0.250609							74
75.01	ONCOLOGY	0.356040							75.01
76.97	CARDIAC REHABILITATION	2.196382							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1.378609							90
90.01	OP PSYCH	1.489215							90.01
91	Emergency	0.153813							91
92	Observation Beds (Non-Distinct	0.432096							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	30,712	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	30,712	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	26,920	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11,287	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	28,175,243	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	28,175,243	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,175,243	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					917.40	38	
39	Program general inpatient routine service cost (line 9 x line 38)					10,354,694	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)					10,354,694	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	4,701,230	2,469	1,904.10	1,244	2,368,700	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					13,444,156	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					26,167,550	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					746,752	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					991,865	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,738,617	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					24,428,933	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					3,792	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					917.40	88
89	Observation bed cost (line 87 x line 88) (see instructions)					3,478,781	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,609,274	28,175,243	0.057117	3,478,781	198,698	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T008

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,018	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,018	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)	9,018	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,352	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	6,676,819	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,676,819	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,676,819	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	30,712	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	30,712	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	26,920	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,299	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,236	15
16	Nursery days (title V or XIX only)	270	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	28,175,243	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	28,175,243	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,175,243	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					917.40	38	
39	Program general inpatient routine service cost (line 9 x line 38)					3,943,903	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					3,943,903	41	
42	Nursery (Titles V and XIX only)	760,041	1,236	614.92	270	166,028	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	4,701,230	2,469	1,904.10	327	622,641	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,944,488	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					8,677,060	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					272,393	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					280,353	51
52	Total Program excludable cost (sum of lines 50 and 51)					552,746	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					8,124,314	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0008

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					3,792	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T008

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,018	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,018	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)	9,018	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	516	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	6,676,819	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,676,819	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,676,819	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-T008

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)		740.39	38
39	Program general inpatient routine service cost (line 9 x line 38)		382,041	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)		382,041	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		322,800	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)		704,841	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		18,401	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		13,405	51
52	Total Program excludable cost (sum of lines 50 and 51)		31,806	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		673,035	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges			54
55	Target amount per discharge			55
56	Target amount (line 54 x line 55)			56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)			57
58	Bonus payment (see instructions)			58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.			59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.			60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)			61
62	Relief payment (see instructions)			62
63	Allowable Inpatient cost plus incentive payment (see instructions)			63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)			64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)			65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)			66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)			67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)			68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)			69

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0008

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		16,186,329		30
31	Intensive Care Unit		2,489,129		31
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.311784	5,052,164	1,575,184	50
51	Recovery Room	0.259772	328,836	85,422	51
52	Delivery Room & Labor Room	0.591033			52
53	Anesthesiology	0.132357	754,005	99,798	53
54	Radiology-Diagnostic	0.201985	2,289,944	462,534	54
54.01	ULTRASOUND	0.152961	347,083	53,090	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.131769	813,298	107,167	56
57	CT Scan	0.066133	3,852,667	254,788	57
59	Cardiac Catheterization	0.222883	4,582,715	1,021,409	59
60	Laboratory	0.122622	9,700,389	1,189,481	60
62	Whole Blood & Packed Red Blood Cells	0.413776	980,684	405,784	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.139069	2,460,423	342,169	63.02
65	Respiratory Therapy	0.226937	4,984,526	1,131,173	65
66	Physical Therapy	0.369378	1,058,822	391,106	66
67	Occupational Therapy	0.341290	513,842	175,369	67
68	Speech Pathology	0.483746	234,160	113,274	68
70	Electroencephalography	0.166422	408,690	68,015	70
71	Medical Supplies Charged to Patients	0.423549	1,218,202	515,968	71
72	Impl. Dev. Charged to Patients	0.540301	3,485,122	1,883,015	72
73	Drugs Charged to Patients	0.267725	8,164,557	2,185,856	73
74	Renal Dialysis	0.250609	1,570,702	393,632	74
75.01	ONCOLOGY	0.356040			75.01
76.97	CARDIAC REHABILITATION	2.211135	64,185	141,922	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.378609	10,736	14,801	90
90.01	OP PSYCH	1.489215			90.01
91	Emergency	0.156766	4,225,896	662,477	91
92	Observation Beds (Non-Distinct Part)	0.432096	395,103	170,722	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		57,496,751	13,444,156	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		57,496,751		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T008

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
41	Subprovider - IRF		6,614,190		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.311784	159,960	49,873	50
51	Recovery Room	0.259772	32,303	8,391	51
52	Delivery Room & Labor Room	0.591033			52
53	Anesthesiology	0.132357	41,839	5,538	53
54	Radiology-Diagnostic	0.201985	364,215	73,566	54
54.01	ULTRASOUND	0.152961	26,593	4,068	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.131769	58,078	7,653	56
57	CT Scan	0.066133	261,376	17,286	57
59	Cardiac Catheterization	0.222883	61,040	13,605	59
60	Laboratory	0.122622	1,787,122	219,140	60
62	Whole Blood & Packed Red Blood Cells	0.413776	140,616	58,184	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.139069	472,101	65,655	63.02
65	Respiratory Therapy	0.226937	744,696	168,999	65
66	Physical Therapy	0.369378	3,402,535	1,256,822	66
67	Occupational Therapy	0.341290	3,341,225	1,140,327	67
68	Speech Pathology	0.483746	408,946	197,826	68
70	Electroencephalography	0.166422	525,104	87,389	70
71	Medical Supplies Charged to Patients	0.423549	642,449	272,109	71
72	Impl. Dev. Charged to Patients	0.540301	32,515	17,568	72
73	Drugs Charged to Patients	0.267725	3,073,042	822,730	73
74	Renal Dialysis	0.250609	752,114	188,487	74
75.01	ONCOLOGY	0.356040			75.01
76.97	CARDIAC REHABILITATION	2.211135	401	887	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.378609	1,220	1,682	90
90.01	OP PSYCH	1.489215			90.01
91	Emergency	0.156766	15,268	2,394	91
92	Observation Beds (Non-Distinct Part)	0.432096			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		16,344,758	4,680,179	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		16,344,758		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0008

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		7,806,269		30
31	Intensive Care Unit		559,067		31
41	Subprovider - IRF				41
43	Nursery		322,030		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.311784	1,093,595	340,965	50
51	Recovery Room	0.259772	124,479	32,336	51
52	Delivery Room & Labor Room	0.591033	329,175	194,553	52
53	Anesthesiology	0.132357	234,838	31,082	53
54	Radiology-Diagnostic	0.201985	835,302	168,718	54
54.01	ULTRASOUND	0.152961	99,690	15,249	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.131769	259,814	34,235	56
57	CT Scan	0.066133	1,159,230	76,663	57
59	Cardiac Catheterization	0.222883	1,015,443	226,325	59
60	Laboratory	0.122622	3,350,205	410,809	60
62	Whole Blood & Packed Red Blood Cells	0.413776	156,486	64,750	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.139069	859,633	119,548	63.02
65	Respiratory Therapy	0.226937	707,061	160,458	65
66	Physical Therapy	0.369378	261,927	96,750	66
67	Occupational Therapy	0.341290	110,409	37,681	67
68	Speech Pathology	0.483746	76,033	36,781	68
70	Electroencephalography	0.166422	118,976	19,800	70
71	Medical Supplies Charged to Patients	0.423549	860,185	364,330	71
72	Impl. Dev. Charged to Patients	0.540301	539,578	291,535	72
73	Drugs Charged to Patients	0.267725	3,145,560	842,145	73
74	Renal Dialysis	0.250609	383,236	96,042	74
75.01	ONCOLOGY	0.356040			75.01
76.97	CARDIAC REHABILITATION	2.211135	15,501	34,275	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.378609	2,684	3,700	90
90.01	OP PSYCH	1.489215			90.01
91	Emergency	0.156766	1,115,005	174,795	91
92	Observation Beds (Non-Distinct Part)	0.432096	164,230	70,963	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		17,018,275	3,944,488	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		17,018,275		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-T008

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
41	Subprovider - IRF		463,195		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.311784	10,062	3,137	50
51	Recovery Room	0.259772	1,032	268	51
52	Delivery Room & Labor Room	0.591033			52
53	Anesthesiology	0.132357	2,226	295	53
54	Radiology-Diagnostic	0.201985	16,811	3,396	54
54.01	ULTRASOUND	0.152961			54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.131769	2,054	271	56
57	CT Scan	0.066133	21,510	1,423	57
59	Cardiac Catheterization	0.222883	8,532	1,902	59
60	Laboratory	0.122622	110,849	13,593	60
62	Whole Blood & Packed Red Blood Cells	0.413776	4,080	1,688	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.139069	7,469	1,039	63.02
65	Respiratory Therapy	0.226937	61,556	13,969	65
66	Physical Therapy	0.369378	256,939	94,908	66
67	Occupational Therapy	0.341290	242,578	82,789	67
68	Speech Pathology	0.483746	32,556	15,749	68
70	Electroencephalography	0.166422	57,733	9,608	70
71	Medical Supplies Charged to Patients	0.423549	32,381	13,715	71
72	Impl. Dev. Charged to Patients	0.540301			72
73	Drugs Charged to Patients	0.267725	217,498	58,230	73
74	Renal Dialysis	0.250609	25,200	6,315	74
75.01	ONCOLOGY	0.356040			75.01
76.97	CARDIAC REHABILITATION	2.211135			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	1.378609	366	505	90
90.01	OP PSYCH	1.489215			90.01
91	Emergency	0.156766			91
92	Observation Beds (Non-Distinct Part)	0.432096			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,111,432	322,800	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,111,432		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,086,620			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	15,471,233			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	508,625			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	150.61			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1263			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3224			31
32	Sum of lines 30 and 31	0.4487			32
33	Allowable disproportionate share percentage (see instructions)	0.2623			33
34	Disproportionate share adjustment (see instructions)	1,348,081			34
			Prior to October 1	On or after October 1	
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)	9,046,380,143	7,647,644,885		35
35.01	Factor 3 (see instructions)	0.000267556	0.000322053		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,420,413	2,462,947		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	610,077	1,842,149		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,452,226			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by 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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	24,866,785			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	24,866,785			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,833,898			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	26,700,683			59
60	Primary payer payments	8,468			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	26,692,215			61
62	Deductibles billed to program beneficiaries	1,929,652			62
63	Coinsurance billed to program beneficiaries	247,686			63
64	Allowable bad debts (see instructions)	752,248			64
65	Adjusted reimbursable bad debts (see instructions)	488,961			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	215,541			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	25,003,838			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (ER ADJUSTMENT PER PSR)				70
70.93	HVBP payment adjustment amount (see instructions)	157,191			70.93
70.94	HRR adjustment amount (see instructions)	-19,902			70.94
71	Amount due provider (see instructions)	25,141,127			71
71.01	Sequestration adjustment (see instructions)	502,823			71.01
72	Interim payments	23,964,558			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	673,746			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	5,407,146			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

HSP Bonus Payment Amount

Prior to 10/1 On or After 10/1

100	HSP bonus amount (see instructions)				100
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0008

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	7,877			1
2	Medical and other services reimbursed under OPPS (see instructions)	11,412,723			2
3	PPS payments	9,587,062			3
4	Outlier payment (see instructions)	72,393			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	7,877			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	29,423			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	29,423			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)	29,423			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	21,546			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)	7,877			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	9,659,455			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,016,659			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,650,673			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)	7,650,673			30
31	Primary payer payments	2,796			31
32	Subtotal (line 30 minus line 31)	7,647,877			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)	752,517			34
35	Adjusted reimbursable bad debts (see instructions)	489,136			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	321,074			36
37	Subtotal (see instructions)	8,137,013			37
38	MSP-LCC reconciliation amount from PS&R	-706			38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	8,137,719			40
40.01	Sequestration adjustment (see instructions)	162,754			40.01
41	Interim payments	7,748,796			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	226,169			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter I, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T008

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	259			1
2	Medical and other services reimbursed under OPPS (see instructions)	80			2
3	PPS payments	127			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	259			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	966			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	966			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)	966			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	707			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)	259			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	127			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	386			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)	386			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	386			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)	386			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	386			40
40.01	Sequestration adjustment (see instructions)	8			40.01
41	Interim payments	370			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	8			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter I, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0008

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	Total interim payments paid to provider		23,715,429		7,493,379	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		249,129		255,417	2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,964,558		7,748,796	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01				6.01
		.02				6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-T008

**WORKSHEET E-1
PART I**

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

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		11,379,307		370
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,379,307		370
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)				7
8	Name of Contractor		Contractor Number	NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	6,639	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	12,531	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,636	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	29,389	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	406,887,713	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	18,033,813	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	781,316	8
9	Sequestration adjustment amount (see instructions)	15,626	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	765,690	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	902,380	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-136,690	32

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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T008

**WORKSHEET E-3
PART III**

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	11,192,857		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.049000		2
3	Inpatient Rehabilitation LIP payments (see instructions)	455,549		3
4	Outlier payments	133,978		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R 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)	24,706,849		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	11,782,384		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	11,782,384		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	11,782,384		19
20	Deductibles	126,920		20
21	Subtotal (line 19 minus line 20)	11,655,464		21
22	Coinsurance	103,846		22
23	Subtotal (line 21 minus line 22)	11,551,618		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	46,617		24
25	Adjusted reimbursable bad debts (see instructions)	30,301		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,521		26
27	Subtotal (sum of lines 23 and 25)	11,581,919		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	11,581,919		32
32.01	Sequestration adjustment (see instructions)	231,638		32.01
33	Interim payments	11,379,307		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	-29,026		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1,918,071		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	2,933,266				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	15,654,278				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	5,800,116				7
8	Prepaid expenses	6,046,791				8
9	Other current assets	12,956,277				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	43,390,728				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	30,489,907				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	30,489,907				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,240,509				34
35	Total other assets (sum of lines 31-34)	1,240,509				35
36	Total assets (sum of lines 11, 30 and 35)	75,121,144				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	585,036				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	481				43
44	Other current liabilities	16,995,140				44
45	Total current liabilities (sum of lines 37 thru 44)	17,580,657				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	2,201,591				49
50	Total long term liabilities (sum of lines 46 thru 49)	2,201,591				50
51	Total liabilities (sum of lines 45 and 50)	19,782,248				51
CAPITAL ACCOUNTS						
52	General fund balance	55,338,896				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	55,338,896				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	75,121,144				60

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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		28,558,371			1
2	Net income (loss) (from Worksheet G-3, line 29)		-2,186,423			2
3	Total (sum of line 1 and line 2)		26,371,948			3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS RELEASED FROM RESTRICTIO					5
6	NET ASSETS TRANSFERRED					6
7	OTHER	28,966,948				7
8						8
9						9
10	Total additions (sum of lines 4-9)		28,966,948			10
11	Subtotal (line 3 plus line 10)		55,338,896			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		55,338,896			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS RELEASED FROM RESTRICTIO					5
6	NET ASSETS TRANSFERRED					6
7	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) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	41,872,086		41,872,086	1
2	Subprovider IPF				2
3	Subprovider IRF	27,937,120		27,937,120	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)	69,809,206		69,809,206	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	5,094,269		5,094,269	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,094,269		5,094,269	16
17	Total inpatient routine care services (sum of lines 10 and 16)	74,903,475		74,903,475	17
18	Ancillary services	125,541,882		125,541,882	18
19	Outpatient services		198,093,091	198,093,091	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		2,565,762	2,565,762	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	ANESTHESIOLOGISTS REVENUE	5,242,305		5,242,305	27
27.01	PHYSICIAN REVENUE		83,718	83,718	27.01
27.02	CAPITATION		-2,337,385	-2,337,385	27.02
27.03	OCCUPATIONAL HEALTH		1,032,925	1,032,925	27.03
27.04	REGENCY REVENUE		4,352,460	4,352,460	27.04
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	205,687,662	203,790,571	409,478,233	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		168,063,380	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)		168,063,380	43

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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)	409,478,233	1
2	Less contractual allowances and discounts on patients' accounts	280,048,827	2
3	Net patient revenues (line 1 minus line 2)	129,429,406	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	168,063,380	4
5	Net income from service to patients (line 3 minus line 4)	-38,633,974	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	93,896	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	2,833	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	658,924	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	95	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	3,195	21
22	Rental of hosptial space	1,216,492	22
23	Governmental appropriations		23
24	Other (specify)		24
24.01	Other (CAPITATION REVENUE)	27,601,519	24.01
24.02	Other (GRANT INCOME)	1,313,696	24.02
24.03	Other (OTHER INCOME)	2,867,993	24.03
24.04	Other (PHARMACY INCOME)	1,401,782	24.04
24.05	Other (PHO INCOME)	17,250	24.05
24.06	Other (GAIN ON SALE OF ASSETS)	1,244,250	24.06
24.07	Other (PHOTOCOPYING INCOME)	330	24.07
24.08	Other (CLASSES)	25,296	24.08
25	Total other income (sum of lines 6-24)	36,447,551	25
26	Total (line 5 plus line 25)	-2,186,423	26
29	Net income (or loss) for the period (line 26 minus line 28)	-2,186,423	29

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7453

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	383,769	27,026	49,753	2,514	28,821	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	720,759					6
7	Physical Therapy				248,928		7
8	Occupational Therapy				68,377		8
9	Speech Pathology				12,180		9
10	Medical Social Services	1,179			637		10
11	Home Health Aide	71,157					11
12	Supplies (see instructions)					87,410	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)	1,176,864	27,026	49,753	332,636	116,231	24

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7453

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	491,883	-28,652	463,231	-2,735	460,496	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	720,759		720,759		720,759	6
7	Physical Therapy	248,928	1,620	250,548		250,548	7
8	Occupational Therapy	68,377		68,377		68,377	8
9	Speech Pathology	12,180		12,180		12,180	9
10	Medical Social Services	1,816		1,816		1,816	10
11	Home Health Aide	71,157		71,157		71,157	11
12	Supplies (see instructions)	87,410		87,410		87,410	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)	1,702,510	-27,032	1,675,478	-2,735	1,672,743	24

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

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7453

**WORKSHEET H-1
PART I**

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	460,496				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	720,759				6
7	Physical Therapy	250,548				7
8	Occupational Therapy	68,377				8
9	Speech Pathology	12,180				9
10	Medical Social Services	1,816				10
11	Home Health Aide	71,157				11
12	Supplies (see instructions)	87,410				12
13	Drugs					13
14	DME					14
HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	1,672,743				24

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7453

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		460,496	460,496		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		720,759	273,795	994,554	6
7	Physical Therapy		250,548	95,176	345,724	7
8	Occupational Therapy		68,377	25,974	94,351	8
9	Speech Pathology		12,180	4,627	16,807	9
10	Medical Social Services		1,816	690	2,506	10
11	Home Health Aide		71,157	27,030	98,187	11
12	Supplies (see instructions)		87,410	33,204	120,614	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		1,672,743		1,672,743	24

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTERS								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-460,496	1,212,247	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care						720,759	6
7	Physical Therapy						250,548	7
8	Occupational Therapy						68,377	8
9	Speech Pathology						12,180	9
10	Medical Social Services						1,816	10
11	Home Health Aide						71,157	11
12	Supplies (see instructions)						87,410	12
13	Drugs							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-460,496	1,212,247	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						460,496	25
26	Unit Cost Multiplier						0.379870	26

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
1	Administrative and General		21,005	164	312,083	14,053	4,251	1
2	Skilled Nursing Care	994,554						2
3	Physical Therapy	345,724						3
4	Occupational Therapy	94,351						4
5	Speech Pathology	16,807						5
6	Medical Social Services	2,506						6
7	Home Health Aide	98,187						7
8	Supplies	120,614						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)	1,672,743	21,005	164	312,083	14,053	4,251	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 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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 5.02	ADMITTING 5.03	CASHIERING ACCOUNTS RECEIVABLE 5.04	SUBTOTAL (cols.0-4) 4A	OTHER ADMIN GENERAL 5.05	MAIN- TENANCE + REPAIRS 6	
1	Administrative and General	6,090	7,879		365,525	76,792	100,620	1
2	Skilled Nursing Care				994,554	208,944		2
3	Physical Therapy				345,724	72,632		3
4	Occupational Therapy				94,351	19,822		4
5	Speech Pathology				16,807	3,531		5
6	Medical Social Services				2,506	526		6
7	Home Health Aide				98,187	20,628		7
8	Supplies				120,614	25,339		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)	6,090	7,879		2,038,268	428,214	100,620	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 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General	35,141		39,759				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)	35,141		39,759				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 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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)	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	NONPHYSIC. ANESTHET. 19	
1	Administrative and General				16,128			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)				16,128			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 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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)	SUBTOTAL (sum of col.4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtH) 27	TOTAL HHA COSTS 28	
1	Administrative and General	633,965		633,965			1
2	Skilled Nursing Care	1,203,498		1,203,498	376,933	1,580,431	2
3	Physical Therapy	418,356		418,356	131,028	549,384	3
4	Occupational Therapy	114,173		114,173	35,759	149,932	4
5	Speech Pathology	20,338		20,338	6,370	26,708	5
6	Medical Social Services	3,032		3,032	950	3,982	6
7	Home Health Aide	118,815		118,815	37,213	156,028	7
8	Supplies	145,953		145,953	45,712	191,665	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)	2,658,130		2,658,130	633,965	2,658,130	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.				0.313198		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 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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	3,158	89	1,176,864	1,554	15	15,313	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)	3,158	89	1,176,864	1,554	15	15,313	20
21	Total cost to be allocated	21,005	164	312,083	14,053	4,251	6,090	21
22	Unit Cost Multiplier	6.651362		0.265182		283.400000		22
22	Unit Cost Multiplier		1.842697		9.043115		0.397701	22

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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	2,565,762			365,525	3,158	3,158	1
2	Skilled Nursing Care				994,554			2
3	Physical Therapy				345,724			3
4	Occupational Therapy				94,351			4
5	Speech Pathology				16,807			5
6	Medical Social Services				2,506			6
7	Home Health Aide				98,187			7
8	Supplies				120,614			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)	2,565,762			2,038,268	3,158	3,158	20
21	Total cost to be allocated	7,879			428,214	100,620	35,141	21
22	Unit Cost Multiplier	0.003071				31.861938		22
22	Unit Cost Multiplier				0.210087		11.127612	22

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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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	MAINTENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINISTRATION DIRECT NRSING HRS	
		8	9	10	11	12	13	
1	Administrative and General		3,158					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)		3,158					20
21	Total cost to be allocated		39,759					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		12.589930					22

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 15-7453

WORKSHEET H-2
PART II

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME		
		14	15	16	17	19		
1	Administrative and General			2,565,762				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)			2,565,762				20
21	Total cost to be allocated			16,128				21
22	Unit Cost Multiplier			0.006286				22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7453

**WORKSHEET H-3
PARTS I & II**

Check applicable box: Title V 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	1,580,431		1,580,431	13,223	119.52
2	Physical Therapy	3	549,384		549,384	4,129	133.05
3	Occupational Therapy	4	149,932		149,932	925	162.09
4	Speech Pathology	5	26,708		26,708	222	120.31
5	Medical Social Services	6	3,982		3,982	21	189.62
6	Home Health Aide	7	156,028		156,028	3,638	42.89
7	Total (sum of lines 1-6)		2,466,465		2,466,465	22,158	

Limitation Cost Computation				Program Visits		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	23844		8,777		8
9	Physical Therapy	23844		2,581		9
10	Occupational Therapy	23844		582		10
11	Speech Pathology	23844		145		11
12	Medical Social Services	23844		14		12
13	Home Health Aide	23844		2,872		13
14	Total (sum of lines 8-13)			14,971		14

Supplies and Drugs Cost Computations							
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		1	2	3	4	5	
15	Cost of Medical Supplies	8	191,665		191,665	249,860	0.767090
16	Cost of Drugs	9					

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	0.369378			col. 2, line 2
2	Occupational Therapy	67	0.341290			col. 2, line 3
3	Speech Pathology	68	0.483746			col. 2, line 4
4	Medical Supplies Charged to Pat	71	0.423549			col. 2, line 15
5	Drugs Charged to Patients	73	0.267725			col. 2, line 16

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 15-7453

**WORKSHEET H-3
PARTS I & II**

Check applicable box: Title V 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			Total	
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		8,777			1,049,027		1,049,027	1
2	Physical Therapy		2,581			343,402		343,402	2
3	Occupational Therapy		582			94,336		94,336	3
4	Speech Pathology		145			17,445		17,445	4
5	Medical Social Services		14			2,655		2,655	5
6	Home Health Aide		2,872			123,180		123,180	6
7	Total (sum of lines 1-6)		14,971			1,630,045		1,630,045	7

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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/25/2015 Run Time: 16:03 Version: 2015.10 (11/17/2015)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 15-7453

**WORKSHEET H-4
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

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

	Description	Part A 1	Part B		
			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 in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts		7,042		9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services 1	Part B Services 2	
10	Total reasonable cost (see instructions)		-7,042	10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,517,512	11
12	Total PPS Reimbursement - Full Episodes with Outliers		140,056	12
13	Total PPS Reimbursement - LUPA Episodes		14,106	13
14	Total PPS Reimbursement - PEP Episodes		4,850	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		33,630	15
16	Total PPS Outlier Reimbursement - PSP Episodes		3,443	16
17	Total Other Payments		3,546	17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		1,710,101	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,710,101	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,710,101	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		1,710,101	29
30	Other adjustments (see instructions) (specify)		-2,751	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,707,350	31
31.01	Sequestration adjustment (see instructions)		34,148	31.01
32	Interim payments (see instructions)		1,673,202	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1	2	3	4	
1	Total interim payments paid to provider				1,673,202	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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				1,673,202	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0008

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	1,643,551	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	33,881	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)	82.16	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1263	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.3224	8
9	Sum of lines 7 and 8	0.4487	9
10	Allowable disproportionate share percentage (see instructions)	0.0952	10
11	Disproportionate share adjustment (see instructions)	156,466	11
12	Total prospective capital payments (see instructions)	1,833,898	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0008

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NONPATIENT TELEPHONES						5.01
5.02	PURCHASING RECEIVING & STORES						5.02
5.03	ADMITTING						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMIN & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
41	Subprovider - IRF						41
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	ULTRASOUND						54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope						56
57	CT Scan						57
59	Cardiac Catheterization						59
60	Laboratory						60
62	Whole Blood & Packed Red Blood Cells						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB						63.02
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75.01	ONCOLOGY						75.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.01	OP PSYCH						90.01
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
194	OTHER NON REIM COST CENTER						194
194.01	RETAIL PHARMACY						194.01
194.03	ADVERTISING EXPENSE						194.03
194.04	REGENCY HOSPITAL						194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201

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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		
202	TOTAL (sum of lines 118-201)							202