

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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 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 checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.			Date: 11/29/2016 Time: 08:02
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. CATHERINE HOSPITAL (15-0008) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 11/29/2016 08:02
 zzxqfdodNH4ydY5yp59xkLuIPQXn10
 xud2m0393bHq8XsSYybiGmHSBJPbTs
 H:Qh143oDB0e2qp:

PI Encryption: 11/29/2016 08:02
 KZELwipCmh11.7iofjFcFf00ZQxw0
 C0fR0iVCEm2VcGjPVvqhc.U2bcEXv
 ..Kx0uWLNJ0ppbQ2

(Signed) Mary Ann Shaubert
 Officer or Administrator of Provider(s)

Title _____
 Date 11/29/16

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		478,229	-44,101			1
2	SUBPROVIDER - IPF		8,154				2
3	SUBPROVIDER - IRF		164,468	-74			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		650,851	-44,175			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	ST. CATHERINE HOSPITAL OA BHS	15-S008	23844	4	07 / 01 / 2015	N	P	P	4
5	Subprovider - IRF	ST. CATHERINE HOSPITAL - REHAB	15-T008	23844	5	01 / 01 / 2002	N	P	P	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	ST. CATHERINE HHA	15-7453	23844		01 / 01 / 1996	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2015	To: 06 / 30 / 2016	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.	1,809	134	274	484	9,223	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	163	488			489	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 is in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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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	110

Miscellaneous Cost Reporting Information

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

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare 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	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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.	N

		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	11/02/2016	Y	11/02/2016
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	

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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

Home Office Costs		Y/N	Date	
		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	

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	149	54,534			10,795	1,362	27,009	1
2	HMO and other (see instructions)						1,479	9,879		2
3	HMO IPF Subprovider						236	73		3
4	HMO IRF Subprovider						256	977		4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		149	54,534			10,795	1,362	27,009	7
8	Intensive Care Unit	31	10	3,660			1,546	199	2,916	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						248	1,112	13
14	Total (see instructions)		159	58,194			12,341	1,809	31,037	14
15	CAH Visits									15
16	Subprovider - IPF	40	16	5,856			2,165	95	2,804	16
17	Subprovider - IRF	41	30	10,980			6,757	163	8,812	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					16,905		24,551	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)		205							27
28	Observation Bed Days								4,962	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							236	265	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)					2,398	416	6,360	1
2	HMO and other (see instructions)					242	2,530		2
3	HMO IPF Subprovider						8		3
4	HMO IRF Subprovider						95		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)		837.75			2,398	416	6,360	14
15	CAH Visits								15
16	Subprovider - IPF		18.48			176	9	235	16
17	Subprovider - IRF		43.28			654	16	840	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		16.68						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)		916.19						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)		
	1	2	3	4	5	6		
SALARIES								
1	Total salaries (see instructions)	200	56,082,193	56,082,193	1,808,930.00	31.00	1	
2	Non-physician anesthetist Part A						2	
3	Non-physician anesthetest Part B		669,729	669,729	6,448.00	103.87	3	
4	Physician-Part A - Administrative						4	
4.01	Physician-Part A - Teaching						4.01	
5	Physician-Part B		2,007,192	2,007,192	14,121.00	142.14	5	
6	Non-physician-Part B						6	
7	Interns & residents (in an approved program)	21					7	
7.01	Contracted interns & residents (in an approved program)						7.01	
8	Home office personnel						8	
9	SNF	44					9	
10	Excluded area salaries (see instructions)		4,939,999	4,939,999	118,463.00	41.70	10	
OTHER WAGES & RELATED COSTS								
11	Contract labor (see instructions)						11	
12	Contract management and administrative services						12	
13	Contract labor: Physician-Part A - Administrative		671,818	671,818	4,191.00	160.30	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		483,503	483,503	12,881.00	37.54	26	
27	Administrative & General		5,529,650	5,529,650	176,024.00	31.41	27	
28	Administrative & General under contract (see instructions)		1,782,061	1,782,061	12,506.00	142.50	28	
29	Maintenance & Repairs		1,291,561	1,291,561	41,662.00	31.00	29	
30	Operation of Plant		679,732	679,732	16,712.00	40.67	30	
31	Laundry & Linen Service		93,502	93,502	6,382.00	14.65	31	
32	Housekeeping		1,728,627	1,728,627	107,350.00	16.10	32	
33	Housekeeping under contract (see instructions)						33	
34	Dietary		1,559,015	-894,861	664,154	39,873.00	16.66	34
35	Dietary under contract (see instructions)						35	
36	Cafeteria			894,861	894,861	53,748.00	16.65	36
37	Maintenance of Personnel						37	
38	Nursing Administration		1,109,364	1,109,364	28,138.00	39.43	38	
39	Central Services and Supply						39	
40	Pharmacy		1,536,893	1,536,893	37,006.00	41.53	40	
41	Medical Records & Medical Records Library		97,427	97,427	3,687.00	26.42	41	
42	Social Service						42	
43	Other General Service						43	

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		55,187,333		55,187,333	1,800,867.00	30.64	1
2	Excluded area salaries (see instructions)		4,939,999		4,939,999	118,463.00	41.70	2
3	Subtotal salaries (line 1 minus line 2)		50,247,334		50,247,334	1,682,404.00	29.87	3
4	Subtotal other wages & related costs (see instructions)		8,416,215		8,416,215	200,951.00	41.88	4
5	Subtotal wage-related costs (see instructions)		12,609,093		12,609,093		25.09%	5
6	Total (sum of lines 3 through 5)		71,272,642		71,272,642	1,883,355.00	37.84	6
7	Total overhead cost (see instructions)		15,891,335		15,891,335	535,969.00	29.65	7

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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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KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		3,655		1,008	4,663	1
2	Unduplicated Census Count (see instructions)		359.00		220.00	579.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)		1.10		1.10
5	Other Administrative Personnel		6.18		6.18
6	Direct Nursing Service		6.91		6.91
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
15	Medical Social Service Supervisor				15
16	Home Health Aide		2.49		2.49
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	7,131	1,984	87	173	9,375	21
22	Skilled Nursing Visit Charges	1,164,930	324,285	14,214	28,464	1,531,893	22
23	Physical Therapy Visits	2,178	379	7	48	2,612	23
24	Physical Therapy Visit Charges	415,198	72,395	1,331	9,244	498,168	24
25	Occupational Therapy Visits	846	320	2	21	1,189	25
26	Occupational Therapy Visit Charges	161,466	61,252	378	4,033	227,129	26
27	Speech Pathology Visits	47	10			57	27
28	Speech Pathology Visit Charges	8,883	1,890			10,773	28
29	Medical Social Service Visits	12	4		1	17	29
30	Medical Social Service Visit Charges	2,604	868		215	3,687	30
31	Home Health Aide Visits	2,398	1,222	7	28	3,655	31
32	Home Health Aide Visit Charges	292,056	149,334	859	3,444	445,693	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	12,612	3,919	103	271	16,905	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,045,137	610,024	16,782	45,400	2,717,343	35
36	Total Number of Episodes (standard/non-outlier)	533		42	16	591	36
37	Total Number of Outlier Episodes		87		2	89	37
38	Total Non-Routine Medical Supply Charges	290,088	82,174	3,483	3,090	378,835	38

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)		0.270373	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		30,282,472	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		15,454,899	5
6	Medicaid charges		156,756,422	6
7	Medicaid cost (line 1 times line 6)		42,382,704	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.			8

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

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

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

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		2,510	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		24,113	14
15	State or local indigent care program cost (line 1 times line 14)		6,520	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.		4,010	16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		10,892	17
18	Government grants, appropriations of transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,010	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	17,334,655		17,334,655	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,686,823		4,686,823	21
22	Partial payment by patients approved for charity care	99,497		99,497	22
23	Cost of charity care (line 21 minus line 22)	4,587,326		4,587,326	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24
25	If line 24 is yes, 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)		4,753,541	26
27	Medicare bad debts for the entire hospital complex (see instructions)		906,423	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,847,118	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,040,157	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		5,627,483	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,631,493	31

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194.03	07951	ADVERTISING EXPENSE	42,099	403,837	445,936	-1,977	443,959		443,959	194.03
194.04	07952	REGENCY HOSPITAL		29,794	29,794	-440	29,354		29,354	194.04
194.05	07953	UNUSED SPACE								194.05
200		TOTAL (sum of lines 118-199)	56,082,193	144,492,398	200,574,591		200,574,591	-68,136,583	132,438,008	200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		255,614	1
2							2
3							3
4							4
5			Medical Supplies Charged to P	71		2,960,084	5
6			Impl. Dev. Charged to Patient	72		3,910,956	6
500	Total reclassifications					7,126,654	500
	Code Letter - A						
1	DRUGS CHARGED TO PATIENTS	B	Drugs Charged to Patients	73		4,775,277	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					4,775,277	500
	Code Letter - B						
1	CAFETERIA RECLASS	C	Cafeteria	11	894,861	1,106,294	1
500	Total reclassifications				894,861	1,106,294	500
	Code Letter - C						
1	EQUIPMENET DEPR RECLASS	D	Cap Rel Costs-Bldg & Fixt	1		2,324,163	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
500	Total reclassifications					2,324,163	500
	Code Letter - D						
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Nursery	43	308,989	153,737	1
2			Delivery Room & Labor Room	52	831,637	413,781	2
500	Total reclassifications				1,140,626	567,518	500
	Code Letter - F						
1	RECLASS RENTAL EQUIPMENT	G	Cap Rel Costs-Mvble Equip	2		629,739	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	
		1	2	3	4	5
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
500	Total reclassifications					500
	Code Letter - G				629,739	
1	RECLASS EQUIPMENT DEPR	H	Cap Rel Costs-Mvble Equip	2		1
2					2,960,904	2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38						38
500	Total reclassifications					500
	Code Letter - H				2,960,904	
1	RECLASS PROPERTY INSURANCE	J	Cap Rel Costs-Bldg & Fixt	1		1
500	Total reclassifications				193,057	500
	Code Letter - J				193,057	
1	RECLASS FRINGE BENEFITS	L	Employee Benefits Department	4		1
2	257	L			9,810,937	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
21						21	
22						22	
23						23	
24						24	
25						25	
26						26	
27						27	
28						28	
29						29	
30						30	
31						31	
32						32	
33						33	
34						34	
35						35	
36						36	
37						37	
38						38	
39						39	
500	Total reclassifications					9,810,937	500
	Code Letter - L						
1	RECLASS SERVICE CONTRACT COSTS	M	Housekeeping	9		8,959	1
2			Pharmacy	15		13,235	2
3			Adults & Pediatrics	30		12,650	3
4			Operating Room	50		474,047	4
5			Anesthesiology	53		5,600	5
6			Radiology-Diagnostic	54		167,259	6
7			ULTRASOUND	54.01		18,225	7
8			Radioisotope	56		92,027	8
9			CT Scan	57		172,297	9
10			Cardiac Catheterization	59		161,201	10
11			Laboratory	60		2,978	11
12			NONINVASIVE LAB	63.02		151	12
13			Respiratory Therapy	65		3,492	13
14			Speech Pathology	68		34	14
15			Clinic	90		724	15
500	Total reclassifications					1,132,879	500
	Code Letter - M						
1	RECLASS REPAIRS/MAINTENCE COSTS	N	MAINTENANCE OF PERSONNEL	4.01		6,047	1
2			PURCHASING RECEIVING & STORES	5.02		8,590	2
3			OTHER ADMIN & GENERAL	5.05		84,496	3
4			Operation of Plant	7		8,401	4
5			Housekeeping	9		4,220	5
6			Dietary	10		230,897	6
7			Medical Records & Library	16		3,474	7
8			Adults & Pediatrics	30		48,250	8
9			Intensive Care Unit	31		20,160	9
10			Subprovider - IPF	40		1,091	10
11			Operating Room	50		106,438	11
12			Recovery Room	51		26,293	12
13			Radiology-Diagnostic	54		7,268	13
14			Cardiac Catheterization	59		6,350	14
15			Laboratory	60		8,025	15
16			Clinic	90		6,005	16
17			OP PSYCH	90.01		1,880	17
18			Emergency	91		37,763	18
19			ADVERTISING EXPENSE	194.03		1,125	19
20			Nursing Administration	13		3,009	20
21			Physicians' Private Offices	192		16,805	21
500	Total reclassifications					636,587	500
	Code Letter - N						
	GRAND TOTAL (Increases)				2,035,487	31,264,009	

(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.

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		131,290	1	
2			Intensive Care Unit	31		55,611	2	
3			Subprovider - IRF	41		15,320	3	
4			Emergency	91		53,393	4	
5			Operating Room	50		3,137,137	5	
6			Cardiac Catheterization	59		3,733,903	6	
500	Total reclassifications					7,126,654	500	
	Code letter - A							
1	DRUGS CHARGED TO PATIENTS	B	Pharmacy	15		4,421,247	1	
2			Adults & Pediatrics	30		579	2	
3			Anesthesiology	53		30,869	3	
4			Radiology-Diagnostic	54		11	4	
5			Radioisotope	56		201,993	5	
6			Respiratory Therapy	65		69,553	6	
7			Clinic	90		22,110	7	
8			Employee Benefits Department	4		17,406	8	
9			Operating Room	50		11,509	9	
500	Total reclassifications					4,775,277	500	
	Code letter - B							
1	CAFETERIA RECLASS	C	Dietary	10	894,861	1,106,294	1	
500	Total reclassifications				894,861	1,106,294	500	
	Code letter - C							
1	EQUIPMENET DEPR RECLASS	D	OTHER ADMIN & GENERAL	5.05		1,270,035	9	
2			Maintenance & Repairs	6		386,790	2	
3			Operation of Plant	7		36,307	3	
4			Housekeeping	9		2,951	4	
5			Dietary	10		19,591	5	
6			Nursing Administration	13		8,525	6	
7			PURCHASING RECEIVING & STORES	5.02		171	7	
8			Pharmacy	15		2,527	8	
9			Adults & Pediatrics	30		311,102	9	
10			Intensive Care Unit	31		4,593	10	
11			Subprovider - IRF	41		91,516	11	
12			Operating Room	50		8,569	12	
13			Radiology-Diagnostic	54		51,869	13	
14			ULTRASOUND	54.01		1,238	14	
15			Radioisotope	56		8,421	15	
16			CT Scan	57		21,256	16	
17			Cardiac Catheterization	59		44,608	17	
18			Laboratory	60		16,957	18	
19			NONINVASIVE LAB	63.02		231	19	
20			Physical Therapy	66		459	20	
21			Electroencephalography	70		1,932	21	
22			Drugs Charged to Patients	73		4,451	22	
23			CARDIAC REHABILITATION	76.97		1,599	23	
24			Clinic	90		17,450	24	
25			Emergency	91		8,694	25	
26			Physicians' Private Offices	192		1,881	26	
27			REGENCY HOSPITAL	194.04		440	27	
500	Total reclassifications					2,324,163	500	
	Code letter - D							
1	RECLASS LABOR AND DELIVERY EXPENSE	F	Adults & Pediatrics	30	308,989	153,737	1	
2			Adults & Pediatrics	30	831,637	413,781	2	
500	Total reclassifications				1,140,626	567,518	500	
	Code letter - F							
1	RECLASS RENTAL EQUIPMENT	G	ADMITTING	5.03		36	10	
2			MAINTENANCE OF PERSONNEL	4.01		163	2	
3			OTHER ADMIN & GENERAL	5.05		10,812	3	
4			Maintenance & Repairs	6		9,331	4	
5			Operation of Plant	7		16,492	5	
6			Laundry & Linen Service	8		18,335	6	
7			Dietary	10		22,850	7	
8			PURCHASING RECEIVING & STORES	5.02		5,597	8	
9			Adults & Pediatrics	30		1,074	9	
10			Intensive Care Unit	31		7,539	10	
11			Subprovider - IRF	41		1,641	11	
12			Operating Room	50		220,071	12	
13			Radiology-Diagnostic	54		131,672	13	
14			ULTRASOUND	54.01		26,221	14	
15			Radioisotope	56		824	15	

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	
16			CT Scan	57		41,971	16	
17			Cardiac Catheterization	59		61,597	17	
18			NONINVASIVE LAB	63.02		21,185	18	
19			Respiratory Therapy	65		8,063	19	
20			Physical Therapy	66		477	20	
21			Occupational Therapy	67		399	21	
22			Electroencephalography	70		1,970	22	
23			Clinic	90		21,252	23	
24			ADVERTISING EXPENSE	194.03		167	24	
500	Total reclassifications					629,739	500	
	Code letter - G							
1	RECLASS EQUIPMENT DEPR	H	ADMITTING	5.03		380	9 1	
2			OTHER ADMIN & GENERAL	5.05		1,067,027	2	
3			Maintenance & Repairs	6		164,345	3	
4			Operation of Plant	7		24,754	4	
5			Laundry & Linen Service	8		713	5	
6			Housekeeping	9		12,912	6	
7			Dietary	10		25,281	7	
8			Nursing Administration	13		55,742	8	
9			PURCHASING RECEIVING & STORES	5.02		852	9	
10			Pharmacy	15		112,197	10	
11			Medical Records & Library	16		1,171	11	
12			Adults & Pediatrics	30		108,046	12	
13			Intensive Care Unit	31		59,562	13	
14			Subprovider - IRF	41		26,289	14	
15			Operating Room	50		303,674	15	
16			Recovery Room	51		220	16	
17			Anesthesiology	53		35,439	17	
18			Radiology-Diagnostic	54		336,220	18	
19			ULTRASOUND	54.01		37,035	19	
20			Radioisotope	56		23,320	20	
21			CT Scan	57		226,498	21	
22			Cardiac Catheterization	59		41,371	22	
23			Laboratory	60		56,493	23	
24			Whole Blood & Packed Red Bloo	62		11,830	24	
25			NONINVASIVE LAB	63.02		62,437	25	
26			Respiratory Therapy	65		21,390	26	
27			Physical Therapy	66		13,634	27	
28			Occupational Therapy	67		728	28	
29			Speech Pathology	68		6,606	29	
30			Electroencephalography	70		22,967	30	
31			Drugs Charged to Patients	73		646	31	
32			ONCOLOGY	75.01		434	32	
33			CARDIAC REHABILITATION	76.97		13,875	33	
34			Clinic	90		4,423	34	
35			Emergency	91		80,251	35	
36			Physicians' Private Offices	192		59	36	
37			RETAIL PHARMACY	194.01		1,362	37	
38			ADVERTISING EXPENSE	194.03		721	38	
500	Total reclassifications					2,960,904	500	
	Code letter - H							
1	RECLASS PROPERTY INSURANCE	J	OTHER ADMIN & GENERAL	5.05		193,057	12 1	
500	Total reclassifications					193,057	500	
	Code letter - J							
1	RECLASS FRINGE BENEFITTS	L	Employee Benefits Department	4		22,432	1	
2	257	L	MAINTENANCE OF PERSONNEL	4.01		127,843	2	
3			ADMITTING	5.03		257,747	3	
4			OTHER ADMIN & GENERAL	5.05		140,032	4	
5			Maintenance & Repairs	6		304,732	5	
6			Operation of Plant	7		117,602	6	
7			Laundry & Linen Service	8		28,321	7	
8			Housekeeping	9		551,909	8	
9			Dietary	10		453,654	9	
10			Nursing Administration	13		203,928	10	
11			PURCHASING RECEIVING & STORES	5.02		57,307	11	
12			Pharmacy	15		213,262	12	
13			Medical Records & Library	16		19,791	13	
14			Adults & Pediatrics	30		2,454,856	14	
15			Intensive Care Unit	31		385,766	15	
16			Subprovider - IPF	40		154,822	16	
17			Subprovider - IRF	41		380,989	17	
18			Operating Room	50		604,447	18	

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	
19			Recovery Room	51		52,155	19	
20			Radiology-Diagnostic	54		374,682	20	
21			ULTRASOUND	54.01		34,588	21	
22			Radioisotope	56		45,759	22	
23			CT Scan	57		77,852	23	
24			Cardiac Catheterization	59		208,232	24	
25			Laboratory	60		454,082	25	
26			Whole Blood & Packed Red Bloo	62		28,627	26	
27			NONINVASIVE LAB	63.02		170,396	27	
28			Respiratory Therapy	65		206,987	28	
29			Physical Therapy	66		171,028	29	
30			Occupational Therapy	67		86,104	30	
31			Speech Pathology	68		22,874	31	
32			Electroencephalography	70		39,433	32	
33			ONCOLOGY	75.01		39,061	33	
34			CARDIAC REHABILITATION	76.97		109,365	34	
35			Clinic	90		441,381	35	
36			Emergency	91		512,526	36	
37			Home Health Agency	101		204,394	37	
38			RETAIL PHARMACY	194.01		49,757	38	
39			ADVERTISING EXPENSE	194.03		2,214	39	
500	Total reclassifications					9,810,937	500	
	Code letter - L							
1	RECLASS SERVICE CONTRACT COSTS	M	Maintenance & Repairs	6		1,132,879	1	
2							2	
3							3	
4							4	
5							5	
6							6	
7							7	
8							8	
9							9	
10							10	
11							11	
12							12	
13							13	
14							14	
15							15	
500	Total reclassifications					1,132,879	500	
	Code letter - M							
1	RECLASS REPAIRS/MAINTENCE COSTS	N	Maintenance & Repairs	6		636,587	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	
500	Total reclassifications					636,587	500	
	Code letter - N							
	GRAND TOTAL (Decreases)				2,035,487	31,264,009		

(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.

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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								1
2	Land Improvements	2,638,270					2,638,270		2
3	Buildings and Fixtures	66,021,703	4,264,279		4,264,279		70,285,982		3
4	Building Improvements	36,426	8,944		8,944		45,370		4
5	Fixed Equipment								5
6	Movable Equipment	107,130,558	2,245,479		2,245,479	170,544	109,205,493		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	175,826,957	6,518,702		6,518,702	170,544	182,175,115		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	175,826,957	6,518,702		6,518,702	170,544	182,175,115		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	72,969,622		72,969,622	0.400547					1
2	Cap Rel Costs-Mvble Equip	109,205,493		109,205,493	0.599453					2
3	Total (sum of lines 1-2)	182,175,115		182,175,115	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	2,853,605			193,057				3,046,662	1
2	Cap Rel Costs-Mvble Equip	4,861,946	629,739						5,491,685	2
3	Total (sum of lines 1-2)	7,715,551	629,739		193,057				8,538,347	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.)

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)					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	-30,703	NONPATIENT TELEPHONES	5.01	7
8	Television and radio service (chapter 21)	A	-3,018	Cap Rel Costs-Mvble Equip	2	9 8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-2,369,820			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-151,879			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests					14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures	A	394,338	Cap Rel Costs-Bldg & Fixt	1	9 26
27	Depreciation--movable equipment	A	103,087	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	-36,705	CARDIAC REHABILITATION	76.97	33
33.07	LAB REVENUE	B	-2,480	Laboratory	60	33.07
33.08	OFFSET OTHER INCOME	B	-179	Housekeeping	9	33.08
33.09	OFFSET OTHER INCOME	B	-10	Operating Room	50	33.09
33.10	OFFSET OTHER INCOME	B	-500	Subprovider - IPF	40	33.10
33.11	OFFSET OTHER INCOME	B	-14,374	Physical Therapy	66	33.11
33.12	OTHER RELEASED TEMP REST OP	B	-2,953	Emergency	91	33.12
33.13	OTHER OPERATING REVENUE	B	-80	MAINTENANCE OF PERSONNEL	4.01	33.13
33.14	OTHER INCOME	B	-28,454	Clinic	90	33.14
33.15	OFFSET OCC HEALTH COSTS FOR BP/US	A	-1,729,263	Clinic	90	33.15
33.16	OFFSET INTERCO REVENUE	B	-85,363	NONINVASIVE LAB	63.02	33.16
33.19	OTHER OPERATING REVENUE	B	-228,413	OTHER ADMIN & GENERAL	5.05	33.19
33.23	OTHER OPER REV	B	-10,900	PURCHASING RECEIVING & STORES	5.02	33.23
33.26	CAFETERIA REVENUE	B	-835,039	Cafeteria	11	33.26
33.28	OTHER OPER REVENUE	B	-20,344	Operation of Plant	7	33.28
33.29	OTHER OPERATING REVENUE	B	-7,380	Maintenance & Repairs	6	33.29
33.30	OTHER OPERATING REVENUE	B	-43,538	Laundry & Linen Service	8	33.30
33.31	OFFSET OTHER REVENUE	B	-13,178	Subprovider - IRF	41	33.31
33.32	OFFSET OTHER REVENUE	B	-825	Respiratory Therapy	65	33.32
33.33	OFFSET OTHER REVENUE	B	-2,199	Medical Records & Library	16	33.33
34	OFFSET TELEPHONE DEPRECIATION	A	-412	Cap Rel Costs-Mvble Equip	2	9 34
34.01	OFFSET CONTRIBUTIONS	A	-41,147	OTHER ADMIN & GENERAL	5.05	34.01
34.03	OFFSET CAPITATION EXPENSE	A	-55,159,111	OTHER ADMIN & GENERAL	5.05	34.03
35	CRNA SALARIES	A	-669,729	Anesthesiology	53	35
36	OFFSET CONTRIBUTIONS	A	-1,209	Nursing Administration	13	36
37	OFFSET CONTRIBUTIONS	A	-425	Clinic	90	37
37.01	CONTRIBUTIONS	A	-640	Radiology-Diagnostic	54	37.01
38	OFFSET NONWAGE CRNA/ANEST COSTS	A	-102,225	Anesthesiology	53	38
38.01	OFFSET OTHER ANEST PHYS COSTS	A	-379,962	Anesthesiology	53	38.01
39	OFFSET FEES FOR ON CALL SURGEONS	A	-550,503	Operating Room	50	39
40	MDWISE ADD BACK	A	4,721,172	OTHER ADMIN & GENERAL	5.05	40
41	OFFSET MEDICAID ASSESSMENT	A	-3,909,525	OTHER ADMIN & GENERAL	5.05	41
42	OFFSET OTHER PHYSICIAN EXPENSES	A	-14,916	Adults & Pediatrics	30	42

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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
				3	4	5	
43	OFFSET EKG READS AT CLINIC	A	-4,472	Clinic	90		43
43.01	OFFSET OTHER PHYSICIAN EXPENSES	A	-8,575	Cardiac Catheterization	59		43.01
43.02	OFFSET OTHER PHYSICIAN EXPENSES	A	-44,280	ONCOLOGY	75.01		43.02
44	OFFSET OTHER INCOME	B	-1,458	Radiology-Diagnostic	54		44
45	OFFSET OTHER INCOME	B	-877	Adults & Pediatrics	30		45
46	ELIMINATE PHYSICIAN COSTS	A	-6,102,033	OTHER ADMIN & GENERAL	5.05		46
46.02	OFFSET OCC HEALTH PHYS PART B	A	-193	Clinic	90		46.02
46.03	OFFSET ADMIN PHYS PART B	A	-268,410	OTHER ADMIN & GENERAL	5.05		46.03
46.04	OFFSET ONCOLOGY PHYSICIAN COSTS	A	-351,140	ONCOLOGY	75.01		46.04
47	HHA MARKETING EXPENSE	A	-2,735	Home Health Agency	101		47
48	OFFSET OTHER INCOME	B	-119,382	Intensive Care Unit	31		48
48.01	OFFSET OTHER INCOME	B	-4,224	Intensive Care Unit	31		48.01
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-68,136,583				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.

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	135,104		135,104	9	1
2	2	Cap Rel Costs-Mvble Equip	DEPRECIATION EQUIP	1,801,385		1,801,385	9	2
3	5.05	OTHER ADMIN & GENERAL	A&G OTHER	13,566,509	18,632,614	-5,066,105		3
3.01	5.01	NONPATIENT TELEPHONES	TELECOMMUNICATIONS	534,934		534,934		3.01
3.02	16	Medical Records & Library	MEDICAL RECORDS	2,442,803		2,442,803		3.02
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			18,480,735	18,632,614	-151,879		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:

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	29,302		29,302	211,500	293	29,793	1,490	1
2	13	Nursing Administrati AGGREGATE	4,471	4,471						2
3	16	Medical Records & Li	19,428		19,428	211,500	204	20,743	1,037	3
4	30	Adults & Pediatrics AGGREGATE	46,050	38,200	7,850	211,500	78	7,931	397	4
5	31	Intensive Care Unit AGGREGATE	42,679	42,679						5
6	50	Operating Room	36,472		36,472	246,400	163	19,309	965	6
7	54	Radiology-Diagnostic	25,000		25,000	271,900	106	13,857	693	7
8	59	Cardiac Catheterizat	15,150		15,150	211,500	76	7,728	386	8
9	60	Laboratory	26,542		26,542	260,300	172	21,525	1,076	9
10	65	Respiratory Therapy AGGREGATE	19,656	19,656						10
11	90	Clinic	138,724		138,724	211,500	1,182	120,189	6,009	11
12	90	Clinic	39,516		39,516	211,500	336	34,165	1,708	12
13	76.97	CARDIAC REHABILITATI	20,350		20,350	211,500	102	10,372	519	13
14	90	Clinic	9,675		9,675	211,500	97	9,863	493	14
15	53	Anesthesiology AGGREGATE	1,576,931	1,576,931						15
16	91	Emergency	237,000		237,000	211,500	1,185	120,494	6,025	16
17	90	Clinic OCC HEALTH SALA	430,261	430,261						17
18	90	Clinic AGGREGATE	40,066	40,066						18
19	68	Speech Pathology	11,549		11,549	211,500	89	9,050	453	19
20	53	Anesthesiology	55,260		55,260	211,500	308	31,318	1,566	20
200		TOTAL	2,824,082	2,152,264	671,818		4,391	456,337	22,817	200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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					29,793			1
2	13	Nursing Administrati AGGREGATE							4,471	2
3	16	Medical Records & Li					20,743			3
4	30	Adults & Pediatrics AGGREGATE					7,931			4
5	31	Intensive Care Unit AGGREGATE							42,679	5
6	50	Operating Room					19,309	17,163		6
7	54	Radiology-Diagnostic					13,857	11,143		7
8	59	Cardiac Catheterizat					7,728	7,422		8
9	60	Laboratory					21,525	5,017		9
10	65	Respiratory Therapy AGGREGATE								10
11	90	Clinic					120,189	18,535		11
12	90	Clinic					34,165	5,351		12
13	76.97	CARDIAC REHABILITATI					10,372	9,978		13
14	90	Clinic					9,863			14
15	53	Anesthesiology AGGREGATE								15
16	91	Emergency					120,494	116,506		16
17	90	Clinic OCC HEALTH SALA								17
18	90	Clinic AGGREGATE								18
19	68	Speech Pathology					9,050	2,499		19
20	53	Anesthesiology					31,318	23,942		20
200		TOTAL					456,337	217,556		200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	3,046,662	3,046,662					1
2	Cap Rel Costs-Mvble Equip	5,491,685		5,491,685				2
4	Employee Benefits Department	9,923,402	1,189		9,924,591			4
4.01	MAINTENANCE OF PERSONNEL	658,297	15,421		73,985	747,703		4.01
5.01	NONPATIENT TELEPHONES	504,231	5,802				510,033	5.01
5.02	PURCHASING RECEIVING & STORES	449,004	57,751	2,370	60,359	7,766	6,104	5.02
5.03	ADMITTING	1,035,095	24,782	1,059	169,311	23,001	8,011	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	21,076,747	300,857	243,387	800,045	39,437	163,650	5.05
6	Maintenance & Repairs	6,439,343	416,974	458,253	240,511	17,000	2,670	6
7	Operation of Plant	2,248,696	112,149	66,848	126,578	10,866	8,011	7
8	Laundry & Linen Service	596,743	11,703	1,983	17,412	2,238	763	8
9	Housekeeping	2,217,807	46,921	35,830	321,900	45,686	4,578	9
10	Dietary	1,194,751	81,687	68,924	123,677	16,254	9,537	10
11	Cafeteria	1,166,116	26,050		166,638	21,898		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,257,062	19,281	154,375	206,582	10,419	3,433	13
14	Central Services & Supply							14
15	Pharmacy	2,490,292	29,395	312,127	286,196	14,497	9,918	15
16	Medical Records & Library	2,689,101	25,462	3,257	18,143	1,368	12,589	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,109,564	462,643	307,520	2,153,333	178,233	51,118	30
31	Intensive Care Unit	2,906,032	64,612	166,817	452,411	27,808	7,630	31
40	Subprovider - IPF	1,649,974	54,198		203,161	15,317	5,341	40
41	Subprovider - IRF	3,592,967	102,551	75,297	428,512	35,873	12,589	41
43	Nursery	462,726	13,107		57,539	3,722		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,591,111	225,881	833,832	584,742	38,185	28,229	50
51	Recovery Room	390,832	8,695	612	58,342	3,282	1,526	51
52	Delivery Room & Labor Room	1,245,418	35,289		154,865	10,021		52
53	Anesthesiology	179,719	2,292	102,051			2,289	53
54	Radiology-Diagnostic	2,233,643	63,674	892,073	314,930	25,346	15,259	54
54.01	ULTRASOUND	438,279	7,786	103,034	69,605	3,465	1,526	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	778,099	13,895	64,879	92,783	3,854	3,433	56
57	CT Scan	711,561	8,688	630,286	75,872	4,857	3,433	57
59	Cardiac Catheterization	1,771,067	46,119	107,211	212,664	12,822	19,837	59
60	Laboratory	4,730,162	84,194	157,916	425,035	35,309	27,848	60
62	Whole Blood & Packed Red Blood Cells	931,199	5,272	32,692	25,837	1,732	2,670	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	627,898	16,581	182,257	117,538	9,051	3,052	63.02
65	Respiratory Therapy	1,373,452	16,760	59,648	219,319	15,964	6,104	65
66	Physical Therapy	2,524,215	63,208	38,551	223,083	12,814	11,826	66
67	Occupational Therapy	1,495,527	17,498	2,025	90,070	6,200		67
68	Speech Pathology	494,866	5,494	18,380	45,613	2,047	763	68
70	Electroencephalography	277,483	29,574	66,655	36,488	2,967	5,722	70
71	Medical Supplies Charged to Patients	3,215,698						71
72	Impl. Dev. Charged to Patients	3,910,956						72
73	Drugs Charged to Patients	4,775,736		1,795				73
74	Renal Dialysis	806,194	2,700					74
75.01	ONCOLOGY	230,892	7,141	1,300	42,527	3,133	4,959	75.01
76.97	CARDIAC REHABILITATION	460,111	39,751	37,059	80,200	5,097	6,867	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	158,715	34,129	11,638	331,726	26,647	5,722	90
90.01	OP PSYCH	53,466	2,793					90.01
91	Emergency	3,848,264	72,054	222,529	528,820	36,950	14,115	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,923,245	19,353		230,091	13,146	5,722	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	130,384,105	2,701,356	5,464,470	9,866,443	744,272	476,844	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,000					190
192	Physicians' Private Offices	322,600	203,162	21,417			6,867	192
194	OTHER NON REIM COST CENTER	101,335		3,789				194
194.01	RETAIL PHARMACY	1,156,655	7,470		50,308	2,992		194.01
194.03	ADVERTISING EXPENSE	443,959	6,840	2,009	7,840	439	3,052	194.03
194.04	REGENCY HOSPITAL	29,354	119,834				23,270	194.04

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1	2	4	4.01	5.01	
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	132,438,008	3,046,662	5,491,685	9,924,591	747,703	510,033	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	583,354						5.02
5.03	ADMITTING	9,626	1,270,885					5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	15,793		22,639,916	22,639,916			5.05
6	Maintenance & Repairs	183,320		7,758,071	1,599,683	9,357,754		6
7	Operation of Plant	27,303		2,600,451	536,203	471,905	3,608,559	7
8	Laundry & Linen Service	47,745		678,587	139,922	49,246	19,999	8
9	Housekeeping	81,644		2,754,366	567,939	197,436	80,179	9
10	Dietary	56,636		1,551,466	319,906	343,727	139,588	10
11	Cafeteria			1,380,702	284,695	109,613	44,514	11
12	Maintenance of Personnel							12
13	Nursing Administration	3,250		1,654,402	341,131	81,132	32,948	13
14	Central Services & Supply							14
15	Pharmacy	4,379		3,146,804	648,858	123,687	50,230	15
16	Medical Records & Library	1,878		2,751,798	567,410	107,142	43,510	16
17	Social Service							17
19	Nonphysician Anesthetists							19
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	41,878	147,640	17,451,929	3,598,506	1,946,725	790,569	30
31	Intensive Care Unit	6,040	16,276	3,647,626	752,126	271,877	110,410	31
40	Subprovider - IPF		22,248	1,950,239	402,131	228,056	92,614	40
41	Subprovider - IRF	9,581	22,700	4,280,070	882,533	431,520	175,241	41
43	Nursery		3,404	540,498	111,449	55,153	22,398	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	18,828	108,911	7,429,719	1,531,978	950,471	385,988	50
51	Recovery Room	137	6,636	470,062	96,925	36,588	14,858	51
52	Delivery Room & Labor Room		13,404	1,458,997	300,839	148,491	60,303	52
53	Anesthesiology	1,030	9,167	296,548	61,147	9,644	3,917	53
54	Radiology-Diagnostic	3,716	65,515	3,614,156	745,225	267,929	108,807	54
54.01	ULTRASOUND	495	15,509	639,699	131,903	32,760	13,304	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,852	26,076	984,871	203,076	58,468	23,744	56
57	CT Scan	813	88,322	1,523,832	314,208	36,558	14,846	57
59	Cardiac Catheterization	1,909	52,796	2,224,425	458,668	194,060	78,808	59
60	Laboratory	11,867	187,442	5,659,773	1,167,023	354,275	143,872	60
62	Whole Blood & Packed Red Blood Cells	764	8,139	1,008,305	207,908	22,182	9,008	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,031	35,496	993,904	204,939	69,770	28,334	63.02
65	Respiratory Therapy	1,257	29,991	1,722,495	355,172	70,524	28,640	65
66	Physical Therapy	2,921	28,026	2,904,644	598,926	265,970	108,011	66
67	Occupational Therapy	402	18,098	1,629,820	336,062	73,628	29,900	67
68	Speech Pathology	1,155	4,145	572,463	118,040	23,116	9,387	68
70	Electroencephalography	244	12,776	431,909	89,058	124,441	50,536	70
71	Medical Supplies Charged to Patients		26,011	3,241,709	668,427			71
72	Impl. Dev. Charged to Patients		25,937	3,936,893	811,772			72
73	Drugs Charged to Patients		117,438	4,894,969	1,009,323			73
74	Renal Dialysis		9,471	818,365	168,744	11,362	4,614	74
75.01	ONCOLOGY	1,131	4,324	295,407	60,912	30,048	12,202	75.01
76.97	CARDIAC REHABILITATION	3,260	1,718	634,063	130,741	167,267	67,928	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic	8,248	5,106	581,931	119,992	143,609	58,320	90
90.01	OP PSYCH		1,545	57,804	11,919	11,754	4,773	90.01
91	Emergency	10,385	149,545	4,882,662	1,006,785	303,191	123,126	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency	4,142	7,073	2,202,772	454,203	81,434	33,070	101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	565,660	1,270,885	129,899,122	22,116,407	7,904,759	3,018,496	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen			8,000	1,650	33,664	13,671	190
192	Physicians' Private Offices	172		554,218	114,278	854,872	347,165	192
194	OTHER NON REIM COST CENTER			105,124	21,676			194
194.01	RETAIL PHARMACY	152		1,217,577	251,060	31,434	12,765	194.01
194.03	ADVERTISING EXPENSE	15,654		479,793	98,931	28,782	11,688	194.03
194.04	REGENCY HOSPITAL	1,716		174,174	35,914	504,243	204,774	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING & STORES	ADMITTING	SUBTOTAL (cols.0-4) 4A	OTHER ADMIN GENERAL 5.05	MAIN- TENANCE + REPAIRS 6	OPERATION OF PLANT 7	
201	Negative Cost Centers	5.02	5.03	4A	5.05	6	7	201
202	TOTAL (sum of lines 118-201)	583,354	1,270,885	132,438,008	22,639,916	9,357,754	3,608,559	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	887,754						8
9	Housekeeping		3,599,920					9
10	Dietary		158,960	2,513,647				10
11	Cafeteria		50,692		1,870,216			11
12	Maintenance of Personnel							12
13	Nursing Administration		37,520		35,401	2,182,534		13
14	Central Services & Supply							14
15	Pharmacy		57,200		49,257		4,076,036	15
16	Medical Records & Library		49,549		4,647			16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	251,187	900,282	1,598,367	605,615	987,421		30
31	Intensive Care Unit	36,019	125,732	91,631	94,487	154,055		31
40	Subprovider - IPF	41,878	105,467	139,974	52,045	84,856		40
41	Subprovider - IRF	55,498	199,560	425,729	121,889	198,733		41
43	Nursery	7,990	25,506		12,645	20,617		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	90,589	439,554		129,747	211,546		50
51	Recovery Room	17,863	16,920		11,153	18,184		51
52	Delivery Room & Labor Room	21,518	68,671		34,049	55,515		52
53	Anesthesiology		4,460					53
54	Radiology-Diagnostic	23,575	123,906		86,122			54
54.01	ULTRASOUND	24,245	15,150		11,772			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	6,603	27,039		13,096			56
57	CT Scan		16,906		16,503			57
59	Cardiac Catheterization	19,855	89,745		43,568	71,036		59
60	Laboratory		163,838		119,974			60
62	Whole Blood & Packed Red Blood Cells		10,258		5,886			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	13,225	32,266		30,754			63.02
65	Respiratory Therapy		32,614		54,242			65
66	Physical Therapy	28,883	123,000		43,540			66
67	Occupational Therapy		34,050		21,066			67
68	Speech Pathology		10,690		6,956			68
70	Electroencephalography	12,922	57,549		10,082			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						4,076,036	73
74	Renal Dialysis		5,255					74
75.01	ONCOLOGY		13,896		10,646			75.01
76.97	CARDIAC REHABILITATION	13,959	77,354		17,320	28,240		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	5,437	66,413		90,544	147,627		90
90.01	OP PSYCH		5,436					90.01
91	Emergency	166,824	140,214		125,550	204,704		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		37,660					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	838,070	3,323,312	2,255,701	1,858,556	2,182,534	4,076,036	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		15,568					190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		14,537		10,167			194.01
194.03	ADVERTISING EXPENSE		13,311		1,493			194.03
194.04	REGENCY HOSPITAL	49,684	233,192	257,946				194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	PHARMACY	
		8	9	10	11	13	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	887,754	3,599,920	2,513,647	1,870,216	2,182,534	4,076,036	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NONPATIENT TELEPHONES						5.01
5.02	PURCHASING RECEIVING & STORES						5.02
5.03	ADMITTING						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMIN & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	3,524,056					16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	409,427	28,540,028		28,540,028		30
31	Intensive Care Unit	45,136	5,329,099		5,329,099		31
40	Subprovider - IPF	61,697	3,158,957		3,158,957		40
41	Subprovider - IRF	62,950	6,833,723		6,833,723		41
43	Nursery	9,441	805,697		805,697		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	302,027	11,471,619		11,471,619		50
51	Recovery Room	18,403	700,956		700,956		51
52	Delivery Room & Labor Room	37,170	2,185,553		2,185,553		52
53	Anesthesiology	25,422	401,138		401,138		53
54	Radiology-Diagnostic	181,683	5,151,403		5,151,403		54
54.01	ULTRASOUND	43,009	911,842		911,842		54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	72,314	1,389,211		1,389,211		56
57	CT Scan	244,931	2,167,784		2,167,784		57
59	Cardiac Catheterization	146,411	3,326,576		3,326,576		59
60	Laboratory	519,506	8,128,261		8,128,261		60
62	Whole Blood & Packed Red Blood Cells	22,571	1,286,118		1,286,118		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	98,436	1,471,628		1,471,628		63.02
65	Respiratory Therapy	83,171	2,346,858		2,346,858		65
66	Physical Therapy	77,720	4,150,694		4,150,694		66
67	Occupational Therapy	50,187	2,174,713		2,174,713		67
68	Speech Pathology	11,494	752,146		752,146		68
70	Electroencephalography	35,430	811,927		811,927		70
71	Medical Supplies Charged to Patients	72,133	3,982,269		3,982,269		71
72	Impl. Dev. Charged to Patients	71,926	4,820,591		4,820,591		72
73	Drugs Charged to Patients	325,672	10,306,000		10,306,000		73
74	Renal Dialysis	26,265	1,034,605		1,034,605		74
75.01	ONCOLOGY	11,992	435,103		435,103		75.01
76.97	CARDIAC REHABILITATION	4,764	1,141,636		1,141,636		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	14,161	1,228,034		1,228,034		90
90.01	OP PSYCH	4,285	95,971		95,971		90.01
91	Emergency	414,709	7,367,765		7,367,765		91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	19,613	2,828,752		2,828,752		101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	3,524,056	126,736,657		126,736,657		118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		72,553		72,553		190
192	Physicians' Private Offices		1,870,533		1,870,533		192
194	OTHER NON REIM COST CENTER		126,800		126,800		194
194.01	RETAIL PHARMACY		1,537,540		1,537,540		194.01
194.03	ADVERTISING EXPENSE		633,998		633,998		194.03
194.04	REGENCY HOSPITAL		1,459,927		1,459,927		194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		16	24	25	26			
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,524,056	132,438,008		132,438,008			202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		1,189		1,189	1,189		4
4.01	MAINTENANCE OF PERSONNEL		15,421		15,421	9	15,430	4.01
5.01	NONPATIENT TELEPHONES		5,802		5,802			5.01
5.02	PURCHASING RECEIVING & STORES		57,751	2,370	60,121	7	160	5.02
5.03	ADMITTING		24,782	1,059	25,841	20	475	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL		300,857	243,387	544,244	95	814	5.05
6	Maintenance & Repairs		416,974	458,253	875,227	28	351	6
7	Operation of Plant		112,149	66,848	178,997	15	224	7
8	Laundry & Linen Service		11,703	1,983	13,686	2	46	8
9	Housekeeping		46,921	35,830	82,751	38	943	9
10	Dietary		81,687	68,924	150,611	15	335	10
11	Cafeteria		26,050		26,050	20	452	11
12	Maintenance of Personnel							12
13	Nursing Administration		19,281	154,375	173,656	24	215	13
14	Central Services & Supply							14
15	Pharmacy		29,395	312,127	341,522	34	299	15
16	Medical Records & Library		25,462	3,257	28,719	2	28	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		462,643	307,520	770,163	273	3,678	30
31	Intensive Care Unit		64,612	166,817	231,429	53	574	31
40	Subprovider - IPF		54,198		54,198	24	316	40
41	Subprovider - IRF		102,551	75,297	177,848	51	740	41
43	Nursery		13,107		13,107	7	77	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		225,881	833,832	1,059,713	69	788	50
51	Recovery Room		8,695	612	9,307	7	68	51
52	Delivery Room & Labor Room		35,289		35,289	18	207	52
53	Anesthesiology		2,292	102,051	104,343			53
54	Radiology-Diagnostic		63,674	892,073	955,747	37	523	54
54.01	ULTRASOUND		7,786	103,034	110,820	8	71	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope		13,895	64,879	78,774	11	80	56
57	CT Scan		8,688	630,286	638,974	9	100	57
59	Cardiac Catheterization		46,119	107,211	153,330	25	265	59
60	Laboratory		84,194	157,916	242,110	50	729	60
62	Whole Blood & Packed Red Blood Cells		5,272	32,692	37,964	3	36	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB		16,581	182,257	198,838	14	187	63.02
65	Respiratory Therapy		16,760	59,648	76,408	26	329	65
66	Physical Therapy		63,208	38,551	101,759	26	264	66
67	Occupational Therapy		17,498	2,025	19,523	11	128	67
68	Speech Pathology		5,494	18,380	23,874	5	42	68
70	Electroencephalography		29,574	66,655	96,229	4	61	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			1,795	1,795			73
74	Renal Dialysis		2,700		2,700			74
75.01	ONCOLOGY		7,141	1,300	8,441	5	65	75.01
76.97	CARDIAC REHABILITATION		39,751	37,059	76,810	9	105	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		34,129	11,638	45,767	39	550	90
90.01	OP PSYCH		2,793		2,793			90.01
91	Emergency		72,054	222,529	294,583	62	763	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		19,353		19,353	27	271	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		2,701,356	5,464,470	8,165,826	1,182	15,359	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,000		8,000			190
192	Physicians' Private Offices		203,162	21,417	224,579			192
194	OTHER NON REIM COST CENTER			3,789	3,789			194
194.01	RETAIL PHARMACY		7,470		7,470	6	62	194.01
194.03	ADVERTISING EXPENSE		6,840	2,009	8,849	1	9	194.03
194.04	REGENCY HOSPITAL		119,834		119,834			194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	MAINT OF PERSONNEL	
		0	1	2	2A	4	4.01	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,046,662	5,491,685	8,538,347	1,189	15,430	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	5,802						5.01
5.02	PURCHASING RECEIVING & STORES	69	60,357					5.02
5.03	ADMITTING	91	996	27,423				5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	1,862	1,634		548,649			5.05
6	Maintenance & Repairs	30	18,968		38,767	933,371		6
7	Operation of Plant	91	2,825		12,994	47,069	242,215	7
8	Laundry & Linen Service	9	4,940		3,391	4,912	1,342	8
9	Housekeeping	52	8,447		13,764	19,693	5,382	9
10	Dietary	108	5,860		7,753	34,284	9,369	10
11	Cafeteria				6,899	10,933	2,988	11
12	Maintenance of Personnel							12
13	Nursing Administration	39	336		8,267	8,092	2,212	13
14	Central Services & Supply							14
15	Pharmacy	113	453		15,725	12,337	3,372	15
16	Medical Records & Library	143	194		13,751	10,687	2,921	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	582	4,333	3,213	87,194	194,173	53,062	30
31	Intensive Care Unit	87	625	354	18,227	27,118	7,411	31
40	Subprovider - IPF	61		484	9,745	22,747	6,216	40
41	Subprovider - IRF	143	991	494	21,388	43,041	11,763	41
43	Nursery			74	2,701	5,501	1,503	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	321	1,948	2,370	37,126	94,803	25,908	50
51	Recovery Room	17	14	144	2,349	3,649	997	51
52	Delivery Room & Labor Room			292	7,291	14,811	4,048	52
53	Anesthesiology	26	107	200	1,482	962	263	53
54	Radiology-Diagnostic	174	384	1,426	18,060	26,724	7,303	54
54.01	ULTRASOUND	17	51	338	3,197	3,268	893	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	39	192	568	4,921	5,832	1,594	56
57	CT Scan	39	84	1,922	7,615	3,646	997	57
59	Cardiac Catheterization	226	198	1,149	11,115	19,356	5,290	59
60	Laboratory	317	1,228	3,843	28,282	35,337	9,657	60
62	Whole Blood & Packed Red Blood Cells	30	79	177	5,039	2,212	605	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	35	210	773	4,967	6,959	1,902	63.02
65	Respiratory Therapy	69	130	653	8,607	7,034	1,922	65
66	Physical Therapy	135	302	610	14,515	26,529	7,250	66
67	Occupational Therapy		42	394	8,144	7,344	2,007	67
68	Speech Pathology	9	119	90	2,861	2,306	630	68
70	Electroencephalography	65	25	278	2,158	12,412	3,392	70
71	Medical Supplies Charged to Patients			566	16,199			71
72	Impl. Dev. Charged to Patients			564	19,673			72
73	Drugs Charged to Patients			2,556	24,460			73
74	Renal Dialysis			206	4,089	1,133	310	74
75.01	ONCOLOGY	56	117	94	1,476	2,997	819	75.01
76.97	CARDIAC REHABILITATION	78	337	37	3,168	16,684	4,559	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	65	853	111	2,908	14,324	3,915	90
90.01	OP PSYCH			34	289	1,172	320	90.01
91	Emergency	161	1,074	3,255	24,399	30,241	8,265	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	65	429	154	11,007	8,122	2,220	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,424	58,525	27,423	535,963	788,444	202,607	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				40	3,358	918	190
192	Physicians' Private Offices	78	18		2,769	85,268	23,303	192
194	OTHER NON REIM COST CENTER				525			194
194.01	RETAIL PHARMACY		16		6,084	3,135	857	194.01
194.03	ADVERTISING EXPENSE	35	1,620		2,398	2,871	785	194.03
194.04	REGENCY HOSPITAL	265	178		870	50,295	13,745	194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NONPATIENT TELEPHONES	PURCHASING RECEIVING & STORES	ADMITTING	OTHER ADMIN GENERAL	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	
		5.01	5.02	5.03	5.05	6	7	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,802	60,357	27,423	548,649	933,371	242,215	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	28,328						8
9	Housekeeping		131,070					9
10	Dietary		5,788	214,123				10
11	Cafeteria		1,846					11
12	Maintenance of Personnel							12
13	Nursing Administration		1,366			931	195,138	13
14	Central Services & Supply							14
15	Pharmacy		2,083			1,295	377,233	15
16	Medical Records & Library		1,804			122		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,016	32,779	136,156	15,929	88,286		30
31	Intensive Care Unit	1,149	4,578	7,805	2,485	13,774		31
40	Subprovider - IPF	1,336	3,840	11,924	1,369	7,587		40
41	Subprovider - IRF	1,771	7,266	36,265	3,206	17,768		41
43	Nursery	255	929		333	1,843		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,891	16,004		3,412	18,914		50
51	Recovery Room	570	616		293	1,626		51
52	Delivery Room & Labor Room	687	2,500		896	4,963		52
53	Anesthesiology		162					53
54	Radiology-Diagnostic	752	4,511		2,265			54
54.01	ULTRASOUND	774	552		310			54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	211	984		344			56
57	CT Scan		616		434			57
59	Cardiac Catheterization	634	3,268		1,146	6,351		59
60	Laboratory		5,965		3,155			60
62	Whole Blood & Packed Red Blood Cells		373		155			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	422	1,175		809			63.02
65	Respiratory Therapy		1,187		1,427			65
66	Physical Therapy	922	4,478		1,145			66
67	Occupational Therapy		1,240		554			67
68	Speech Pathology		389		183			68
70	Electroencephalography	412	2,095		265			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						377,233	73
74	Renal Dialysis		191					74
75.01	ONCOLOGY		506		280			75.01
76.97	CARDIAC REHABILITATION	445	2,816		456	2,525		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	173	2,418		2,381	13,199		90
90.01	OP PSYCH		198					90.01
91	Emergency	5,323	5,105		3,302	18,302		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,371					101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	26,743	120,999	192,150	48,882	195,138	377,233	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		567					190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY		529		267			194.01
194.03	ADVERTISING EXPENSE		485		39			194.03
194.04	REGENCY HOSPITAL	1,585	8,490	21,973				194.04
194.05	UNUSED SPACE							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	
		8	9	10	11	13	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	28,328	131,070	214,123	49,188	195,138	377,233	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NONPATIENT TELEPHONES						5.01
5.02	PURCHASING RECEIVING & STORES						5.02
5.03	ADMITTING						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMIN & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	58,371					16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	6,807	1,404,644		1,404,644		30
31	Intensive Care Unit	750	316,419		316,419		31
40	Subprovider - IPF	1,026	120,873		120,873		40
41	Subprovider - IRF	1,047	323,782		323,782		41
43	Nursery	157	26,487		26,487		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,022	1,269,289		1,269,289		50
51	Recovery Room	306	19,963		19,963		51
52	Delivery Room & Labor Room	618	71,620		71,620		52
53	Anesthesiology	423	107,968		107,968		53
54	Radiology-Diagnostic	3,021	1,020,927		1,020,927		54
54.01	ULTRASOUND	715	121,014		121,014		54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,202	94,752		94,752		56
57	CT Scan	4,072	658,508		658,508		57
59	Cardiac Catheterization	2,434	204,787		204,787		59
60	Laboratory	8,418	339,091		339,091		60
62	Whole Blood & Packed Red Blood Cells	375	47,048		47,048		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,637	217,928		217,928		63.02
65	Respiratory Therapy	1,383	99,175		99,175		65
66	Physical Therapy	1,292	159,227		159,227		66
67	Occupational Therapy	834	40,221		40,221		67
68	Speech Pathology	191	30,699		30,699		68
70	Electroencephalography	589	117,985		117,985		70
71	Medical Supplies Charged to Patients	1,199	17,964		17,964		71
72	Impl. Dev. Charged to Patients	1,196	21,433		21,433		72
73	Drugs Charged to Patients	5,415	411,459		411,459		73
74	Renal Dialysis	437	9,066		9,066		74
75.01	ONCOLOGY	199	15,055		15,055		75.01
76.97	CARDIAC REHABILITATION	79	108,108		108,108		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	235	86,938		86,938		90
90.01	OP PSYCH	71	4,877		4,877		90.01
91	Emergency	6,895	401,730		401,730		91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	326	43,345		43,345		101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	58,371	7,932,382		7,932,382		118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		12,883		12,883		190
192	Physicians' Private Offices		336,015		336,015		192
194	OTHER NON REIM COST CENTER		4,314		4,314		194
194.01	RETAIL PHARMACY		18,426		18,426		194.01
194.03	ADVERTISING EXPENSE		17,092		17,092		194.03
194.04	REGENCY HOSPITAL		217,235		217,235		194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		16	24	25	26			
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	58,371	8,538,347		8,538,347			202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	425,368						1
2	Cap Rel Costs-Mvble Equip		2,960,904					2
4	Employee Benefits Department	166		53,295,771				4
4.01	MAINTENANCE OF PERSONNEL	2,153		397,303	90,210			4.01
5.01	NONPATIENT TELEPHONES	810				1,337		5.01
5.02	PURCHASING RECEIVING & STORES	8,063	1,278	324,134	937	16	1,516,253	5.02
5.03	ADMITTING	3,460	571	909,213	2,775	21	25,020	5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL	42,005	131,225	4,296,303	4,758	429	41,048	5.05
6	Maintenance & Repairs	58,217	247,072	1,291,561	2,051	7	476,481	6
7	Operation of Plant	15,658	36,042	679,732	1,311	21	70,966	7
8	Laundry & Linen Service	1,634	1,069	93,502	270	2	124,099	8
9	Housekeeping	6,551	19,318	1,728,627	5,512	12	212,208	9
10	Dietary	11,405	37,161	664,154	1,961	25	147,208	10
11	Cafeteria	3,637		894,861	2,642			11
12	Maintenance of Personnel							12
13	Nursing Administration	2,692	83,233	1,109,364	1,257	9	8,448	13
14	Central Services & Supply							14
15	Pharmacy	4,104	168,287	1,536,893	1,749	26	11,383	15
16	Medical Records & Library	3,555	1,756	97,427	165	33	4,880	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,593	165,803	11,563,506	21,504	134	108,850	30
31	Intensive Care Unit	9,021	89,941	2,429,483	3,355	20	15,699	31
40	Subprovider - IPF	7,567		1,090,992	1,848	14		40
41	Subprovider - IRF	14,318	40,597	2,301,143	4,328	33	24,904	41
43	Nursery	1,830		308,989	449			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,537	449,570	3,140,109	4,607	74	48,939	50
51	Recovery Room	1,214	330	313,302	396	4	356	51
52	Delivery Room & Labor Room	4,927		831,637	1,209			52
53	Anesthesiology	320	55,022			6	2,678	53
54	Radiology-Diagnostic	8,890	480,971	1,691,198	3,058	40	9,659	54
54.01	ULTRASOUND	1,087	55,552	373,787	418	4	1,287	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,940	34,980	498,252	465	9	4,813	56
57	CT Scan	1,213	339,826	407,439	586	9	2,113	57
59	Cardiac Catheterization	6,439	57,804	1,142,024	1,547	52	4,962	59
60	Laboratory	11,755	85,142	2,282,473	4,260	73	30,844	60
62	Whole Blood & Packed Red Blood Cells	736	17,626	138,746	209	7	1,987	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,315	98,266	631,190	1,092	8	5,280	63.02
65	Respiratory Therapy	2,340	32,160	1,177,763	1,926	16	3,268	65
66	Physical Therapy	8,825	20,785	1,197,972	1,546	31	7,591	66
67	Occupational Therapy	2,443	1,092	483,683	748		1,044	67
68	Speech Pathology	767	9,910	244,945	247	2	3,001	68
70	Electroencephalography	4,129	35,938	195,944	358	15	635	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		968					73
74	Renal Dialysis	377						74
75.01	ONCOLOGY	997	701	228,374	378	13	2,939	75.01
76.97	CARDIAC REHABILITATION	5,550	19,981	430,683	615	18	8,474	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,765	6,275	1,781,393	3,215	15	21,438	90
90.01	OP PSYCH	390						90.01
91	Emergency	10,060	119,979	2,839,806	4,458	37	26,992	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,702		1,235,609	1,586	15	10,767	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	377,157	2,946,231	52,983,516	89,796	1,250	1,470,261	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,117						190
192	Physicians' Private Offices	28,365	11,547			18	447	192
194	OTHER NON REIM COST CENTER		2,043					194
194.01	RETAIL PHARMACY	1,043		270,156	361		396	194.01
194.03	ADVERTISING EXPENSE	955	1,083	42,099	53	8	40,688	194.03
194.04	REGENCY HOSPITAL	16,731				61	4,461	194.04
194.05	UNUSED SPACE							194.05

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DEPRECIATI EXPENSE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINT OF PERSONNEL FTE'S	NONPATIENT TELEPHONES NUMBER OF TELEPHONES	PURCHASING RECEIVING & STORES COSTED REQ	
		1	2	4	4.01	5.01	5.02	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,046,662	5,491,685	9,924,591	747,703	510,033	583,354	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.162415	1.854733	0.186217	8.288471	381.475692	0.384734	203
204	Cost to be allocated (Per Wkst. B, Part II)			1,189	15,430	5,802	60,357	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000022	0.171045	4.339566	0.039807	205

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	468,748,243						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL		-22,639,916	109,798,092				5.05
6	Maintenance & Repairs			7,758,071	310,494			6
7	Operation of Plant			2,600,451	15,658	294,836		7
8	Laundry & Linen Service			678,587	1,634	1,634	96,665	8
9	Housekeeping			2,754,366	6,551	6,551		9
10	Dietary			1,551,466	11,405	11,405		10
11	Cafeteria			1,380,702	3,637	3,637		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,654,402	2,692	2,692		13
14	Central Services & Supply							14
15	Pharmacy			3,146,804	4,104	4,104		15
16	Medical Records & Library			2,751,798	3,555	3,555		16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	54,459,589		17,451,929	64,593	64,593	27,351	30
31	Intensive Care Unit	6,003,747		3,647,626	9,021	9,021	3,922	31
40	Subprovider - IPF	8,206,594		1,950,239	7,567	7,567	4,560	40
41	Subprovider - IRF	8,373,188		4,280,070	14,318	14,318	6,043	41
43	Nursery	1,255,785		540,498	1,830	1,830	870	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	40,173,882		7,429,719	31,537	31,537	9,864	50
51	Recovery Room	2,447,873		470,062	1,214	1,214	1,945	51
52	Delivery Room & Labor Room	4,944,157		1,458,997	4,927	4,927	2,343	52
53	Anesthesiology	3,381,536		296,548	320	320		53
54	Radiology-Diagnostic	24,166,463		3,614,156	8,890	8,890	2,567	54
54.01	ULTRASOUND	5,720,841		639,699	1,087	1,087	2,640	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	9,618,744		984,871	1,940	1,940	719	56
57	CT Scan	32,579,256		1,523,832	1,213	1,213		57
59	Cardiac Catheterization	19,474,668		2,224,425	6,439	6,439	2,162	59
60	Laboratory	69,100,531		5,659,773	11,755	11,755		60
62	Whole Blood & Packed Red Blood Cells	3,002,232		1,008,305	736	736		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	13,093,415		993,904	2,315	2,315	1,440	63.02
65	Respiratory Therapy	11,062,854		1,722,495	2,340	2,340		65
66	Physical Therapy	10,337,906		2,904,644	8,825	8,825	3,145	66
67	Occupational Therapy	6,675,619		1,629,820	2,443	2,443		67
68	Speech Pathology	1,528,832		572,463	767	767		68
70	Electroencephalography	4,712,680		431,909	4,129	4,129	1,407	70
71	Medical Supplies Charged to Patients	9,594,748		3,241,709				71
72	Impl. Dev. Charged to Patients	9,567,166		3,936,893				72
73	Drugs Charged to Patients	43,318,902		4,894,969				73
74	Renal Dialysis	3,493,575		818,365	377	377		74
75.01	ONCOLOGY	1,595,154		295,407	997	997		75.01
76.97	CARDIAC REHABILITATION	633,734		634,063	5,550	5,550	1,520	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,883,617		581,931	4,765	4,765	592	90
90.01	OP PSYCH	569,899		57,804	390	390		90.01
91	Emergency	55,162,197		4,882,662	10,060	10,060	18,165	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,608,859		2,202,772	2,702	2,702		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	468,748,243	-22,639,916	107,259,206	262,283	246,625	91,255	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			8,000	1,117	1,117		190
192	Physicians' Private Offices			554,218	28,365	28,365		192
194	OTHER NON REIM COST CENTER			105,124				194
194.01	RETAIL PHARMACY			1,217,577	1,043	1,043		194.01
194.03	ADVERTISING EXPENSE			479,793	955	955		194.03
194.04	REGENCY HOSPITAL			174,174	16,731	16,731	5,410	194.04
194.05	UNUSED SPACE							194.05

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,270,885		22,639,916	9,357,754	3,608,559	887,754	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.002711		0.206196	30.138276	12.239208	9.183820	203
204	Cost to be allocated (Per Wkst. B, Part II)	27,423		548,649	933,371	242,215	28,328	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000059		0.004997	3.006084	0.821525	0.293053	205

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	MAINTENANCE OF PERSONNEL							4.01
5.01	NONPATIENT TELEPHONES							5.01
5.02	PURCHASING RECEIVING & STORES							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE							5.04
5.05	OTHER ADMIN & GENERAL							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	258,286						9
10	Dietary	11,405	154,115					10
11	Cafeteria	3,637		66,407				11
12	Maintenance of Personnel							12
13	Nursing Administration	2,692		1,257	988,645			13
14	Central Services & Supply							14
15	Pharmacy	4,104		1,749		10,000		15
16	Medical Records & Library	3,555		165			468,748,243	16
17	Social Service							17
19	Nonphysician Anesthetists							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	64,593	97,998	21,504	447,283		54,459,589	30
31	Intensive Care Unit	9,021	5,618	3,355	69,784		6,003,747	31
40	Subprovider - IPF	7,567	8,582	1,848	38,438		8,206,594	40
41	Subprovider - IRF	14,318	26,102	4,328	90,022		8,373,188	41
43	Nursery	1,830		449	9,339		1,255,785	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,537		4,607	95,826		40,173,882	50
51	Recovery Room	1,214		396	8,237		2,447,873	51
52	Delivery Room & Labor Room	4,927		1,209	25,147		4,944,157	52
53	Anesthesiology	320					3,381,536	53
54	Radiology-Diagnostic	8,890		3,058			24,166,463	54
54.01	ULTRASOUND	1,087		418			5,720,841	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,940		465			9,618,744	56
57	CT Scan	1,213		586			32,579,256	57
59	Cardiac Catheterization	6,439		1,547	32,178		19,474,668	59
60	Laboratory	11,755		4,260			69,100,531	60
62	Whole Blood & Packed Red Blood Cells	736		209			3,002,232	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	2,315		1,092			13,093,415	63.02
65	Respiratory Therapy	2,340		1,926			11,062,854	65
66	Physical Therapy	8,825		1,546			10,337,906	66
67	Occupational Therapy	2,443		748			6,675,619	67
68	Speech Pathology	767		247			1,528,832	68
70	Electroencephalography	4,129		358			4,712,680	70
71	Medical Supplies Charged to Patients						9,594,748	71
72	Impl. Dev. Charged to Patients						9,567,166	72
73	Drugs Charged to Patients					10,000	43,318,902	73
74	Renal Dialysis	377					3,493,575	74
75.01	ONCOLOGY	997		378			1,595,154	75.01
76.97	CARDIAC REHABILITATION	5,550		615	12,792		633,734	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,765		3,215	66,872		1,883,617	90
90.01	OP PSYCH	390					569,899	90.01
91	Emergency	10,060		4,458	92,727		55,162,197	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,702					2,608,859	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	238,440	138,300	65,993	988,645	10,000	468,748,243	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,117						190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY	1,043		361				194.01
194.03	ADVERTISING EXPENSE	955		53				194.03
194.04	REGENCY HOSPITAL	16,731	15,815					194.04
194.05	UNUSED SPACE							194.05

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,599,920	2,513,647	1,870,216	2,182,534	4,076,036	3,524,056	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.937728	16.310203	28.162935	2.207601	407.603600	0.007518	203
204	Cost to be allocated (Per Wkst. B, Part II)	131,070	214,123	49,188	195,138	377,233	58,371	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.507461	1.389372	0.740705	0.197379	37.723300	0.000125	205

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
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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 SERV COST CENTERS								
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
41	Subprovider - IRF							41
43	Nursery							43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope							56
57	CT Scan							57
59	Cardiac Catheterization							59
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB							63.02
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	ONCOLOGY							75.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	Clinic							90
90.01	OP PSYCH							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency							101
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)							118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	OTHER NON REIM COST CENTER							194
194.01	RETAIL PHARMACY							194.01
194.03	ADVERTISING EXPENSE							194.03

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
194.04	REGENCY HOSPITAL							194.04
194.05	UNUSED SPACE							194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	28,540,028		28,540,028		28,540,028	30
31	Intensive Care Unit	5,329,099		5,329,099		5,329,099	31
40	Subprovider - IPF	3,158,957		3,158,957		3,158,957	40
41	Subprovider - IRF	6,833,723		6,833,723		6,833,723	41
43	Nursery	805,697		805,697		805,697	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,471,619		11,471,619	17,163	11,488,782	50
51	Recovery Room	700,956		700,956		700,956	51
52	Delivery Room & Labor Room	2,185,553		2,185,553		2,185,553	52
53	Anesthesiology	401,138		401,138	23,942	425,080	53
54	Radiology-Diagnostic	5,151,403		5,151,403	11,143	5,162,546	54
54.01	ULTRASOUND	911,842		911,842		911,842	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	1,389,211		1,389,211		1,389,211	56
57	CT Scan	2,167,784		2,167,784		2,167,784	57
59	Cardiac Catheterization	3,326,576		3,326,576	7,422	3,333,998	59
60	Laboratory	8,128,261		8,128,261	5,017	8,133,278	60
62	Whole Blood & Packed Red Blood Cells	1,286,118		1,286,118		1,286,118	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	1,471,628		1,471,628		1,471,628	63.02
65	Respiratory Therapy	2,346,858		2,346,858		2,346,858	65
66	Physical Therapy	4,150,694		4,150,694		4,150,694	66
67	Occupational Therapy	2,174,713		2,174,713		2,174,713	67
68	Speech Pathology	752,146		752,146	2,499	754,645	68
70	Electroencephalography	811,927		811,927		811,927	70
71	Medical Supplies Charged to Patients	3,982,269		3,982,269		3,982,269	71
72	Impl. Dev. Charged to Patients	4,820,591		4,820,591		4,820,591	72
73	Drugs Charged to Patients	10,306,000		10,306,000		10,306,000	73
74	Renal Dialysis	1,034,605		1,034,605		1,034,605	74
75.01	ONCOLOGY	435,103		435,103		435,103	75.01
76.97	CARDIAC REHABILITATION	1,141,636		1,141,636	9,978	1,151,614	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,228,034		1,228,034	23,886	1,251,920	90
90.01	OP PSYCH	95,971		95,971		95,971	90.01
91	Emergency	7,367,765		7,367,765	116,506	7,484,271	91
92	Observation Beds (Non-Distinct Part)	4,429,478		4,429,478		4,429,478	92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,828,752		2,828,752		2,828,752	101
200	Subtotal (sum of lines 30 thru 199)	131,166,135		131,166,135	217,556	131,383,691	200
201	Less Observation Beds	4,429,478		4,429,478		4,429,478	201
202	Total (line 200 minus line 201)	126,736,657		126,736,657		126,954,213	202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	44,587,980		44,587,980				30
31	Intensive Care Unit	6,003,747		6,003,747				31
40	Subprovider - IPF	8,206,594		8,206,594				40
41	Subprovider - IRF	8,373,188		8,373,188				41
43	Nursery	1,255,785		1,255,785				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,255,880	27,918,002	40,173,882	0.285549	0.285549	0.285976	50
51	Recovery Room	863,091	1,584,782	2,447,873	0.286353	0.286353	0.286353	51
52	Delivery Room & Labor Room	1,824,962	3,119,195	4,944,157	0.442048	0.442048	0.442048	52
53	Anesthesiology	2,177,090	1,204,446	3,381,536	0.118626	0.118626	0.125706	53
54	Radiology-Diagnostic	6,048,733	18,117,730	24,166,463	0.213163	0.213163	0.213624	54
54.01	ULTRASOUND	904,739	4,816,102	5,720,841	0.159390	0.159390	0.159390	54.01
54.02	AUDIOLOGY							54.02
56	Radioisotope	1,988,981	7,629,763	9,618,744	0.144427	0.144427	0.144427	56
57	CT Scan	9,842,001	22,737,255	32,579,256	0.066539	0.066539	0.066539	57
59	Cardiac Catheterization	9,312,121	10,162,547	19,474,668	0.170816	0.170816	0.171197	59
60	Laboratory	24,618,053	44,482,478	69,100,531	0.117630	0.117630	0.117702	60
62	Whole Blood & Packed Red Blood Cells	2,178,236	823,996	3,002,232	0.428387	0.428387	0.428387	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63.02	NONINVASIVE LAB	4,793,364	8,300,051	13,093,415	0.112395	0.112395	0.112395	63.02
65	Respiratory Therapy	9,200,994	1,861,860	11,062,854	0.212139	0.212139	0.212139	65
66	Physical Therapy	6,361,315	3,976,591	10,337,906	0.401502	0.401502	0.401502	66
67	Occupational Therapy	5,152,229	1,523,390	6,675,619	0.325769	0.325769	0.325769	67
68	Speech Pathology	869,227	659,605	1,528,832	0.491974	0.491974	0.493609	68
70	Electroencephalography	1,077,763	3,634,917	4,712,680	0.172286	0.172286	0.172286	70
71	Medical Supplies Charged to Patients	5,005,786	4,588,962	9,594,748	0.415047	0.415047	0.415047	71
72	Impl. Dev. Charged to Patients	5,476,449	4,090,717	9,567,166	0.503868	0.503868	0.503868	72
73	Drugs Charged to Patients	25,805,069	17,513,833	43,318,902	0.237910	0.237910	0.237910	73
74	Renal Dialysis	3,056,175	437,400	3,493,575	0.296145	0.296145	0.296145	74
75.01	ONCOLOGY	2,593	1,592,561	1,595,154	0.272766	0.272766	0.272766	75.01
76.97	CARDIAC REHABILITATION	142,004	491,730	633,734	1.801444	1.801444	1.817188	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	128,021	1,755,596	1,883,617	0.651955	0.651955	0.664636	90
90.01	OP PSYCH	3,147	566,752	569,899	0.168400	0.168400	0.168400	90.01
91	Emergency	12,664,561	42,497,636	55,162,197	0.133565	0.133565	0.135678	91
92	Observation Beds (Non-Distinct Part)	1,220,689	8,650,920	9,871,609	0.448709	0.448709	0.448709	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,608,859	2,608,859				101
200	Subtotal (sum of lines 30 thru 199)	221,400,567	247,347,676	468,748,243				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	221,400,567	247,347,676	468,748,243				202

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check [] Title V [XX] PPS
Applicable [XX] 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)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,404,644		1,404,644	31,971	43.93	10,795	474,224	30
31	Intensive Care Unit	316,419		316,419	2,916	108.51	1,546	167,756	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	120,873		120,873	2,804	43.11	2,165	93,333	40
41	Subprovider - IRF	323,782		323,782	8,812	36.74	6,757	248,252	41
42	Subprovider I								42
43	Nursery	26,487		26,487	1,112	23.82			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,192,205		2,192,205	47,615		21,263	983,565	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	1,269,289	40,173,882	0.031595	4,945,215	156,244	50
51	Recovery Room	19,963	2,447,873	0.008155	294,818	2,404	51
52	Delivery Room & Labor Room	71,620	4,944,157	0.014486	18,375	266	52
53	Anesthesiology	107,968	3,381,536	0.031929	703,877	22,474	53
54	Radiology-Diagnostic	1,020,927	24,166,463	0.042246	2,631,069	111,152	54
54.01	ULTRASOUND	121,014	5,720,841	0.021153	386,168	8,169	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	94,752	9,618,744	0.009851	1,064,469	10,486	56
57	CT Scan	658,508	32,579,256	0.020212	4,235,114	85,600	57
59	Cardiac Catheterization	204,787	19,474,668	0.010516	5,342,160	56,178	59
60	Laboratory	339,091	69,100,531	0.004907	10,273,478	50,412	60
62	Whole Blood & Packed Red Blood	47,048	3,002,232	0.015671	915,111	14,341	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	217,928	13,093,415	0.016644	2,521,086	41,961	63.02
65	Respiratory Therapy	99,175	11,062,854	0.008965	5,434,876	48,724	65
66	Physical Therapy	159,227	10,337,906	0.015402	1,039,678	16,013	66
67	Occupational Therapy	40,221	6,675,619	0.006025	565,445	3,407	67
68	Speech Pathology	30,699	1,528,832	0.020080	222,294	4,464	68
70	Electroencephalography	117,985	4,712,680	0.025036	327,685	8,204	70
71	Medical Supplies Charged to Pat	17,964	9,594,748	0.001872	1,446,920	2,709	71
72	Impl. Dev. Charged to Patients	21,433	9,567,166	0.002240	3,132,313	7,016	72
73	Drugs Charged to Patients	411,459	43,318,902	0.009498	9,732,919	92,443	73
74	Renal Dialysis	9,066	3,493,575	0.002595	1,442,983	3,745	74
75.01	ONCOLOGY	15,055	1,595,154	0.009438			75.01
76.97	CARDIAC REHABILITATION	108,108	633,734	0.170589	63,776	10,879	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	86,938	1,883,617	0.046155			90
90.01	OP PSYCH	4,877	569,899	0.008558			90.01
91	Emergency	401,730	55,162,197	0.007283	5,000,834	36,421	91
92	Observation Beds (Non-Distinct	218,006	9,871,609	0.022084	612,007	13,516	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,914,838	397,712,090		62,352,670	807,228	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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

(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)	31,971		10,795		30
31	Intensive Care Unit	2,916		1,546		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	2,804		2,165		40
41	Subprovider - IRF	8,812		6,757		41
42	Subprovider I					42
43	Nursery	1,112				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	47,615		21,263		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	40,173,882			4,945,215		9,067,924		50
51	Recovery Room	2,447,873			294,818		292,126		51
52	Delivery Room & Labor Room	4,944,157			18,375				52
53	Anesthesiology	3,381,536			703,877		678,918		53
54	Radiology-Diagnostic	24,166,463			2,631,069		4,280,316		54
54.01	ULTRASOUND	5,720,841			386,168		629,747		54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	9,618,744			1,064,469		3,534,729		56
57	CT Scan	32,579,256			4,235,114		5,989,363		57
59	Cardiac Catheterization	19,474,668			5,342,160		4,928,583		59
60	Laboratory	69,100,531			10,273,478		4,774,687		60
62	Whole Blood & Packed Red Blood	3,002,232			915,111		84,812		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	13,093,415			2,521,086		3,269,602		63.02
65	Respiratory Therapy	11,062,854			5,434,876		629,632		65
66	Physical Therapy	10,337,906			1,039,678		124,713		66
67	Occupational Therapy	6,675,619			565,445		23,873		67
68	Speech Pathology	1,528,832			222,294		48,665		68
70	Electroencephalography	4,712,680			327,685		943,511		70
71	Medical Supplies Charged to Pat	9,594,748			1,446,920		2,225,865		71
72	Impl. Dev. Charged to Patients	9,567,166			3,132,313		2,132,722		72
73	Drugs Charged to Patients	43,318,902			9,732,919		6,469,167		73
74	Renal Dialysis	3,493,575			1,442,983		270,905		74
75.01	ONCOLOGY	1,595,154					816,666		75.01
76.97	CARDIAC REHABILITATION	633,734			63,776		220,315		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,883,617					345,629		90
90.01	OP PSYCH	569,899					130,736		90.01
91	Emergency	55,162,197			5,000,834		6,269,823		91
92	Observation Beds (Non-Distinct	9,871,609			612,007		2,065,478		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	397,712,090			62,352,670		60,248,507		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.285549	9,067,924			2,589,337			50
51	Recovery Room	0.286353	292,126			83,651			51
52	Delivery Room & Labor Room	0.442048							52
53	Anesthesiology	0.118626	678,918			80,537			53
54	Radiology-Diagnostic	0.213163	4,280,316			912,405			54
54.01	ULTRASOUND	0.159390	629,747			100,375			54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.144427	3,534,729			510,510			56
57	CT Scan	0.066539	5,989,363			398,526			57
59	Cardiac Catheterization	0.170816	4,928,583			841,881			59
60	Laboratory	0.117630	4,774,687			561,646			60
62	Whole Blood & Packed Red Blood	0.428387	84,812			36,332			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.112395	3,269,602			367,487			63.02
65	Respiratory Therapy	0.212139	629,632			133,570			65
66	Physical Therapy	0.401502	124,713			50,073			66
67	Occupational Therapy	0.325769	23,873			7,777			67
68	Speech Pathology	0.491974	48,665			23,942			68
70	Electroencephalography	0.172286	943,511			162,554			70
71	Medical Supplies Charged to Pat	0.415047	2,225,865			923,839			71
72	Impl. Dev. Charged to Patients	0.503868	2,132,722			1,074,610			72
73	Drugs Charged to Patients	0.237910	6,469,167		52,656	1,539,080		12,527	73
74	Renal Dialysis	0.296145	270,905			80,227			74
75.01	ONCOLOGY	0.272766	816,666			222,759			75.01
76.97	CARDIAC REHABILITATION	1.801444	220,315			396,885			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.651955	345,629			225,335			90
90.01	OP PSYCH	0.168400	130,736			22,016			90.01
91	Emergency	0.133565	6,269,823			837,429			91
92	Observation Beds (Non-Distinct	0.448709	2,065,478			926,799			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		60,248,507		52,656	13,109,582		12,527	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		60,248,507		52,656	13,109,582		12,527	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-S008

**WORKSHEET D
PART II**

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

(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	1,269,289	40,173,882	0.031595	5,125	162	50
51	Recovery Room	19,963	2,447,873	0.008155	1,607	13	51
52	Delivery Room & Labor Room	71,620	4,944,157	0.014486			52
53	Anesthesiology	107,968	3,381,536	0.031929	1,162	37	53
54	Radiology-Diagnostic	1,020,927	24,166,463	0.042246	91,757	3,876	54
54.01	ULTRASOUND	121,014	5,720,841	0.021153	4,208	89	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	94,752	9,618,744	0.009851	6,777	67	56
57	CT Scan	658,508	32,579,256	0.020212	105,519	2,133	57
59	Cardiac Catheterization	204,787	19,474,668	0.010516	17,646	186	59
60	Laboratory	339,091	69,100,531	0.004907	451,941	2,218	60
62	Whole Blood & Packed Red Blood	47,048	3,002,232	0.015671	1,830	29	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	217,928	13,093,415	0.016644	58,093	967	63.02
65	Respiratory Therapy	99,175	11,062,854	0.008965	55,019	493	65
66	Physical Therapy	159,227	10,337,906	0.015402	131,814	2,030	66
67	Occupational Therapy	40,221	6,675,619	0.006025	89,617	540	67
68	Speech Pathology	30,699	1,528,832	0.020080	21,212	426	68
70	Electroencephalography	117,985	4,712,680	0.025036	37,438	937	70
71	Medical Supplies Charged to Pat	17,964	9,594,748	0.001872	31,608	59	71
72	Impl. Dev. Charged to Patients	21,433	9,567,166	0.002240			72
73	Drugs Charged to Patients	411,459	43,318,902	0.009498	668,215	6,347	73
74	Renal Dialysis	9,066	3,493,575	0.002595	34,200	89	74
75.01	ONCOLOGY	15,055	1,595,154	0.009438			75.01
76.97	CARDIAC REHABILITATION	108,108	633,734	0.170589			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	86,938	1,883,617	0.046155			90
90.01	OP PSYCH	4,877	569,899	0.008558			90.01
91	Emergency	401,730	55,162,197	0.007283	142,598	1,039	91
92	Observation Beds (Non-Distinct		9,871,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,696,832	397,712,090		1,957,386	21,737	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-S008

**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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-S008

**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	40,173,882			5,125				50
51	Recovery Room	2,447,873			1,607				51
52	Delivery Room & Labor Room	4,944,157							52
53	Anesthesiology	3,381,536			1,162				53
54	Radiology-Diagnostic	24,166,463			91,757				54
54.01	ULTRASOUND	5,720,841			4,208				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	9,618,744			6,777				56
57	CT Scan	32,579,256			105,519				57
59	Cardiac Catheterization	19,474,668			17,646				59
60	Laboratory	69,100,531			451,941				60
62	Whole Blood & Packed Red Blood	3,002,232			1,830				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	13,093,415			58,093				63.02
65	Respiratory Therapy	11,062,854			55,019				65
66	Physical Therapy	10,337,906			131,814				66
67	Occupational Therapy	6,675,619			89,617				67
68	Speech Pathology	1,528,832			21,212				68
70	Electroencephalography	4,712,680			37,438				70
71	Medical Supplies Charged to Pat	9,594,748			31,608				71
72	Impl. Dev. Charged to Patients	9,567,166							72
73	Drugs Charged to Patients	43,318,902			668,215				73
74	Renal Dialysis	3,493,575			34,200				74
75.01	ONCOLOGY	1,595,154							75.01
76.97	CARDIAC REHABILITATION	633,734							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,883,617							90
90.01	OP PSYCH	569,899							90.01
91	Emergency	55,162,197			142,598				91
92	Observation Beds (Non-Distinct	9,871,609							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	397,712,090			1,957,386				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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-S008

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.285549							50
51	Recovery Room	0.286353							51
52	Delivery Room & Labor Room	0.442048							52
53	Anesthesiology	0.118626							53
54	Radiology-Diagnostic	0.213163							54
54.01	ULTRASOUND	0.159390							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.144427							56
57	CT Scan	0.066539							57
59	Cardiac Catheterization	0.170816							59
60	Laboratory	0.117630							60
62	Whole Blood & Packed Red Blood	0.428387							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.112395							63.02
65	Respiratory Therapy	0.212139							65
66	Physical Therapy	0.401502							66
67	Occupational Therapy	0.325769							67
68	Speech Pathology	0.491974							68
70	Electroencephalography	0.172286							70
71	Medical Supplies Charged to Pat	0.415047							71
72	Impl. Dev. Charged to Patients	0.503868							72
73	Drugs Charged to Patients	0.237910							73
74	Renal Dialysis	0.296145							74
75.01	ONCOLOGY	0.272766							75.01
76.97	CARDIAC REHABILITATION	1.801444							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.651955							90
90.01	OP PSYCH	0.168400							90.01
91	Emergency	0.133565							91
92	Observation Beds (Non-Distinct)	0.448709							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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	1,269,289	40,173,882	0.031595	86,606	2,736	50
51	Recovery Room	19,963	2,447,873	0.008155	13,082	107	51
52	Delivery Room & Labor Room	71,620	4,944,157	0.014486			52
53	Anesthesiology	107,968	3,381,536	0.031929	19,395	619	53
54	Radiology-Diagnostic	1,020,927	24,166,463	0.042246	285,057	12,043	54
54.01	ULTRASOUND	121,014	5,720,841	0.021153	21,524	455	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	94,752	9,618,744	0.009851	57,019	562	56
57	CT Scan	658,508	32,579,256	0.020212	233,786	4,725	57
59	Cardiac Catheterization	204,787	19,474,668	0.010516	77,073	810	59
60	Laboratory	339,091	69,100,531	0.004907	1,729,600	8,487	60
62	Whole Blood & Packed Red Blood	47,048	3,002,232	0.015671	102,082	1,600	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	217,928	13,093,415	0.016644	360,181	5,995	63.02
65	Respiratory Therapy	99,175	11,062,854	0.008965	750,690	6,730	65
66	Physical Therapy	159,227	10,337,906	0.015402	3,306,314	50,924	66
67	Occupational Therapy	40,221	6,675,619	0.006025	3,107,558	18,723	67
68	Speech Pathology	30,699	1,528,832	0.020080	341,486	6,857	68
70	Electroencephalography	117,985	4,712,680	0.025036	228,188	5,713	70
71	Medical Supplies Charged to Pat	17,964	9,594,748	0.001872	546,304	1,023	71
72	Impl. Dev. Charged to Patients	21,433	9,567,166	0.002240	14,200	32	72
73	Drugs Charged to Patients	411,459	43,318,902	0.009498	3,162,146	30,034	73
74	Renal Dialysis	9,066	3,493,575	0.002595	540,757	1,403	74
75.01	ONCOLOGY	15,055	1,595,154	0.009438			75.01
76.97	CARDIAC REHABILITATION	108,108	633,734	0.170589	186	32	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	86,938	1,883,617	0.046155	976	45	90
90.01	OP PSYCH	4,877	569,899	0.008558			90.01
91	Emergency	401,730	55,162,197	0.007283	10,545	77	91
92	Observation Beds (Non-Distinct		9,871,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,696,832	397,712,090		14,994,755	159,732	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	40,173,882			86,606				50
51	Recovery Room	2,447,873			13,082				51
52	Delivery Room & Labor Room	4,944,157							52
53	Anesthesiology	3,381,536			19,395				53
54	Radiology-Diagnostic	24,166,463			285,057		308		54
54.01	ULTRASOUND	5,720,841			21,524				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	9,618,744			57,019				56
57	CT Scan	32,579,256			233,786		3,073		57
59	Cardiac Catheterization	19,474,668			77,073				59
60	Laboratory	69,100,531			1,729,600				60
62	Whole Blood & Packed Red Blood	3,002,232			102,082				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	13,093,415			360,181		1,155		63.02
65	Respiratory Therapy	11,062,854			750,690		97		65
66	Physical Therapy	10,337,906			3,306,314				66
67	Occupational Therapy	6,675,619			3,107,558				67
68	Speech Pathology	1,528,832			341,486				68
70	Electroencephalography	4,712,680			228,188		7,230		70
71	Medical Supplies Charged to Pat	9,594,748			546,304		3,182		71
72	Impl. Dev. Charged to Patients	9,567,166			14,200				72
73	Drugs Charged to Patients	43,318,902			3,162,146		33,827		73
74	Renal Dialysis	3,493,575			540,757		10,800		74
75.01	ONCOLOGY	1,595,154							75.01
76.97	CARDIAC REHABILITATION	633,734			186				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,883,617			976				90
90.01	OP PSYCH	569,899							90.01
91	Emergency	55,162,197			10,545				91
92	Observation Beds (Non-Distinct	9,871,609							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	397,712,090			14,994,755		59,672		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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 [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [XX] 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	0.285549							50
51	Recovery Room	0.286353							51
52	Delivery Room & Labor Room	0.442048							52
53	Anesthesiology	0.118626							53
54	Radiology-Diagnostic	0.213163	308			66			54
54.01	ULTRASOUND	0.159390							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.144427							56
57	CT Scan	0.066539	3,073			204			57
59	Cardiac Catheterization	0.170816							59
60	Laboratory	0.117630							60
62	Whole Blood & Packed Red Blood	0.428387							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.112395	1,155			130			63.02
65	Respiratory Therapy	0.212139	97			21			65
66	Physical Therapy	0.401502							66
67	Occupational Therapy	0.325769							67
68	Speech Pathology	0.491974							68
70	Electroencephalography	0.172286	7,230			1,246			70
71	Medical Supplies Charged to Pat	0.415047	3,182			1,321			71
72	Impl. Dev. Charged to Patients	0.503868							72
73	Drugs Charged to Patients	0.237910	33,827		1,767	8,048		420	73
74	Renal Dialysis	0.296145	10,800			3,198			74
75.01	ONCOLOGY	0.272766							75.01
76.97	CARDIAC REHABILITATION	1.801444							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.651955							90
90.01	OP PSYCH	0.168400							90.01
91	Emergency	0.133565							91
92	Observation Beds (Non-Distinct)	0.448709							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		59,672		1,767	14,234		420	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		59,672		1,767	14,234		420	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,404,644		1,404,644	31,971	43.93	1,362	59,833	30
31	Intensive Care Unit	316,419		316,419	2,916	108.51	199	21,593	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	120,873		120,873	2,804	43.11	95	4,095	40
41	Subprovider - IRF	323,782		323,782	8,812	36.74	163	5,989	41
42	Subprovider I								42
43	Nursery	26,487		26,487	1,112	23.82	248	5,907	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,192,205		2,192,205	47,615		2,067	97,417	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	1,269,289	40,173,882	0.031595	374,528	11,833	50
51	Recovery Room	19,963	2,447,873	0.008155	52,255	426	51
52	Delivery Room & Labor Room	71,620	4,944,157	0.014486	301,544	4,368	52
53	Anesthesiology	107,968	3,381,536	0.031929	81,321	2,596	53
54	Radiology-Diagnostic	1,020,927	24,166,463	0.042246	204,344	8,633	54
54.01	ULTRASOUND	121,014	5,720,841	0.021153	47,844	1,012	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	94,752	9,618,744	0.009851	25,777	254	56
57	CT Scan	658,508	32,579,256	0.020212	272,299	5,504	57
59	Cardiac Catheterization	204,787	19,474,668	0.010516	302,294	3,179	59
60	Laboratory	339,091	69,100,531	0.004907	1,084,143	5,320	60
62	Whole Blood & Packed Red Blood	47,048	3,002,232	0.015671	52,320	820	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	217,928	13,093,415	0.016644	131,749	2,193	63.02
65	Respiratory Therapy	99,175	11,062,854	0.008965	217,326	1,948	65
66	Physical Therapy	159,227	10,337,906	0.015402	72,071	1,110	66
67	Occupational Therapy	40,221	6,675,619	0.006025	35,463	214	67
68	Speech Pathology	30,699	1,528,832	0.020080	67,463	1,355	68
70	Electroencephalography	117,985	4,712,680	0.025036	29,509	739	70
71	Medical Supplies Charged to Pat	17,964	9,594,748	0.001872	351,314	658	71
72	Impl. Dev. Charged to Patients	21,433	9,567,166	0.002240	89,754	201	72
73	Drugs Charged to Patients	411,459	43,318,902	0.009498	1,211,512	11,507	73
74	Renal Dialysis	9,066	3,493,575	0.002595	106,790	277	74
75.01	ONCOLOGY	15,055	1,595,154	0.009438	20		75.01
76.97	CARDIAC REHABILITATION	108,108	633,734	0.170589	430	73	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	86,938	1,883,617	0.046155	610	28	90
90.01	OP PSYCH	4,877	569,899	0.008558			90.01
91	Emergency	401,730	55,162,197	0.007283	267,623	1,949	91
92	Observation Beds (Non-Distinct	218,006	9,871,609	0.022084	34,246	756	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,914,838	397,712,090		5,414,549	66,953	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	31,971		1,362	30
31	Intensive Care Unit	2,916		199	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	2,804		95	40
41	Subprovider - IRF	8,812		163	41
42	Subprovider I				42
43	Nursery	1,112		248	43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	47,615		2,067	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	40,173,882			374,528				50
51	Recovery Room	2,447,873			52,255				51
52	Delivery Room & Labor Room	4,944,157			301,544				52
53	Anesthesiology	3,381,536			81,321				53
54	Radiology-Diagnostic	24,166,463			204,344				54
54.01	ULTRASOUND	5,720,841			47,844				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	9,618,744			25,777				56
57	CT Scan	32,579,256			272,299				57
59	Cardiac Catheterization	19,474,668			302,294				59
60	Laboratory	69,100,531			1,084,143				60
62	Whole Blood & Packed Red Blood	3,002,232			52,320				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	13,093,415			131,749				63.02
65	Respiratory Therapy	11,062,854			217,326				65
66	Physical Therapy	10,337,906			72,071				66
67	Occupational Therapy	6,675,619			35,463				67
68	Speech Pathology	1,528,832			67,463				68
70	Electroencephalography	4,712,680			29,509				70
71	Medical Supplies Charged to Pat	9,594,748			351,314				71
72	Impl. Dev. Charged to Patients	9,567,166			89,754				72
73	Drugs Charged to Patients	43,318,902			1,211,512				73
74	Renal Dialysis	3,493,575			106,790				74
75.01	ONCOLOGY	1,595,154			20				75.01
76.97	CARDIAC REHABILITATION	633,734			430				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	1,883,617			610				90
90.01	OP PSYCH	569,899							90.01
91	Emergency	55,162,197			267,623				91
92	Observation Beds (Non-Distinct	9,871,609			34,246				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	397,712,090			5,414,549				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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	0.285549							50
51	Recovery Room	0.286353							51
52	Delivery Room & Labor Room	0.442048							52
53	Anesthesiology	0.118626							53
54	Radiology-Diagnostic	0.213163							54
54.01	ULTRASOUND	0.159390							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.144427							56
57	CT Scan	0.066539							57
59	Cardiac Catheterization	0.170816							59
60	Laboratory	0.117630							60
62	Whole Blood & Packed Red Blood	0.428387							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.112395							63.02
65	Respiratory Therapy	0.212139							65
66	Physical Therapy	0.401502							66
67	Occupational Therapy	0.325769							67
68	Speech Pathology	0.491974							68
70	Electroencephalography	0.172286							70
71	Medical Supplies Charged to Pat	0.415047							71
72	Impl. Dev. Charged to Patients	0.503868							72
73	Drugs Charged to Patients	0.237910							73
74	Renal Dialysis	0.296145							74
75.01	ONCOLOGY	0.272766							75.01
76.97	CARDIAC REHABILITATION	1.801444							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.651955							90
90.01	OP PSYCH	0.168400							90.01
91	Emergency	0.133565							91
92	Observation Beds (Non-Distinct)	0.448709							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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-S008

**WORKSHEET D
PART II**

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

(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	1,269,289	40,173,882	0.031595			50
51	Recovery Room	19,963	2,447,873	0.008155			51
52	Delivery Room & Labor Room	71,620	4,944,157	0.014486			52
53	Anesthesiology	107,968	3,381,536	0.031929			53
54	Radiology-Diagnostic	1,020,927	24,166,463	0.042246	17,246	729	54
54.01	ULTRASOUND	121,014	5,720,841	0.021153	1,235	26	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	94,752	9,618,744	0.009851			56
57	CT Scan	658,508	32,579,256	0.020212			57
59	Cardiac Catheterization	204,787	19,474,668	0.010516	1,201	13	59
60	Laboratory	339,091	69,100,531	0.004907	33,261	163	60
62	Whole Blood & Packed Red Blood	47,048	3,002,232	0.015671			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	217,928	13,093,415	0.016644	7,305	122	63.02
65	Respiratory Therapy	99,175	11,062,854	0.008965	241	2	65
66	Physical Therapy	159,227	10,337,906	0.015402	8,972	138	66
67	Occupational Therapy	40,221	6,675,619	0.006025	6,746	41	67
68	Speech Pathology	30,699	1,528,832	0.020080	1,189	24	68
70	Electroencephalography	117,985	4,712,680	0.025036	2,400	60	70
71	Medical Supplies Charged to Pat	17,964	9,594,748	0.001872	1,586	3	71
72	Impl. Dev. Charged to Patients	21,433	9,567,166	0.002240	836	2	72
73	Drugs Charged to Patients	411,459	43,318,902	0.009498	45,914	436	73
74	Renal Dialysis	9,066	3,493,575	0.002595			74
75.01	ONCOLOGY	15,055	1,595,154	0.009438			75.01
76.97	CARDIAC REHABILITATION	108,108	633,734	0.170589			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	86,938	1,883,617	0.046155			90
90.01	OP PSYCH	4,877	569,899	0.008558			90.01
91	Emergency	401,730	55,162,197	0.007283	8,216	60	91
92	Observation Beds (Non-Distinct		9,871,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,696,832	397,712,090		136,348	1,819	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-S008

**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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-S008

**WORKSHEET D
PART IV**

Check [] Title V [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] 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	40,173,882							50
51	Recovery Room	2,447,873							51
52	Delivery Room & Labor Room	4,944,157							52
53	Anesthesiology	3,381,536							53
54	Radiology-Diagnostic	24,166,463			17,246				54
54.01	ULTRASOUND	5,720,841			1,235				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	9,618,744							56
57	CT Scan	32,579,256							57
59	Cardiac Catheterization	19,474,668			1,201				59
60	Laboratory	69,100,531			33,261				60
62	Whole Blood & Packed Red Blood	3,002,232							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	13,093,415			7,305				63.02
65	Respiratory Therapy	11,062,854			241				65
66	Physical Therapy	10,337,906			8,972				66
67	Occupational Therapy	6,675,619			6,746				67
68	Speech Pathology	1,528,832			1,189				68
70	Electroencephalography	4,712,680			2,400				70
71	Medical Supplies Charged to Pat	9,594,748			1,586				71
72	Impl. Dev. Charged to Patients	9,567,166			836				72
73	Drugs Charged to Patients	43,318,902			45,914				73
74	Renal Dialysis	3,493,575							74
75.01	ONCOLOGY	1,595,154							75.01
76.97	CARDIAC REHABILITATION	633,734							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	1,883,617							90
90.01	OP PSYCH	569,899							90.01
91	Emergency	55,162,197			8,216				91
92	Observation Beds (Non-Distinct	9,871,609							92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	397,712,090			136,348				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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-S008

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	0.285549							50
51	Recovery Room	0.286353							51
52	Delivery Room & Labor Room	0.442048							52
53	Anesthesiology	0.118626							53
54	Radiology-Diagnostic	0.213163							54
54.01	ULTRASOUND	0.159390							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.144427							56
57	CT Scan	0.066539							57
59	Cardiac Catheterization	0.170816							59
60	Laboratory	0.117630							60
62	Whole Blood & Packed Red Blood	0.428387							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.112395							63.02
65	Respiratory Therapy	0.212139							65
66	Physical Therapy	0.401502							66
67	Occupational Therapy	0.325769							67
68	Speech Pathology	0.491974							68
70	Electroencephalography	0.172286							70
71	Medical Supplies Charged to Pat	0.415047							71
72	Impl. Dev. Charged to Patients	0.503868							72
73	Drugs Charged to Patients	0.237910							73
74	Renal Dialysis	0.296145							74
75.01	ONCOLOGY	0.272766							75.01
76.97	CARDIAC REHABILITATION	1.801444							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.651955							90
90.01	OP PSYCH	0.168400							90.01
91	Emergency	0.133565							91
92	Observation Beds (Non-Distinct)	0.448709							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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	1,269,289	40,173,882	0.031595			50
51	Recovery Room	19,963	2,447,873	0.008155			51
52	Delivery Room & Labor Room	71,620	4,944,157	0.014486			52
53	Anesthesiology	107,968	3,381,536	0.031929			53
54	Radiology-Diagnostic	1,020,927	24,166,463	0.042246	14,146	598	54
54.01	ULTRASOUND	121,014	5,720,841	0.021153	594	13	54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope	94,752	9,618,744	0.009851	2,494	25	56
57	CT Scan	658,508	32,579,256	0.020212	4,553	92	57
59	Cardiac Catheterization	204,787	19,474,668	0.010516	4,832	51	59
60	Laboratory	339,091	69,100,531	0.004907	75,410	370	60
62	Whole Blood & Packed Red Blood	47,048	3,002,232	0.015671	1,020	16	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB	217,928	13,093,415	0.016644	8,867	148	63.02
65	Respiratory Therapy	99,175	11,062,854	0.008965	25,287	227	65
66	Physical Therapy	159,227	10,337,906	0.015402	97,739	1,505	66
67	Occupational Therapy	40,221	6,675,619	0.006025	89,253	538	67
68	Speech Pathology	30,699	1,528,832	0.020080	10,345	208	68
70	Electroencephalography	117,985	4,712,680	0.025036	13,804	346	70
71	Medical Supplies Charged to Pat	17,964	9,594,748	0.001872	15,555	29	71
72	Impl. Dev. Charged to Patients	21,433	9,567,166	0.002240			72
73	Drugs Charged to Patients	411,459	43,318,902	0.009498	114,106	1,084	73
74	Renal Dialysis	9,066	3,493,575	0.002595	23,143	60	74
75.01	ONCOLOGY	15,055	1,595,154	0.009438			75.01
76.97	CARDIAC REHABILITATION	108,108	633,734	0.170589			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	86,938	1,883,617	0.046155			90
90.01	OP PSYCH	4,877	569,899	0.008558			90.01
91	Emergency	401,730	55,162,197	0.007283	1,884	14	91
92	Observation Beds (Non-Distinct		9,871,609				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,696,832	397,712,090		503,032	5,324	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	40,173,882							50
51	Recovery Room	2,447,873							51
52	Delivery Room & Labor Room	4,944,157							52
53	Anesthesiology	3,381,536							53
54	Radiology-Diagnostic	24,166,463			14,146				54
54.01	ULTRASOUND	5,720,841			594				54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	9,618,744			2,494				56
57	CT Scan	32,579,256			4,553				57
59	Cardiac Catheterization	19,474,668			4,832				59
60	Laboratory	69,100,531			75,410				60
62	Whole Blood & Packed Red Blood	3,002,232			1,020				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	13,093,415			8,867				63.02
65	Respiratory Therapy	11,062,854			25,287				65
66	Physical Therapy	10,337,906			97,739				66
67	Occupational Therapy	6,675,619			89,253				67
68	Speech Pathology	1,528,832			10,345				68
70	Electroencephalography	4,712,680			13,804				70
71	Medical Supplies Charged to Pat	9,594,748			15,555				71
72	Impl. Dev. Charged to Patients	9,567,166							72
73	Drugs Charged to Patients	43,318,902			114,106				73
74	Renal Dialysis	3,493,575			23,143				74
75.01	ONCOLOGY	1,595,154							75.01
76.97	CARDIAC REHABILITATION	633,734							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	1,883,617							90
90.01	OP PSYCH	569,899							90.01
91	Emergency	55,162,197			1,884				91
92	Observation Beds (Non-Distinct	9,871,609							92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	397,712,090			503,032				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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.285549							50
51	Recovery Room	0.286353							51
52	Delivery Room & Labor Room	0.442048							52
53	Anesthesiology	0.118626							53
54	Radiology-Diagnostic	0.213163							54
54.01	ULTRASOUND	0.159390							54.01
54.02	AUDIOLOGY								54.02
56	Radioisotope	0.144427							56
57	CT Scan	0.066539							57
59	Cardiac Catheterization	0.170816							59
60	Laboratory	0.117630							60
62	Whole Blood & Packed Red Blood	0.428387							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63.02	NONINVASIVE LAB	0.112395							63.02
65	Respiratory Therapy	0.212139							65
66	Physical Therapy	0.401502							66
67	Occupational Therapy	0.325769							67
68	Speech Pathology	0.491974							68
70	Electroencephalography	0.172286							70
71	Medical Supplies Charged to Pat	0.415047							71
72	Impl. Dev. Charged to Patients	0.503868							72
73	Drugs Charged to Patients	0.237910							73
74	Renal Dialysis	0.296145							74
75.01	ONCOLOGY	0.272766							75.01
76.97	CARDIAC REHABILITATION	1.801444							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.651955							90
90.01	OP PSYCH	0.168400							90.01
91	Emergency	0.133565							91
92	Observation Beds (Non-Distinct)	0.448709							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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	31,971	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	31,971	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)	27,009	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)	10,795	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)	28,540,028	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)	28,540,028	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)	28,540,028	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)					892.68	38	
39	Program general inpatient routine service cost (line 9 x line 38)					9,636,481	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)					9,636,481	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,329,099	2,916	1,827.54	1,546	2,825,377	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)					13,365,018	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					25,826,876	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					641,980	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					807,228	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,449,208	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					24,377,668	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)					4,962	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					892.68	88
89	Observation bed cost (line 87 x line 88) (see instructions)					4,429,478	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,404,644	28,540,028	0.049217	4,429,478	218,006	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-S008

**WORKSHEET D-1
PART I**

Check [] Title V - I/P [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] Title XVIII, Part A [XX] 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)	2,804	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,804	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)	2,804	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,165	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,158,957	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,158,957	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,158,957	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-S008

WORKSHEET D-1
PART II

Check [] Title V - I/P [] Hospital [] SUB (Other) [XX] PPS
Applicable [XX] Title XVIII, Part A [XX] 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)	1,126.59	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,439,067	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	2,439,067	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	406,151	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,845,218	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	93,333	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	21,737	51
52	Total Program excludable cost (sum of lines 50 and 51)	115,070	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,730,148	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	8,812	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,812	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	8,812	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)	6,757	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)	6,833,723	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)	6,833,723	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)	6,833,723	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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) [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] TEFRA
Boxes: [] Title XIX - I/P [XX] 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)	775.50	38
39	Program general inpatient routine service cost (line 9 x line 38)	5,240.054	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	5,240.054	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,275.781	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	9,515.835	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	248.252	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	159.732	51
52	Total Program excludable cost (sum of lines 50 and 51)	407.984	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	9,107.851	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	31,971	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	31,971	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)	27,009	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,362	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)	1,112	15
16	Nursery days (title V or XIX only)	248	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)	28,540,028	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)	28,540,028	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)	28,540,028	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)					892.68	38	
39	Program general inpatient routine service cost (line 9 x line 38)					1,215,830	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,215,830	41	
42	Nursery (Titles V and XIX only)	805,697	1,112	724.55	248	179,688	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,329,099	2,916	1,827.54	199	363,680	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,244,026	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,003,224	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					87,333	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					66,953	51
52	Total Program excludable cost (sum of lines 50 and 51)					154,286	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					2,848,938	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)					4,962	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-S008

WORKSHEET D-1
PART I

Check [] Title V - I/P [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [] Title XVIII, Part A [XX] 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)	2,804	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,804	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)	2,804	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)	95	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,158,957	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,158,957	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,158,957	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-S008

WORKSHEET D-1
PART II

Check [] Title V - I/P [] Hospital [] SUB (Other) [XX] PPS
Applicable [] Title XVIII, Part A [XX] IPF [] TEFRA
Boxes: [XX] 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)		1,126.59	38
39	Program general inpatient routine service cost (line 9 x line 38)		107,026	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)		107,026	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		28,791	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)		135,817	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		4,095	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		1,819	51
52	Total Program excludable cost (sum of lines 50 and 51)		5,914	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		129,903	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	8,812	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,812	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	8,812	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)	163	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)	6,833,723	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)	6,833,723	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)	6,833,723	37

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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) [XX] PPS
Applicable [] Title XVIII, Part A [] IPF [] TEFRA
Boxes: [XX] Title XIX - I/P [XX] 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)	775.50	38
39	Program general inpatient routine service cost (line 9 x line 38)	126,407	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)	126,407	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	136,796	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	263,203	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	5,989	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,324	51
52	Total Program excludable cost (sum of lines 50 and 51)	11,313	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	251,890	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		15,791,988		30
31	Intensive Care Unit		3,158,955		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.285976	4,945,215	1,414,213	50
51	Recovery Room	0.286353	294,818	84,422	51
52	Delivery Room & Labor Room	0.442048	18,375	8,123	52
53	Anesthesiology	0.125706	703,877	88,482	53
54	Radiology-Diagnostic	0.213624	2,631,069	562,059	54
54.01	ULTRASOUND	0.159390	386,168	61,551	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.144427	1,064,469	153,738	56
57	CT Scan	0.066539	4,235,114	281,800	57
59	Cardiac Catheterization	0.171197	5,342,160	914,562	59
60	Laboratory	0.117702	10,273,478	1,209,209	60
62	Whole Blood & Packed Red Blood Cells	0.428387	915,111	392,022	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.112395	2,521,086	283,357	63.02
65	Respiratory Therapy	0.212139	5,434,876	1,152,949	65
66	Physical Therapy	0.401502	1,039,678	417,433	66
67	Occupational Therapy	0.325769	565,445	184,204	67
68	Speech Pathology	0.493609	222,294	109,726	68
70	Electroencephalography	0.172286	327,685	56,456	70
71	Medical Supplies Charged to Patients	0.415047	1,446,920	600,540	71
72	Impl. Dev. Charged to Patients	0.503868	3,132,313	1,578,272	72
73	Drugs Charged to Patients	0.237910	9,732,919	2,315,559	73
74	Renal Dialysis	0.296145	1,442,983	427,332	74
75.01	ONCOLOGY	0.272766			75.01
76.97	CARDIAC REHABILITATION	1.817188	63,776	115,893	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.664636			90
90.01	OP PSYCH	0.168400			90.01
91	Emergency	0.135678	5,000,834	678,503	91
92	Observation Beds (Non-Distinct Part)	0.448709	612,007	274,613	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		62,352,670	13,365,018	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		62,352,670		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-S008

WORKSHEET D-3

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

(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
40	Subprovider - IPF		6,336,183		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.285976	5,125	1,466	50
51	Recovery Room	0.286353	1,607	460	51
52	Delivery Room & Labor Room	0.442048			52
53	Anesthesiology	0.125706	1,162	146	53
54	Radiology-Diagnostic	0.213624	91,757	19,601	54
54.01	ULTRASOUND	0.159390	4,208	671	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.144427	6,777	979	56
57	CT Scan	0.066539	105,519	7,021	57
59	Cardiac Catheterization	0.171197	17,646	3,021	59
60	Laboratory	0.117702	451,941	53,194	60
62	Whole Blood & Packed Red Blood Cells	0.428387	1,830	784	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.112395	58,093	6,529	63.02
65	Respiratory Therapy	0.212139	55,019	11,672	65
66	Physical Therapy	0.401502	131,814	52,924	66
67	Occupational Therapy	0.325769	89,617	29,194	67
68	Speech Pathology	0.493609	21,212	10,470	68
70	Electroencephalography	0.172286	37,438	6,450	70
71	Medical Supplies Charged to Patients	0.415047	31,608	13,119	71
72	Impl. Dev. Charged to Patients	0.503868			72
73	Drugs Charged to Patients	0.237910	668,215	158,975	73
74	Renal Dialysis	0.296145	34,200	10,128	74
75.01	ONCOLOGY	0.272766			75.01
76.97	CARDIAC REHABILITATION	1.817188			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.664636			90
90.01	OP PSYCH	0.168400			90.01
91	Emergency	0.135678	142,598	19,347	91
92	Observation Beds (Non-Distinct Part)	0.448709			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,957,386	406,151	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,957,386		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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
40	Subprovider - IPF				40
41	Subprovider - IRF		6,400,174		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.285976	86,606	24,767	50
51	Recovery Room	0.286353	13,082	3,746	51
52	Delivery Room & Labor Room	0.442048			52
53	Anesthesiology	0.125706	19,395	2,438	53
54	Radiology-Diagnostic	0.213624	285,057	60,895	54
54.01	ULTRASOUND	0.159390	21,524	3,431	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.144427	57,019	8,235	56
57	CT Scan	0.066539	233,786	15,556	57
59	Cardiac Catheterization	0.171197	77,073	13,195	59
60	Laboratory	0.117702	1,729,600	203,577	60
62	Whole Blood & Packed Red Blood Cells	0.428387	102,082	43,731	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.112395	360,181	40,483	63.02
65	Respiratory Therapy	0.212139	750,690	159,251	65
66	Physical Therapy	0.401502	3,306,314	1,327,492	66
67	Occupational Therapy	0.325769	3,107,558	1,012,346	67
68	Speech Pathology	0.493609	341,486	168,561	68
70	Electroencephalography	0.172286	228,188	39,314	70
71	Medical Supplies Charged to Patients	0.415047	546,304	226,742	71
72	Impl. Dev. Charged to Patients	0.503868	14,200	7,155	72
73	Drugs Charged to Patients	0.237910	3,162,146	752,306	73
74	Renal Dialysis	0.296145	540,757	160,142	74
75.01	ONCOLOGY	0.272766			75.01
76.97	CARDIAC REHABILITATION	1.817188	186	338	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.664636	976	649	90
90.01	OP PSYCH	0.168400			90.01
91	Emergency	0.135678	10,545	1,431	91
92	Observation Beds (Non-Distinct Part)	0.448709			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		14,994,755	4,275,781	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		14,994,755		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		2,714,660		30
31	Intensive Care Unit		390,025		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery		303,645		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.285976	374,528	107,106	50
51	Recovery Room	0.286353	52,255	14,963	51
52	Delivery Room & Labor Room	0.442048	301,544	133,297	52
53	Anesthesiology	0.125706	81,321	10,223	53
54	Radiology-Diagnostic	0.213624	204,344	43,653	54
54.01	ULTRASOUND	0.159390	47,844	7,626	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.144427	25,777	3,723	56
57	CT Scan	0.066539	272,299	18,119	57
59	Cardiac Catheterization	0.171197	302,294	51,752	59
60	Laboratory	0.117702	1,084,143	127,606	60
62	Whole Blood & Packed Red Blood Cells	0.428387	52,320	22,413	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.112395	131,749	14,808	63.02
65	Respiratory Therapy	0.212139	217,326	46,103	65
66	Physical Therapy	0.401502	72,071	28,937	66
67	Occupational Therapy	0.325769	35,463	11,553	67
68	Speech Pathology	0.493609	67,463	33,300	68
70	Electroencephalography	0.172286	29,509	5,084	70
71	Medical Supplies Charged to Patients	0.415047	351,314	145,812	71
72	Impl. Dev. Charged to Patients	0.503868	89,754	45,224	72
73	Drugs Charged to Patients	0.237910	1,211,512	288,231	73
74	Renal Dialysis	0.296145	106,790	31,625	74
75.01	ONCOLOGY	0.272766	20	5	75.01
76.97	CARDIAC REHABILITATION	1.817188	430	781	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.664636	610	405	90
90.01	OP PSYCH	0.168400			90.01
91	Emergency	0.135678	267,623	36,311	91
92	Observation Beds (Non-Distinct Part)	0.448709	34,246	15,366	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,414,549	1,244,026	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,414,549		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-S008

WORKSHEET D-3

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

(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
40	Subprovider - IPF		302,545		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.285976			50
51	Recovery Room	0.286353			51
52	Delivery Room & Labor Room	0.442048			52
53	Anesthesiology	0.125706			53
54	Radiology-Diagnostic	0.213624	17,246	3,684	54
54.01	ULTRASOUND	0.159390	1,235	197	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.144427			56
57	CT Scan	0.066539			57
59	Cardiac Catheterization	0.171197	1,201	206	59
60	Laboratory	0.117702	33,261	3,915	60
62	Whole Blood & Packed Red Blood Cells	0.428387			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.112395	7,305	821	63.02
65	Respiratory Therapy	0.212139	241	51	65
66	Physical Therapy	0.401502	8,972	3,602	66
67	Occupational Therapy	0.325769	6,746	2,198	67
68	Speech Pathology	0.493609	1,189	587	68
70	Electroencephalography	0.172286	2,400	413	70
71	Medical Supplies Charged to Patients	0.415047	1,586	658	71
72	Impl. Dev. Charged to Patients	0.503868	836	421	72
73	Drugs Charged to Patients	0.237910	45,914	10,923	73
74	Renal Dialysis	0.296145			74
75.01	ONCOLOGY	0.272766			75.01
76.97	CARDIAC REHABILITATION	1.817188			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.664636			90
90.01	OP PSYCH	0.168400			90.01
91	Emergency	0.135678	8,216	1,115	91
92	Observation Beds (Non-Distinct Part)	0.448709			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		136,348	28,791	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		136,348		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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
40	Subprovider - IPF				40
41	Subprovider - IRF		204,487		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.285976			50
51	Recovery Room	0.286353			51
52	Delivery Room & Labor Room	0.442048			52
53	Anesthesiology	0.125706			53
54	Radiology-Diagnostic	0.213624	14,146	3,022	54
54.01	ULTRASOUND	0.159390	594	95	54.01
54.02	AUDIOLOGY				54.02
56	Radioisotope	0.144427	2,494	360	56
57	CT Scan	0.066539	4,553	303	57
59	Cardiac Catheterization	0.171197	4,832	827	59
60	Laboratory	0.117702	75,410	8,876	60
62	Whole Blood & Packed Red Blood Cells	0.428387	1,020	437	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63.02	NONINVASIVE LAB	0.112395	8,867	997	63.02
65	Respiratory Therapy	0.212139	25,287	5,364	65
66	Physical Therapy	0.401502	97,739	39,242	66
67	Occupational Therapy	0.325769	89,253	29,076	67
68	Speech Pathology	0.493609	10,345	5,106	68
70	Electroencephalography	0.172286	13,804	2,378	70
71	Medical Supplies Charged to Patients	0.415047	15,555	6,456	71
72	Impl. Dev. Charged to Patients	0.503868			72
73	Drugs Charged to Patients	0.237910	114,106	27,147	73
74	Renal Dialysis	0.296145	23,143	6,854	74
75.01	ONCOLOGY	0.272766			75.01
76.97	CARDIAC REHABILITATION	1.817188			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.664636			90
90.01	OP PSYCH	0.168400			90.01
91	Emergency	0.135678	1,884	256	91
92	Observation Beds (Non-Distinct Part)	0.448709			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		503,032	136,796	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		503,032		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	5,176,125			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	15,700,976			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)	506,271			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)	145.44			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1222			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3809			31
32	Sum of lines 30 and 31	0.5031			32
33	Allowable disproportionate share percentage (see instructions)	0.3072			33
34	Disproportionate share adjustment (see instructions)	1,603,362			34
		Prior to		On or after	
		October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	7,647,644,885		6,406,145,534	35
35.01	Factor 3 (see instructions)	0.000322053		0.000326996	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,462,947		2,094,784	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	620,798		1,568,227	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,189,025			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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	25,175,759			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)	25,175,759			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,885,197			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	1,036			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)	27,061,992			59
60	Primary payer payments	48,628			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	27,013,364			61
62	Deductibles billed to program beneficiaries	1,818,740			62
63	Coinsurance billed to program beneficiaries	203,602			63
64	Allowable bad debts (see instructions)	624,390			64
65	Adjusted reimbursable bad debts (see instructions)	405,854			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	271,179			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	25,396,876			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)	104,501			70.93
70.94	HRR adjustment amount (see instructions)	-21,966			70.94
71	Amount due provider (see instructions)	25,479,411			71
71.01	Sequestration adjustment (see instructions)	509,588			71.01
72	Interim payments	24,491,594			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	478,229			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	701,706			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

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	12,527			1
2	Medical and other services reimbursed under OPPS (see instructions)	13,109,582			2
3	PPS payments	10,733,645			3
4	Outlier payment (see instructions)	121,295			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)	12,527			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	52,656			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)	52,656			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)	52,656			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	40,129			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	12,527			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)	10,854,940			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	1,659			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,113,802			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)	8,752,006			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)	8,752,006			30
31	Primary payer payments	4,421			31
32	Subtotal (line 30 minus line 31)	8,747,585			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)	658,965			34
35	Adjusted reimbursable bad debts (see instructions)	428,327			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	410,838			36
37	Subtotal (see instructions)	9,175,912			37
38	MSP-LCC reconciliation amount from PS&R	495			38
39	Other adjustments ()	910			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	9,176,327			40
40.01	Sequestration adjustment (see instructions)	183,527			40.01
41	Interim payments	9,036,901			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-44,101			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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-S008

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	420			1
2	Medical and other services reimbursed under OPPS (see instructions)	14,234			2
3	PPS payments	9,496			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)	420			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,767			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	1,767			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	1,767			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	1,347			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)	420			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)	9,496			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,884			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)	8,032			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)	8,032			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	8,032			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)	8,032			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	8,032			40
40.01	Sequestration adjustment (see instructions)	161			40.01
41	Interim payments	7,945			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-74			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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		24,025,561		8,570,127
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		350,933		355,674
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	01/22/2016	01/22/2016	111,100
		.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	115,100		111,100
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)		24,491,594		9,036,901
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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-S008

**WORKSHEET E-1
PART I**

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

	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		2,150,480		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. E or Wkst. E-3, line and column as appropriate)		2,150,480		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		11,344,261		7,945
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)		11,344,261		7,945
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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	6,360	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	12,341	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,479	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	29,925	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	468,748,243	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	17,334,655	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-S008

**WORKSHEET E-3
PART II**

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

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,934,057	1
2	Net IPF PPS Outlier payment	428,679	2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	7,661,202	9
10	Teaching adjustment factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,362,736	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	2,362,736	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,362,736	18
19	Deductibles	98,196	19
20	Subtotal (line 18 minus line 19)	2,264,540	20
21	Coinsurance	70,168	21
22	Subtotal (line 20 minus line 21)	2,194,372	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,794	23
24	Adjusted reimbursable bad debts (see instructions)	8,316	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,942	25
26	Subtotal (sum of lines 22 and 24)	2,202,688	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	2,202,688	31
31.01	Sequestration adjustment (see instructions)	44,054	31.01
32	Interim payments	2,150,480	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	8,154	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	11,151,709		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.087100		2
3	Inpatient Rehabilitation LIP payments (see instructions)	715,940		3
4	Outlier payments	85,712		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)	24.076503		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	11,953,361		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)	11,953,361		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	11,953,361		19
20	Deductibles	144,956		20
21	Subtotal (line 19 minus line 20)	11,808,405		21
22	Coinsurance	128,730		22
23	Subtotal (line 21 minus line 22)	11,679,675		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	98,347		24
25	Adjusted reimbursable bad debts (see instructions)	63,926		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,152		26
27	Subtotal (sum of lines 23 and 25)	11,743,601		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)	11,743,601		32
32.01	Sequestration adjustment (see instructions)	234,872		32.01
33	Interim payments	11,344,261		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	164,468		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	286,051		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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0008

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	3,408,330		8
9	5,414,549		9
10			10
11			11
12	8,822,879		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	8,822,879		16
17	8,822,879		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-S008

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	302,545		8
9	136,348		9
10			10
11			11
12	438,893		12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	438,893		16
17	438,893		17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-T008

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	Routine service charges	204,487		8
9	Ancillary service charges	503,032		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	707,519		12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	707,519		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	707,519		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter I, §115.2			43

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	1,107,925				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	15,805,589				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	6,048,920				7
8	Prepaid expenses	8,078,568				8
9	Other current assets	1,553,235				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	32,594,237				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	30,569,312				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)	30,569,312				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	12,228,261				34
35	Total other assets (sum of lines 31-34)	12,228,261				35
36	Total assets (sum of lines 11, 30 and 35)	75,391,810				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	882,362				37
38	Salaries, wages and fees payable	6,193,607				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	651,963				43
44	Other current liabilities	15,708,075				44
45	Total current liabilities (sum of lines 37 thru 44)	23,436,007				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	2,563,723				49
50	Total long term liabilities (sum of lines 46 thru 49)	2,563,723				50
51	Total liabilities (sum of lines 45 and 50)	25,999,730				51
CAPITAL ACCOUNTS						
52	General fund balance	49,392,080				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)	49,392,080				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	75,391,810				60

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		55,338,896			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,494,108			2
3	Total (sum of line 1 and line 2)		56,833,004			3
4	Additions (credit adjustments) (specify)					4
5	NET ASSETS RELEASED FROM RESTRICTIO	363,776				5
6	NET ASSETS TRANSFERRED					6
7	OTHER					7
8						8
9						9
10	Total additions (sum of lines 4-9)		363,776			10
11	Subtotal (line 3 plus line 10)		57,196,780			11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFERS	7,804,700				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		7,804,700			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,392,080			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	TRANSFERS					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	44,743,020		44,743,020	1
2	Subprovider IPF	10,708,218		10,708,218	2
3	Subprovider IRF	27,883,194		27,883,194	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)	83,334,432		83,334,432	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,238,517		6,238,517	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,238,517		6,238,517	16
17	Total inpatient routine care services (sum of lines 10 and 16)	89,572,949		89,572,949	17
18	Ancillary services	134,176,912		134,176,912	18
19	Outpatient services		236,782,953	236,782,953	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		2,608,859	2,608,859	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	ANESTHESIOLOGISTS REVENUE	4,713,978		4,713,978	27
27.01	PHYSICIAN REVENUE	83,873	7,100	90,973	27.01
27.02	CAPITATION		-4,721,172	-4,721,172	27.02
27.03	OCCUPATIONAL HEALTH		1,488,757	1,488,757	27.03
27.04	REGENCY REVENUE		4,688,706	4,688,706	27.04
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	228,547,712	240,855,203	469,402,915	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		200,574,591	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)		200,574,591	43

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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)	469,402,915	1
2	Less contractual allowances and discounts on patients' accounts	330,143,751	2
3	Net patient revenues (line 1 minus line 2)	139,259,164	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	200,574,591	4
5	Net income from service to patients (line 3 minus line 4)	-61,315,427	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	58,102	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	2,753	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	727,674	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	277,002	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	6,259	21
22	Rental of hospial space	795,588	22
23	Governmental appropriations		23
24	Other (specify)		24
24.01	Other (CAPITATION REVENUE)	56,292,638	24.01
24.02	Other (GRANT INCOME)	-162,835	24.02
24.03	Other (OTHER INCOME)	3,020,455	24.03
24.04	Other (PHARMACY INCOME)	1,708,302	24.04
24.05	Other (CLASSES)	36,821	24.05
24.06	Other (TEMP RESTRICTED)	46,776	24.06
25	Total other income (sum of lines 6-24)	62,809,535	25
26	Total (line 5 plus line 25)	1,494,108	26
29	Net income (or loss) for the period (line 26 minus line 28)	1,494,108	29

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	356,819	294,187	55,170	2,965	19,927	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	783,922					6
7	Physical Therapy				243,823		7
8	Occupational Therapy				138,584		8
9	Speech Pathology				6,900		9
10	Medical Social Services	1,352			180		10
11	Home Health Aide	93,516					11
12	Supplies (see instructions)					133,029	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)	1,235,609	294,187	55,170	392,452	152,956	24

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	729,068	-204,394	524,674	-2,735	521,939	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	783,922		783,922		783,922	6
7	Physical Therapy	243,823		243,823		243,823	7
8	Occupational Therapy	138,584		138,584		138,584	8
9	Speech Pathology	6,900		6,900		6,900	9
10	Medical Social Services	1,532		1,532		1,532	10
11	Home Health Aide	93,516		93,516		93,516	11
12	Supplies (see instructions)	133,029		133,029		133,029	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	2,130,374	-204,394	1,925,980	-2,735	1,923,245	24

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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 15-7453

**WORKSHEET H-1
PART I**

		CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE
		0	1	2	3
GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures				1
2	Capital Related-Movable Equipment				2
3	Plant Operation & Maintenance				3
4	Transportation (see instructions)				4
5	Administrative and General	521,939			5
HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	783,922			6
7	Physical Therapy	243,823			7
8	Occupational Therapy	138,584			8
9	Speech Pathology	6,900			9
10	Medical Social Services	1,532			10
11	Home Health Aide	93,516			11
12	Supplies (see instructions)	133,029			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)	1,923,245			24

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		521,939	521,939		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		783,922	291,983	1,075,905	6
7	Physical Therapy		243,823	90,816	334,639	7
8	Occupational Therapy		138,584	51,618	190,202	8
9	Speech Pathology		6,900	2,570	9,470	9
10	Medical Social Services		1,532	571	2,103	10
11	Home Health Aide		93,516	34,832	128,348	11
12	Supplies (see instructions)		133,029	49,549	182,578	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)		1,923,245		1,923,245	24

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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					-521,939	1,401,306	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care						783,922	6
7	Physical Therapy						243,823	7
8	Occupational Therapy						138,584	8
9	Speech Pathology						6,900	9
10	Medical Social Services						1,532	10
11	Home Health Aide						93,516	11
12	Supplies (see instructions)						133,029	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)					-521,939	1,401,306	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						521,939	25
26	Unit Cost Multiplier						0.372466	26

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		19,353		230,091	13,146	5,722	1
2	Skilled Nursing Care	1,075,905						2
3	Physical Therapy	334,639						3
4	Occupational Therapy	190,202						4
5	Speech Pathology	9,470						5
6	Medical Social Services	2,103						6
7	Home Health Aide	128,348						7
8	Supplies	182,578						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)	1,923,245	19,353		230,091	13,146	5,722	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	4,142	7,073		279,527	57,637	81,434	1
2	Skilled Nursing Care				1,075,905	221,847		2
3	Physical Therapy				334,639	69,001		3
4	Occupational Therapy				190,202	39,219		4
5	Speech Pathology				9,470	1,953		5
6	Medical Social Services				2,103	434		6
7	Home Health Aide				128,348	26,465		7
8	Supplies				182,578	37,647		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)	4,142	7,073		2,202,772	454,203	81,434	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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	33,070		37,660				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)	33,070		37,660				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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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				19,613			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)				19,613			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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	508,941		508,941				1
2	Skilled Nursing Care	1,297,752		1,297,752	284,713	1,582,465		2
3	Physical Therapy	403,640		403,640	88,554	492,194		3
4	Occupational Therapy	229,421		229,421	50,332	279,753		4
5	Speech Pathology	11,423		11,423	2,506	13,929		5
6	Medical Social Services	2,537		2,537	557	3,094		6
7	Home Health Aide	154,813		154,813	33,964	188,777		7
8	Supplies	220,225		220,225	48,315	268,540		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)	2,828,752		2,828,752	508,941	2,828,752		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.				0.219389			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: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	2,702		1,235,609	1,586	15	10,767	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	2,702		1,235,609	1,586	15	10,767	20
21	Total cost to be allocated	19,353		230,091	13,146	5,722	4,142	21
22	Unit Cost Multiplier	7.162472		0.186217		381.466667		22
22	Unit Cost Multiplier				8.288777		0.384694	22

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	2,608,859			279,527	2,702	2,702	1
2	Skilled Nursing Care				1,075,905			2
3	Physical Therapy				334,639			3
4	Occupational Therapy				190,202			4
5	Speech Pathology				9,470			5
6	Medical Social Services				2,103			6
7	Home Health Aide				128,348			7
8	Supplies				182,578			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)	2,608,859			2,202,772	2,702	2,702	20
21	Total cost to be allocated	7,073			454,203	81,434	33,070	21
22	Unit Cost Multiplier	0.002711				30.138416		22
22	Unit Cost Multiplier				0.206196		12.239082	22

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		2,702					1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		2,702					20
21	Total cost to be allocated		37,660					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		13.937824					22

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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			2,608,859				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)			2,608,859				20
21	Total cost to be allocated			19,613				21
22	Unit Cost Multiplier			0.007518				22
22	Unit Cost Multiplier							22

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	1,582,465		1,582,465	13,966	113.31
2	Physical Therapy	3	492,194		492,194	3,930	125.24
3	Occupational Therapy	4	279,753		279,753	1,871	149.52
4	Speech Pathology	5	13,929		13,929	100	139.29
5	Medical Social Services	6	3,094		3,094	21	147.33
6	Home Health Aide	7	188,777		188,777	4,663	40.48
7	Total (sum of lines 1-6)		2,560,212		2,560,212	24,551	

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		9,375		8
9	Physical Therapy	23844		2,612		9
10	Occupational Therapy	23844		1,189		10
11	Speech Pathology	23844		57		11
12	Medical Social Services	23844		17		12
13	Home Health Aide	23844		3,655		13
14	Total (sum of lines 8-13)			16,905		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	268,540		268,540	391,662	0.685642
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	0.401502			col. 2, line 2	1
2	Occupational Therapy	67	0.325769			col. 2, line 3	2
3	Speech Pathology	68	0.491974			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.415047			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.237910			col. 2, line 16	5

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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		9,375			1,062,281		1,062,281	1
2	Physical Therapy		2,612			327,127		327,127	2
3	Occupational Therapy		1,189			177,779		177,779	3
4	Speech Pathology		57			7,940		7,940	4
5	Medical Social Services		17			2,505		2,505	5
6	Home Health Aide		3,655			147,954		147,954	6
7	Total (sum of lines 1-6)		16,905			1,725,586		1,725,586	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			378,835			259,745		15
16	Cost of Drugs								16

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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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 B			
		Part A	Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
		1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to 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		6,951		9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)		-6,951	10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,551,957	11
12	Total PPS Reimbursement - Full Episodes with Outliers		253,203	12
13	Total PPS Reimbursement - LUPA Episodes		13,937	13
14	Total PPS Reimbursement - PEP Episodes		24,088	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		44,676	15
16	Total PPS Outlier Reimbursement - PSP Episodes		1,075	16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		1,881,985	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,881,985	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,881,985	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)		1,881,985	29
30	Other adjustments (see instructions) (specify)		33	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,882,018	31
31.01	Sequestration adjustment (see instructions)		37,640	31.01
32	Interim payments (see instructions)		1,844,378	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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				1,844,378	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)				1,844,378	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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ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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	1,673,298	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	32,354	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)	82.49	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)	0.1222	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.3809	8
9	Sum of lines 7 and 8	0.5031	9
10	Allowable disproportionate share percentage (see instructions)	0.1073	10
11	Disproportionate share adjustment (see instructions)	179,545	11
12	Total prospective capital payments (see instructions)	1,885,197	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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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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

KPMG LLP Compu-Max 2552-10

ST. CATHERINE HOSPITAL Provider CCN: 15-0008	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 08:02 Version: 2016.05 (11/01/2016)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	MAINTENANCE OF PERSONNEL						4.01
5.01	NONPATIENT TELEPHONES						5.01
5.02	PURCHASING RECEIVING & STORES						5.02
5.03	ADMITTING						5.03
5.04	CASHIERING ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMIN & GENERAL						5.05
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
40	Subprovider - IPF						40
41	Subprovider - IRF						41
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	ULTRASOUND						54.01
54.02	AUDIOLOGY						54.02
56	Radioisotope						56
57	CT Scan						57
59	Cardiac Catheterization						59
60	Laboratory						60
62	Whole Blood & Packed Red Blood Cells						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.02	NONINVASIVE LAB						63.02
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75.01	ONCOLOGY						75.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
90.01	OP PSYCH						90.01
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
194	OTHER NON REIM COST CENTER						194
194.01	RETAIL PHARMACY						194.01
194.03	ADVERTISING EXPENSE						194.03
194.04	REGENCY HOSPITAL						194.04
194.05	UNUSED SPACE						194.05
200	Cross Foot Adjustments						200

KPMG LLP Compu-Max 2552-10

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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) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
201	Negative Cost Centers	0	2A	24	25	26		201
202	TOTAL (sum of lines 118-201)							202